



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased and family by the direction of the Coroner pursuant to s 57(1)(c) of the Coroners Act 1995)

I, Madeleine Wilson, Coroner, having investigated the death of ZC.

Find, pursuant to Section 28(1) of the *Coroners Act 1995*, that.

- a) The identity of the deceased is ZC, whose date of birth is 25 July 1958.
- b) ZC died in an accidental house fire in the circumstances set out further in this finding.
- c) ZC's cause of death is unable to be determined.
- d) ZC died between 8 and 9 November 2024.

In making the above findings I have had regard to the evidence gained in the investigation into ZC's death which includes:

- The Police Report of Death for the Coroner;
- Report confirming identity;
- Medical records;
- Ambulance Tasmania guidelines relating to delivery of service to people with mental illnesses;
- Tasmania Police guidelines relating to delivery of service to people with mental illnesses
- Memorandum of Understanding between Tasmania Health Service, Ambulance Tasmania and Tasmania Police relating to delivery of service to people with mental illnesses;
- Affidavit of PL;
- Affidavit of Paul Hodgson;
- Affidavit of Kate Pennington;
- Affidavit of Claire Taylor;
- Affidavit of NY;

- Affidavit of Constable Christopher Richardson;
- Report of Fire Investigation Officer James Foster; and
- Report of Forensic Pathologist Dr Donald Ritchey.

Background

ZC, 66, was single and in receipt of a disability support pension.

ZC was born in Melbourne and grew up in Springvale with his parents and sister.

ZC was a singer, guitarist, songwriter and sound engineer. He was heavily involved in music at a community level; he was a co-founder of the Central Vic Jazz Club in 1987, created a music program for a youth justice program and taught music at Loddon Prison in Castlemaine, Victoria. He later ran his own recording studio, produced music albums, managed artists and toured Australia as a sound engineer for numerous large festivals and major events. He had been married twice and had three children. He moved to Tasmania in 2014.

Circumstances surrounding death

ZC owned a three-bedroom Queenslander style house at 6 Beattie Avenue, Bicheno, where he lived alone.

The house featured an open plan living and kitchen area with access obtained from the front door via a set of stairs. A hallway off the open plan area led to three bedrooms, a bathroom and a laundry. A back door and rear stairwell were situated at the end of the laundry, approximately halfway along the building, facing the boundary of 8 Beattie Avenue. A storage area under the house, of equal floor area, was at ground level. The structure was timber weatherboard with clip lock iron roof, and a timber walled storage area which was designed to be well ventilated.

ZC had a long history of mental illness. He had been diagnosed with bipolar disorder in his 40's and was prescribed lithium. He had been admitted to the Northside Mental Health Unit at Launceston General Hospital (LGH) numerous times between 2017 and 2023. In between admissions he was treated in the community by the Adult Community Mental Health Service North (ACMHSN) until early 2023 when he was discharged into the care of his general practitioner. Following discharge for a subsequent admission at Northside in November 2023, he engaged with Statewide Mental Health Services (SMHS) through the Adult Continuing Care Team. The medical records illustrate that the service engaged with him through a combination of phone calls and home visits, including a home visit on

16 October 2024 by his case worker and a Resident Medical Officer (Psychiatry). The medical notes of that visit indicate that ZC's bipolar affective disorder was assessed as being "currently stable" and he had a treatment plan to continue engaging with a psychologist. A psychiatry review was scheduled for three months' time, but earlier if needed. A further home visit was attempted on 30 October 2024; however, ZC was not present when the Continuing Care Team arrived.

Friends and relatives became concerned that ZC's mental health was declining in the days leading up to his death.

On Friday 8 November 2024 police and ambulance services attended ZC's home at 6 Beattie Avenue for a welfare check.

Attending police officers activated their Body Worn Camera (BWC) and the interactions between the police officer, a paramedic and ZC were recorded.

A paramedic assessed ZC as having capacity to make decisions about his mental health. ZC declined transport to the Launceston General Hospital for a mental health assessment. ZC indicated that he intended to cook himself a meal and have an early night.

The BWC recorded that at the time of the attendance two candles were burning in the house. The police officer extinguished one candle in ZC's bedroom. A second lit candle was situated on top of a radiogram inside the front door entrance to the house.

The BWC also captured two smoke alarms installed on the walls of the house, one in the main bedroom and one in the hallway.

Police left the house at approximately 7:30pm. Ambulance Tasmania records indicate that they departed at 8:10pm.

At approximately 1:00am on 9 November 2024, an occupant of the Airbnb adjacent to ZC's house, woke to the sound of a fire alarm coming from 6 Beattie Avenue. They observed that the house was well alight and contacted emergency services.

