MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Madeleine Wilson, Coroner, having investigated the death of William John Dick

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

a) The identity of the deceased is William John Dick, date of birth 19 May 1960.

b) Mr Dick, known as "John", was born to Don and Marjory Dick. He had an older half-sister, Janice and a younger sister, Helen. He was raised in Burnie and Devonport and completed schooling to the end of year 10. Aside from a short period working in a commercial laundry, Mr Dick was unemployed and in receipt of a disability pension. Mr Dick did not have a partner or children. He lived a reclusive lifestyle and preferred his own company. He resided at a boarding house at 11/63 Goulburn Street, in Hobart.

Shortly before 10.45am on 2 June 2024, Dipti Gill was at her unit at 12/63 Goulburn Street, West Hobart when she heard a loud thumping noise from the adjoining unit. She went outside and observed Mr Dick to push open the door of his unit, he was covered in flames, screaming in pain and trying to put out the fire on him. Bystanders tried to extinguish the flames with water and emergency services were contacted. Police arrived at 10.50am and observed smoke spilling from the doorway of Mr Dick's unit. Police found Mr Dick sitting at the base of a set of stairs with obvious severe burns. Attempts were made to relocate Mr Dick so that water could be applied to his burns and an Ambulance was tasked to attend. At the same time, Tasmania Fire Service arrived at the scene and extinguished the fire, which had been contained to Mr Dick's unit.

Upon arrival, Ambulance Tasmania observed Mr Dick sitting on the street, with partial and full thickness burns to his right upper leg to knee, right and left buttocks, right and left shoulders, two-thirds of his back, his scalp, and his right and left arms. Mr Dick was observed to have soot and charring present on his face and head. He was alert and not suffering any respiratory distress. Mr Dick told paramedics that he had been sitting on his mattress, playing with paper and fire and that the mattress caught fire. Mr Dick said he rolled off the bed. It was noted that Mr Dick was a poor historian and appeared to be in shock. Mr Dick's upper clothing was removed and Tasmanian Fire Service applied water from a fire hose to his body, until he was able to be lifted onto a stretcher and transported to the Royal Hobart Hospital (RHH).

Forensic Pathology

Mr Dick's medical history included type II diabetes mellitis, hypertension, obesity (BMI: 45.7), chronic atrial fibrillation, hypercholesterolemia, and autism.

The medical records indicated that Mr Dick had been intubated and ventilated. He had not sustained any burns to his airways. He underwent emergency procedures on the day of admission for burns scrub and debridement. He was treated in the Intensive Care Unit (ICU) by Burns nurses who attended to regular burns dressings. His stay in ICU was complicated by mild multi-organ dysfunction. Mr Dick's next of kin refused consent for further intervention including further wound debridement and grafting due to his guarded prognosis following extensive burns, his complex comorbidities and Mr Dick's difficulty engaging with the health system due to his autism and his goals of care were changed to comfort care. In consultation with his next of kin, arrangements were made for Mr Dick to donate his organs. He died on 8 June 2024 at 11.08am.

State Forensic Pathologist, Dr Andrew Reid examined the body of Mr Dick. He had sustained thermal burns to 47.5% of his total body surface area (BSA).

In Dr Reid's opinion, death was caused by multiorgan dysfunction and progressive failure, following complications of the BSA burns, but noted that the extent of the BSA burns were sufficient alone to cause death.

An investigation into the fire and the circumstances surrounding Mr Dick's death was commenced. The police investigation identified no suspicious circumstances or the involvement of a person, other than Mr Dick.

Tech Safe and Tasmania Fire Service Fire Investigator attended the scene.

Tech Safe ruled out any electrical components being involved in the cause of fire.

Fire investigation

Timothy McKay[1], Regional Fire Investigator commenced an investigation into the fire. He observed that the building at 63 Goulburn Street was a three-storey structure, which was externally clad in a combination of bricks and rendered masonry. The roof was clad in a combination of tiles and corrugated iron roof sheeting which was being replaced at the time. Scaffolding to the front of the building used for the roof replacement caused significant restriction to entry and egress from the structure.

The fire was largely confined to unit number 11, which was located on the ground floor and accessed via a single access door underneath the main front stairway. There was no other means of entry or exit from unit 11 other than through window openings which were also obstructed by the scaffolding.

Mr McKay observed that the unit had an "L- shaped" floor plan, with a living area and passageway, off which is located a bedroom and kitchenette. There was no bed in the bedroom, rather the bed was located immediately inside the front entrance door in the living room.

Mr McKay observed that the unit was internally lined with plasterboard and the floor coverings were carpet and tiles. There were only two windows, in the bedroom and bathroom. The bedroom window was furnished with fabric curtains.

Mr McKay observed that the internal fuel load was very high for the space, with furnishings and household items stored consistently with hoarding behaviour, which likely restricted free movement within the unit.

[1] Mr McKay's extensive training, study, and experience is set out in his Fire Investigation Report (C8). I accept Mr McKay has specialised knowledge in respect of Fire Investigation and accept the expert opinions expressed by him in his report.

