



OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION: **Inquest into the death of Martin John O'Connell**

TITLE OF COURT: Coroner's Court

JURISDICTION: Brisbane

FILE NO(s): COR 1225/05 (7)

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HEARING DATE(s): 3 May 2008, 13 May 2008

FINDINGS OF: Mr John Lock, Coroner

CATCHWORDS: CORONERS: Inquest – Electrocution, Safety Switch (Residual Current Device)

REPRESENTATION:

Mr M Kely – appearing to assist the Coroner

Mr Braithwaite, lawyer of Gilshenan & Luton – representing Mr R. Thorpe

Mr Maher of Counsel ; instructed by Queensland Law Group, Lawyers – representing Ms T. Linnegar

CORONERS FINDINGS AND DECISION

1. These are my findings in relation to the death of Martin John O'Connell who died from electrocution on Sunday, 22 May 2005. These findings seek to explain how the death occurred and consider whether any changes to policies or practices could reduce the likelihood of deaths occurring in similar circumstances in the future. The *Coroners Act 2003*¹ provides that when an inquest is held into a death, the coroner's written findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These findings will be distributed in accordance with the requirements of the Act and also placed on the website of the Office of the State Coroner.

The scope of the Coroner's inquiry and findings

2. A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-
 - a) whether a death in fact happened;
 - b) the identity of the deceased;
 - c) when, where and how the death occurred; and
 - d) what caused the person to die.
3. There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death.
4. An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:- "*It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends... The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.*"²
5. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.³ However, a coroner must not include in the findings or any comments or recommendations, statements that a

¹ *Coroners Act 2003*, s45

² *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625

³ s46

person is or maybe guilty of an offence or is or maybe civilly liable for something.⁴

The admissibility of evidence and the standard of proof

6. Proceedings in a coroner's court are not bound by the rules of evidence because the Act provides that the court "*may inform itself in any way it considers appropriate.*"⁵ That does not mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining what weight should be given to the information.
7. This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt. As already stated, it is an inquiry rather than a trial.⁶
8. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw* sliding scale is applicable.⁷ This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.⁸
9. It is also clear that a Coroner is obliged to comply with the rules of natural justice and to act judicially.⁹ This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*¹⁰ makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

⁴ s45(5) and 46(3)

⁵ s35

⁶ *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625

⁷ *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J

⁸ *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361 per Sir Owen Dixon J

⁹ *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13

¹⁰ (1990) 65 ALJR 167 at 168

The Evidence

10. It is not necessary to repeat or summarise all of the information contained in the exhibits and from the oral evidence given, but I will refer to what I consider to be the more important parts of the evidence.
11. Martin John O'Connell died from electrocution on Sunday, 22 May 2005 at his property of 305 Colburn Avenue, Victoria Point, QLD 4165. He was born on 06 November 1971 and was 33 years old at the time of his death. He was the husband of Mrs Nida O'Connell.
12. He and his wife had lived at the address at Colburn Avenue as owner/occupiers since June 2004, approximately 1 year prior to his death.
13. Mr O'Connell held a current electrical licence (Number 7340S) from New South Wales, expiring on 30 January 2007. The licence is classed as a Qualified Supervisor certificate which permitted him to work as an electrical worker in Queensland but not as a Contractor. His wife, Mrs Nida O'Connell said that he worked most of his working life as an electrician, other than for a couple of years when he worked in the IT industry.
14. His wife gave evidence that he had done some electrical work on the property including installing new lights, switches, ceiling fans and the electricals for the air-conditioner. She has no recollection of the safety switch or Residual Current Device (RCD) ever activating or faulty appliances tripping the electrical circuits.
15. At 1:30pm on Sunday 22 May 2005, Mr O'Connell started preparations for the installation of power and phone lines for a computer. At 2:30pm, Mr O'Connell went about a process to isolate the electrical circuits he believed he was about to work on. This was done by him turning circuits off at the switch board and Mrs O'Connell reporting to him what electrical appliances had turned off around the house and what appliances were still operating.
16. Mrs O'Connell indicated that when she had reported that the power in the lounge room was on and the power in the kitchen was off, he was happy to proceed. He then climbed into the ceiling with a torch and wire and other equipment. At about 4pm, Mrs O'Connell called out to see if he was okay to which she says he replied 'Yes'. At 4:05pm, Mrs O'Connell called out again to check on him, but this time Mr O'Connell did not respond. At 4:10pm, Mrs O'Connell could not hear any noise from the roof so she climbed into the ceiling and saw the him lying in the ceiling. Mrs O'Connell called out to him but did not receive any response. She crawled into the ceiling space and touched him. He was moving a little and dribble was coming from his mouth.