Tasmania Fire Service attended the scene at 1.23am, at which time there was significant fire development extending throughout the structure. Firefighters observed that the whole house was "half gone already" and smoke was seen coming from the wall and roof of the

adjacent cottage with spot fires visible on the block at 8 Beattie Avenue. The timber fence between numbers 6 and 8 Beattie Avenue had burnt through near the cottage. A large eucalypt tree was on fire, and several other fires were burning to the back of number 6 Beattie Avenue. A station wagon was alight in the driveway and the house itself was fully engaged. Several firefighting crews attended and assisted in fighting the fire. The fire was brought under control at approximately 3.18am.

An investigation was commenced by James Foster, Regional Fire Investigator North/North West, Tasmania Fire Service at 9.00am on 9 November 2024 to determine the origin and cause of the fire.¹ He subsequently produced an extensive Fire Investigation Report.

External observations of number 6 Beattie Avenue revealed a total structural collapse of the building with timber components displaying char depth which varied by exposure time and intensity. The fire effects observed were consistent with a fully involved structure fire in a timber-framed house, exhibiting rapid fire spread, high heat release and ventilation-driven behaviour. Mr Foster observed that the patterns aligned with expected fire dynamics in timber structures.

Located within the fire debris were charred partial remains of a body. The body was in the vicinity of the laundry with feet closest to the hallway and head closest to the back door indicative of an attempt to self-extricate towards the back door, away from the fire origin and progression.

Mr Foster determined that the fire emanated from a competent ignition source, namely an open flame in the form of a candle and/or kerosene lamp, igniting a competent fuel source, being a laminated radiogram and/or drapery adjacent to the front door. Remnants of an open candle holder in the shape of a fish and a kerosene lamp were recovered from the scene. In Mr Foster's opinion the fire may have started as a smouldering fire in the vicinity of the radiogram, which once established quickly spread through the room, fuelled by additional combustibles such as window furnishings and nearby furniture. Mr Foster said at no stage of his investigation was there evidence found suggestive of ignition from

¹ Mr Foster holds all relevant qualifications in fire cause determination required by Tasmania Fire Service. He is nationally accredited in Fire Investigation and has completed a number of other relevant units. Mr Foster's qualifications and experience are set out in his comprehensive Fire Investigation Report. I accept that Mr Foster has the expertise to provide opinion evidence as to the cause of the fire.

an incendiary, electrical, mechanical, chemical or natural source. Mr Foster found that there was evidence of carelessness with candles by failing to use a properly contained candle holder and the placement of the candle near drapes, the potential for hot wax to drip and the prospect the candle had not been extinguished before ZC went to sleep. Mr Foster classified the cause of the fire as accidental.

I accept Mr Foster's opinion and find the fire was accidental, most likely the result of carelessness on the part of ZC, by failing to extinguish an open flame from a candle and/or kerosene lamp when he went to bed. This resulted in the flame igniting a laminated radiogram and/or drapes next to the front door of the residence, which once established quickly took hold.

ZC's body was removed from the house and transported to the Hobart Mortuary.

The charred remains were examined Dr Donald Ritchey, a Forensic Pathologist, he noted that the partial remains had been recovered from the site of a house fire and appeared extensively incinerated. There were no samples available for toxicology testing. A postmortem CT scan revealed no evidence of projectiles or unexpected findings. Dr Ritchey was unable to determine the cause of death.

During autopsy, a sample was taken from the spleen of the remains, which was forwarded to Forensic Science Services Tasmania for DNA profiling. A reference sample was also received from PL, the biological daughter of ZC, for comparison purposes. DNA profiling provided extremely strong support for the deceased being ZC.²

I am satisfied that the charred remains located at the scene of the fire at 6 Beattie Avenue, Bicheno were those of ZC.

A police investigation determined that there were no suspicious circumstances.

Mental health prior to fire

In the days leading to his death, friends and family had expressed concern that ZC's mental health was declining. ZC consulted his general practitioner at Bicheno General Practice on 6 November 2024 and arranged for a follow up appointment on 8 November 2024. When ZC failed to attend that appointment, his GP telephoned Tasmania Police and requested a welfare check.

² Report of Damian Crowle, Forensic Scientist dated 11 December 2024.

Senior Constable Christopher Richardson had been stationed at Bicheno Police Station since November 2019. He knew ZC as a member of the local community and had dealt with him in relation to his mental health on several occasions. He was aware that ZC had been transported to the Launceston General Hospital on a number of occasions since November 2019 for treatment related to his mental health.