As part of his investigation, Mr McKay conducted preliminary witness interviews and information gathering. Once firefighting operations to extinguish the fire were concluded, the scene was transferred to Mr McKay who conducted a detailed scene examination, to determine the origin of the fire.

An external examination of the structure revealed that all externally visible fire indicators were localised to the area immediately above and around the single-entry door and window openings of unit 11. Fire language disclosed there had been ventilation of flame through the door opening, but not through the windows associated with the bedroom and bathroom.

An internal examination of the unit identified numerous fire effects and indicators, which demonstrated greater mass loss and consumption by fire of combustible materials in the area of and immediately around the bed, with thermal damage decreasing in extent and severity away from that area. This was consistent with burning of a longer duration in the area of the bed and mattress.

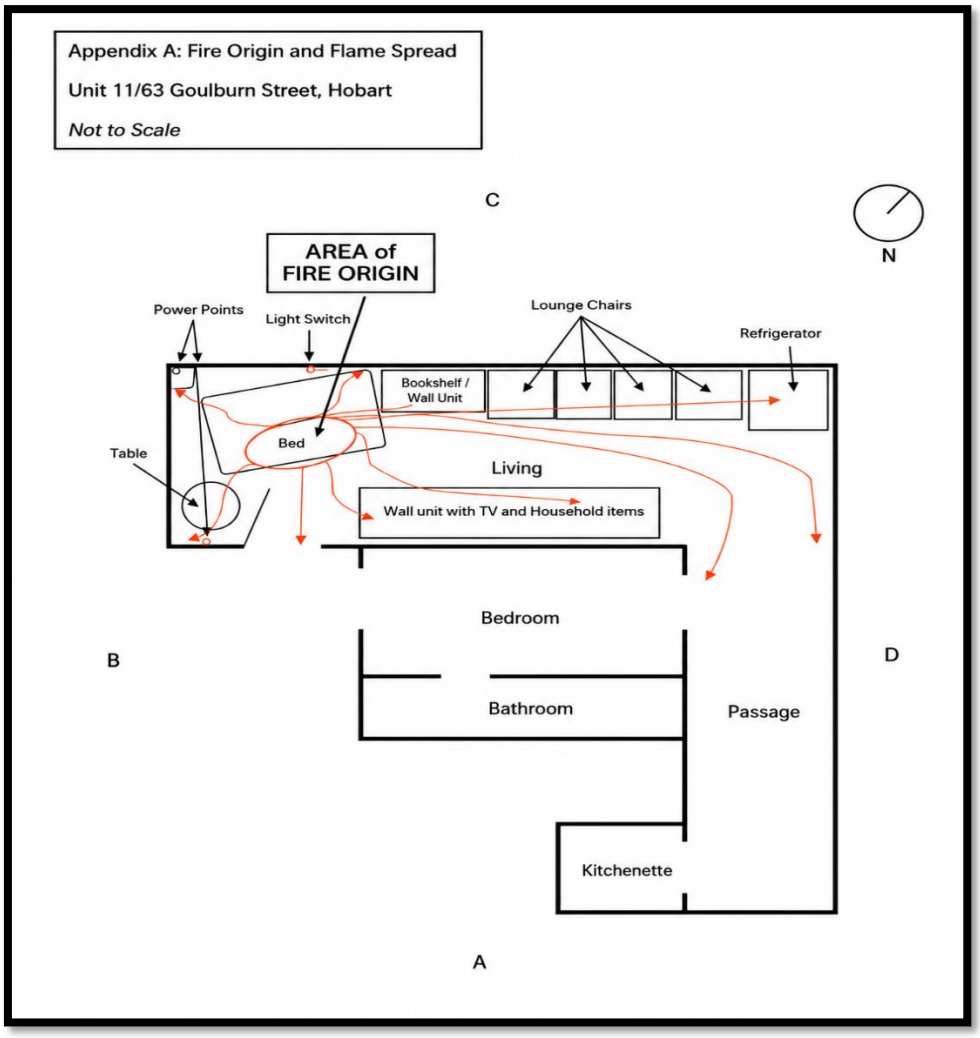
Conversely, the deposition of soot to structural surfaces of the passage, bedroom, bathroom, and kitchenette, but absence of clean burn or calcification of plasterboard in these rooms was consistent with smoke and heated gasses having been present within these areas but limited to no flame activity occurring in these areas. The areas of calcination and clean burn to walls and ceiling at the junction of the living area and mass loss, deformation and discoloration of materials and furnishings within the living area and kitchenette all indicated a direction of fire travel from the area of the living area, consistent with thermal impact from the area of the bed.

Prominent flame vector patterns of calcination and clean burn to internal walls and ceiling were consistent with fire emanating from the mattress and spreading from there to throughout the living area.

Other indicators, including charring to ceiling timbers localised to the area immediately over the bed with a decrease in extent and severity therefrom and the complete consumption of electrical outlets such as switches and power points localised to the area around the bed, (while others remained largely unaffected throughout the unit) and the complete consumption of mattress fabric and upholstery were also noted.