On Wednesday 6 November 2024 at approximately 5.00pm Senior Constable Richardson was contacted by a civilian who told him that ZC's mental health was "starting to slide again".

On Thursday 7 November 2024 at approximately 9.00am Senior Constable Richardson attended ZC's house at 6 Beattie Avenue to check on him. He perceived ZC's conversation to be scattered and unstructured. ZC told him he had attended the locum General Practitioner the day before and had another appointment on the following Monday. Senior Constable Richardson verified this information with the Doctor's surgery. Senior Constable Richardson was given the phone number for ZC's mental health case worker in Launceston and telephoned the phone number. Senior Constable Richardson was told that the case worker was unavailable. He spoke to the Team Leader who advised him that they were aware that ZC's mental health was in decline.

On Friday 8 November 2024, while attending a funeral in Hobart, Senior Constable Richardson received a text message and a voice mail message from two sources informing him that ZC's mental health was in decline. He responded to both messages and requested that the callers contact Ambulance Tasmania to assist ZC. At 3.45pm Senior Constable Richardson's supervisor, Senior Sergeant Robert Baker telephoned him saying he had received a request to assist Ambulance Tasmania with ZC in response to concerns for his mental health, but he was attending a job at Triabunna and was unable to assist. Upon Senior Constable Richardson's return to Bicheno, he made enquiries of Radio Dispatch who advised him that Ambulance Tasmania had not attended the address as Police were unavailable to assist. Arrangements were made for Senior Constable Richardson to meet an Ambulance crew from Swansea at the Bicheno Police Station. Senior Constable Richardson informed the Paramedic, that ZC was known to him and advised him that "really just required a visit to the LGH for a few days for a medication reset".

Upon arrival at 6 Beattie Avenue, Senior Constable Richardson activated his body worn camera (BWC). The interactions between ZC and the emergency responders were recorded.

The attending paramedic spent approximately 55 minutes with ZC.

The VACIS Electronic Patient Care Record completed for the attendance on 8 November 2024 records that Ambulance Tasmania responded to a mental health check as ZC had been observed in his front yard wearing underpants. On arrival he was walking in the house, fully clothed, alert, interactive, warm, pink, dry and no ABC threat.³ ZC was assessed as having normal mental status, noting that he had capacity to make decisions regarding healthcare and could clearly and coherently explain recent events. He expressed “this is ridiculous I’m not allowed to even walk around my house without being made to feel I’m doing something wrong”. He denied auditory or visual hallucinations, advised that he had been taking regular medications as prescribed by a GP and denied suicidal ideation or threats of harm towards himself or others. The notes record that someone identified as “41” had been advocating for ZC’s transportation to an Emergency Department. The paramedic advised ZC he had the capacity to make decisions regarding healthcare and transport to the Emergency Department offered by Ambulance Tasmania but that if he did not feel at risk and would prefer to stay at home then he had the right to decline the offer of voluntary transportation. ZC indicated that he did not feel at risk, had no thoughts of self-harm or suicidal ideation and had been “having a good day until this happened as he didn’t think he had done anything wrong”. He indicated he “had intended to go to the RSL for dinner but will now be too late”, given the time taken for assessment. ZV was advised that if he felt his mental health was declining, he should call 000 and transport to the Emergency Department could be arranged. The notes record the paramedic’s observation that:

“the patient is voluntary and has capacity to make decisions regarding healthcare and is comfortable with staying home tonight. Intends to eat dinner and have evening medication (including temazepam to assist sleep) and go to bed. Pt⁴ to see regular GP/psych team on Monday. 41 believes pt is beginning to show signs of deteriorating mental health however no clinical red flags present to

³ ABC is a reference to checking Airways, Breathing and Circulation.

⁴ Patient

AT⁵ at time of assessment and as explained Pt has the right to make own medical decision”.

Pursuant to section 17 *Mental Health Act 1996* “the Act” a mental health officer (MHO) or police officer may temporarily detain a person for the purpose of assessing the person if the MHO or police officer reasonably believes that the person has a mental illness and the person should be assessed against the assessment criteria and the person’s safety or the safety of other persons is likely to be at risk if the person is not so detained.

A Memorandum of Understanding (MOU) between Tasmania Health Service, Ambulance Tasmania and Tasmania Police addresses the delivery of services to people with mental illnesses. It provides, inter alia, that protective custody, transport and escort of people with mental illnesses should occur in the least restrictive way consistent with the need to protect the person and the public; that patients should not be taken into protective custody if they can be properly examined and assessed against the assessment criteria or treatment criteria without being taken into protective custody, wherever practicable the use of non-police custodians, escorts and assistants is to be preferred and that the Tasmania Health Service and Ambulance Tasmania are the lead agencies in instances where there is no violence or significant risk of violence. Tasmania Police is the lead agency in instances where there is violence or significant risk of violence.

Ambulance Tasmania provide documentary guidance to paramedics undertaking a mental status assessment when evaluating a patient’s mental function. The document addresses the person’s appearance, behaviour, speech, mood, response, perceptions, thought content, thought flow and concentration.

The VACIS records for the attendance on ZC on the 8 November 2024 note that there were no signs of altered conscious state and that his behaviour, concentration, eye movement, insight, mood, perceptions, speech and thought appeared normal. ZC’s personal appearance was neat and clean, extraocular movements were not present. He was assessed as having capacity to make medical decisions; as demonstrated by him being able to clearly explain recent events and his plan for the evening. He denied auditory or visual hallucinations. His GCS⁶ score was assessed as 15 at 7.20pm and 7.30pm.

⁵ Ambulance Tasmania

⁶ Glasgow Coma Scale is a clinical tool used to objectively assess a patient’s level of consciousness. The Scale ranges from 3-15, with lower scores indicating greater injury severity.

The paramedic assessed ZC against the appropriate guidelines and formed a view that ZC had decision making capacity and that there were not reasonable grounds for detaining ZC for the purpose of an assessment. An offer was made to transport ZC to the LGH for assessment if he wished, however he declined. ZC confirmed he had an appointment to see his general practitioner the following Monday 11 November 2024.

Senior Constable Richardson formed the view that ZC was no longer going to voluntarily accompany Ambulance Tasmania to the LGH and that as ZC was not posing a threat to Ambulance Tasmania staff his attendance was no longer required and he left.

ZC was not transported and Ambulance Tasmania left at 8.10pm.

I find that Ambulance Tasmania and Tasmania Police complied with the MOU and guidelines produced by their respective agencies.

I find that Ambulance Tasmania's decision not to take ZC into protective custody on 8 November 2024 was soundly based, following a detailed appraisal by a paramedic. Further, I find that despite concerns that ZC's mental health "was slipping", he had the capacity to make decisions about his medical care and to decline the offer of transportation to the LGH for voluntary admission on 8 November 2024.

I am unable to find that the act of failing to extinguish the flame before going to bed was directly related to ZC's poor mental health and not due to simple carelessness. I make the observation that the presence of the lit candle in the living room did not appear to raise concerns for emergency services during their attendance at the home earlier in the night.

The role of the Coroner

In Tasmania a coroner has jurisdiction to investigate a death if it appears to the coroner that the death is or may be a reportable death.⁷

A reportable death is defined in s3 of the *Coroners Act* 1995 "The Act" and includes a death that occurred in Tasmania, being a death that appears to have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury.

⁷ Section 21(1) Coroners Act 1995

The coroner's role under the Act in investigating any reportable death is inquisitorial. A coroner must investigate the death and determine the matters required by s28(1) of the Act. Those matters include the identity of the deceased, how the deceased died, the cause of death and when and where the deceased died.

The phrases "how death occurred" and "the cause of death" were considered in *Re The State Coroner; ex parte The Minister for Health* [2009] WASCA 165. The court was considering s25(1) of the Coroners Act 1996 (WA) which is virtually identical to s28(1) of the Coroners Act 1995 (Tas). Buss JA, with whom Martin CJ and Miller JA agreed, analysed s25 (1)(b) and (c) in the following terms:

"40 The dictionary meaning of the expression 'how death occurred' is in what way or manner or by what means the death happened or took place. See The Macquarie Dictionary (4th ed, 2002) 694; The Shorter Oxford English Dictionary (5th ed, 2002) 1279

41 However, 'how death occurred' in s25(1)(b) of the Act must be construed not merely by reference to its dictionary meaning, but also in the context of the other provisions of s25(1) and the Act as a whole. For example, the Parliament plainly intended that a finding of 'how death occurred' within s25(1)(b) would be different from a finding of 'the cause of death' within s25(1)(c).

42 In my opinion, s25(1)(b) confers on the coroner the jurisdiction and obligation to find, if possible, the manner in which the deceased happened to die. This does not refer only to the means or mechanism by which the death was suffered or inflicted. It extends to the circumstances attending the death. In my opinion, a construction of s25(1)(b) which entitles and requires the coroner to find, if possible, by what means and in what circumstances the death occurred reflects the public interest which is protected and advanced by a coronial investigation (especially an investigation into deaths where one or more of the conditions of s22(1) of the Act are satisfied)."