In Mr McKay's opinion the fire effects and patterns, in aggregate and individually were consistent with fire emanating from the bed located immediately inside the entry door to unit 11.

Mr McKay reproduced a plan of the unit showing the area of fire origin and flame spread.



Mr McKay did not locate any smoke alarms or the remains of smoke alarms either affixed to the ceiling or walls of the unit or within the fire debris from unit 11.

Based on his detailed scene examination and the fire damage dynamics and observable physical fire indicators, as well as information gained from his investigation, Mr McKay identified a single area of fire origin within the main living area of unit 11, located on the ground floor of the building. In his opinion, which I accept, ignition first occurred on the mattress of the bed located inside the front door to the unit.

Mr McKay eliminated a light switch located on the wall immediately over the bed or the associated down light as a cause of the fire. Similarly, power points near the bed were also ruled out as ignition sources. Mr McKay considered that the most probable cause was a portable open flame device, such as a cigarette lighter or matches being introduced to a combustible material, either being the mattress itself or a combustible item on the mattress.

Mr McKay concluded that the fire damage dynamics were consistent with a rapidly developing fire progressing from the mattress to the adjacent living area, but noted that the flame had not extended to any appreciable extent beyond the living area. In Mr McKay's opinion "migration of smoke and heated gasses throughout the entire apartment has rendered the entirety of unit 11 un-survivable within less than three minutes from the ignition of the fire". Based on his investigation, Mr McKay registered the fire cause classification at unit 11, 63 Goulburn Street as Incendiary.[2]

I accept the opinions expressed by Mr McKay as to the cause and origin of the fire at unit 11, 63 Goulburn Street on 2 June 2026.

Further, given the admissions made at the scene by Mr Dick to the effect that he had "been playing with paper and fire", I find that the fire was caused by Mr Dick lighting paper on the mattress, which ignited the mattress causing Mr Dick to suffer severe burns to half of his body.

c) Mr Dick's cause of death was multiorgan dysfunction and progressive failure.

d) Mr Dick died on 8 June 2024 at Hobart, Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into Mr Dick's death. The evidence includes:

- The Police Report of Death for the Coroner;
- The Hospital Report of death for the Coroner;
- Affidavit confirming identity;

[2] A fire that is intentionally ignited in an area or under circumstances where and when there should not be a fire.

- Medical records;
- Report of Fire Investigator Timothy McKay;
- Tasmania Fire Service Building Compliance Summary Report;
- Affidavit of Helen Howlett;
- Affidavit of Constable Robert Cassidy;
- Affidavit of Constable Jeremiah Tojino;
- Affidavit of Dipti Gill;
- Affidavit of Sal Bartley;
- Affidavit of Paramedic Cameron Banks;
- Affidavit of Constable Tami Nelsen; and
- Report of the forensic pathologist Dr. Andrew Reid

Building Safety Compliance

In the course of his fire scene investigation, Mr McKay identified aspects of the building at 63 Goulburn Street, which gave rise to concerns related to building safety compliance and occupant safety. He reported these concerns to the Hobart City Council and the Assistant Director of the Tasmania Fire Service Building Safety Unit (BSU).

The BSU conducted a fire safety audit of the premises at 63 Goulburn Street on 3 June 2024 and 13 June 2024 and reviewed the available Tasmania Fire Service and Hobart City Council (HCC) building records.

The review established that the building consisted of an existing two storey house constructed in the early 1900's and a three-storey extension completed in 1960 consisting of a four car garage at street level with two storeys of accommodation above. The premises, known as "Ena Waite College" had been affiliated with the University of Tasmania and used as a student hostel until 1980. The building was purchased by its current owner in 1982.

The detailed report outlined a history of internal building works being approved in 1982, 1998 and 2007 but noted that there was no record of those works being formally

completed. Furthermore, several fire safety recommendations and requirements issued by TFS over that period remained outstanding at the time of the inspection in 2024.

The TFS review concluded that it was unlikely that the building approvals issued in 1982, 1998 and 2007 were formally completed in accordance with the relevant legislative requirements of the time. Concerns were also raised about rooms converted to single occupancy units in the absence of relevant building approval and an absence of a schedule of maintenance or routine maintenance records for essential services or an approved evacuation procedure.

Despite the findings of the report, I find that none of the concerns raised were directly connected to the circumstances of the fire at 63 Goulburn Street on 2 June 2024, or the death of Mr Dick.

Comments and Recommendations

The fire investigation report found no evidence of smoke alarms in Mr Dick's unit. However, in this case, Mr Dick was awake and aware of the fire and able to extricate himself from the unit.

As such, the circumstances of Mr Dick's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I extend my appreciation to investigating officer Constable Jeremiah Tojino for his investigation and report.

Following his death, Mr Dick's organs were removed for donation. I acknowledge Mr Dick and his family for that lifesaving gesture and convey my sincere condolences to the family and loved ones of Mr Dick.

Dated: 11 August 2026 at Hobart, in the State of Tasmania.

Madeleine Wilson
Coroner