Buss JA then considered the phrase "cause of death" at [44]- [47]:

“44 The coroner, in finding, if possible, ‘the cause of death’, is not confined or restricted by concepts such as ‘direct cause’, ‘direct or natural cause’ ‘proximate cause’ or the ‘real or effective cause’. Similarly, a coroner is not confined or restricted to a cause that was reasonably foreseeable. See WRB Transport v Chivell [1998] SASC 7002; (1998) LSJS 102 [20] (Lander J, Mullighan J agreeing).

45 In WRB Transport, Lander J said, in the course of considering the coroner’s jurisdiction under s12 of the Coroners Act 1975 (SA) to ascertain ‘the cause or circumstances of the ...death of any person...’:

The Coroner... has to carry out an inquiry into the facts surrounding the death of the deceased to determine what, as a matter of common sense, has been the cause of that person’s death. The inquiry will not be limited to those facts which are immediately proximate in time to the deceased’s death. Some of the events immediately proximate in time to the death of the deceased will be relevant to determine the cause of the death of the deceased. But there will be other facts less proximate in time which will be seen to operate, in some fact situations, as a cause of the death of the deceased. That is a factual inquiry which only has, as its boundaries, common sense [21].

His Honour added that the coroner’s jurisdiction to determine the cause of a deceased’s death is in addition to his or her jurisdiction to determine the circumstances of the deceased’s death [22]- [25]. See also Saraf v Johns [2008] SASC 166; (2008) 101 SASR 87 [18] –[19] (Debelle J).

46 Section 25(1)(c) does not, however authorise a coroner to undertake a Roving Commission for the purpose of inquiring into any possible causal connection, no matter how tenuous, between an act, omission or circumstance on the one hand and the death of the deceased on the other. See R v Doogan; Ex parte Lucas-Smith [2005] ACTSC 74; (2005) 193 FLR 239 (28) (Higgins CJ, Crispin & Bennett JJ).

47 It will be necessary, in any inquest, to delineate those acts, omissions and circumstances which are, at least potentially, to be characterised as causing or a cause of the death of the deceased. This is to be undertaken by applying ordinary common sense and experience to the facts of the particular case. See March v E & MH Stramare Pty Ltd [1991] HCA 12; (1991) 171 CLR 506, 515 (Mason CJ), 522 (Deane J); WRB Transport [21]; Saraf [18]- [19]; Doogan [29]"

Family's concerns

The family of ZC have raised a number of concerns related to the long-term medical management of ZC, citing the lack of acute mental health response capacity on the East Coast of Tasmania, under resourced mental health teams, better support for family members, consistency of care in the management of ZC's condition and concerns about access to patient's medical history by treating doctors and their reliance on family members to provide background information.

I consider those concerns to have an insufficient nexus to the issues which I am required to address, in so far as they relate to the manner and cause of death of ZC in a house fire between 8- 9 November 2024 or the assessment of the paramedic that ZC had capacity to choose not to be transported to the LGH on the 8 November 2024.

Comments and recommendations

In his Fire Investigation Report, Mr Foster stated that:

"In reconstruction of the fire scene, knowledge of whether and when a smoke alarm sounded, or smoke detector activated during the fire is valuable data. Interviews with witnesses provide insight that there were working smoke alarms and they were activating at the time of the 000 call. Axon Bodycam from Tasmania Police⁸ confirms that there were at least two smoke alarms within the premises, one in the main bedroom and one in the hallway. However, the position of these alarms installed on the wall and not installed on the ceiling is not recommended by the Tasmania Fire Service. A working smoke alarm installed on

⁸ Body Camera Footage from Senior Constable Richardson's attendance at ZC's residence on 8 November 2024 was made available to Mr Foster.

the ceiling allows for timely activation to alert occupants in the early stages of a fire.”

It is not possible to say whether installing the working fire alarms on the ceiling of the residence would have activated any sooner than those installed on the walls, and if so, whether it would have allowed sufficient time for ZC to extricate himself via the laundry door.

The need for properly fitted and working smoke alarms in residential accommodation has been the subject of numerous coronial comment and recommendations in the past. Similarly, the inherent dangers associated with leaving open flames unattended are well known. As such, the circumstances of ZC's death are not such as to require me to make recommendations pursuant to Section 28 of the *Coroner's Act 1995*.

I extend my appreciation to Senior Sergeant Robert Baker and Fire Investigation Officer James Foster for their respective investigations and reports.

I convey my sincere condolences to the family and loved ones of ZC.

Dated: 15 May 2026 at Hobart, in the State of Tasmania.

Madeleine Wilson
Coroner