17. Mrs O'Connell then went to the front of her property and called out for help. One of her neighbours attended, Stephen Andrew Berns, of 301 Colburn Avenue, Victoria Point QLD 4165. He obviously thought there may have been an electrical issue and asked where the switchboard was, and he turned off the Main Switch. He crawled into the ceiling and tried to give Mr O'Connell CPR. He stayed with him until the ambulance arrived. He could see that Mr O'Connell was working with wiring but he was not in contact with anything at that time. He saw marks on Mr O'Connell's right hand and on a pair of nearby pliers.
18. Another neighbour, Abdhul Nasser Khanji is also an electrician. He did not know Mr O'Connell. He came over to see if he could assist when he knew it involved an electrical incident. When he looked at the safety switch he saw that one of the circuits had been "bypassed" from the safety features of the RCD so that power to the circuit was still present even if the switch had been off. He could tell it had been bypassed and he had never seen a RCD switch bypassed like this before.
19. Mr Neale Garaty of Workplace, Health and Safety Queensland, Co-ordinated an investigation into the event. He principally relied on the assistance of Mr Gerard Poynting of the Electrical Safety Office who has also provided a statement and gave evidence. In summary the substance of their evidence concluded that:
 - (a) Mr O'Connell did not isolate the main switch, which would have disconnected all power supply to the property;
 - (b) Circuits 5 and 6 were not connected to the Residual Current Device ("RCD") safety switch;
 - (c) The wire found in the roof area had flash marks;
 - (d) A pair of pliers near the wire also had flash marks; and
 - (e) The wire, with burn marks, was found to be connected to Circuit 5 and with power restored, Circuit 5 had 240 volts passing through it, to the wire Mr O'Connell was working on.
20. Mr Poynting said that RCD switches had been around for some years but were only common in the domestic sense in more recent times. Essentially the Electrical Safety Act required that any residence built since 1992 should have one installed. Since 1 September 2002 any contract of sale should record whether or not one has been installed and it is a requirement that any new owner install one within 3 months of the date of possession. He explained that as a safety device it is specifically designed to protect persons rather than property. Other circuit/fuse breaker systems which are part of all electrical circuits are designed for protecting electrical systems from overloaded or faulty equipment. RCD's are relatively easy to install.
21. The inquest had the advantage of photographs of the circuit box and RCD and Mr Poynting prepared an electrical circuit diagram. Other diagrams were prepared by Mr Kanji (the diagram was produced some 2 years after the event) and Mr O'Connell's father (who relied on what Mr

Khanji told him). There are differences in the diagrams the reasons for which are not important but for the purpose of this decision I will rely on the diagram produced by Mr Poynting.

22. The evidence is clear and supports a finding that the circuit box had been modified. A copper bar which joined up the power and light circuits to the main power was necessarily cut by whoever installed the RCD where it related to power circuits 4, 5 and 8. This would disconnect those circuits from the mains power. These circuits were then wired into the RCD and in that way were then reconnected to mains power. In the case of circuits 4 and 8 they were linked to the safety side of the RCD.
23. The conundrum facing this enquiry is that circuit 5 was linked to the line side of the RCD, effectively bypassing the safety feature the RCD was designed for. Power circuit 7 was marked as being for the stove and circuit 9 for the Hot water system which are not usually connected to a RCD, so there is nothing unusual about that.
24. Interestingly power circuit 6 was noted on the power board as being "Spare" at the time of incident, but on inspection by Mr Poynting it was now connected to a power circuit and also was not protected by the RCD. The cover piece of the RCD had written on it that it was for "Earth leakage Unit. PWR only" which Mr Poynting inferred meant in electrical terms as indicating that only the power circuits were protected. Light circuits at that time did not need to be protected by RCD's although they are now.
25. In so far as the wiring for circuit number 5, Mr Poynting said it was most unusual and he had never seen a switchboard like it. It would not be a wiring method he would expect from a professional. He noted that the wiring from circuit 5 to the top of the RCD was looped and although he did not specifically measure the wire, he thought that in that state it would have reached the bottom of the RCD where the other circuits 4 and 8 were attached. The wiring from circuits 4, 5 and 8 was the same colour and diameter.
26. It was also surmised by Mr Poynting that possible reasons for later disconnecting a circuit from the protection of the RCD would be because of nuisance electrical tripping.
27. Mr Poynting also gave evidence that circuit 5 was linked to the power points in the kitchen and laundry area. Mrs O'Connell gave evidence that the kitchen appliances were not working when she was isolating the circuits for her husband. It can be inferred that this was the circuit that he wanted disconnected. Somehow this did not occur.
28. As to why Mr O'Connell did not simply turn off the mains power it is difficult to say. Mr Poynting said that working on live circuits was not permitted in Queensland except in extenuating circumstances. It may have been done to minimise disruption to other areas of the house but

should have been tagged and locked. He also found no testing equipment in the roof space other than an indicative screw driver device which can give false positive readings.

29. He also said that he tested the RCD and it was working and if it had been properly connected to circuit 5 it would have turned the power off before it reached the lethal stage.
30. I accept that Mr O'Connell was an experienced electrician. I also accept the evidence of Mr Barry O'Connell that his son had pointed out the existence of the RCD device and its importance.
31. Rowan Thorpe was the occupier of the house at 305 Colburn Street, Victoria Point prior to selling the property to Mr and Mrs O'Connell in 2003. His partner Tanya Linnegar was the owner. He provided a statement to investigating police and gave a recorded interview. He also gave evidence. He is not an electrician but he did an apprenticeship as an electrician in New South Wales for 3.5 years (out of total of 4) some 20 odd years ago. He recalls that when the house was sold a first contract fell through. He recalls that the electrical circuit did not have a RCD Safety Switch but they had it installed as part of the conditions of the first contract.
32. It should be noted that the law in Queensland does not prohibit the sale of a house without a RCD safety switch, but the law provided that it was necessary to disclose in the contract whether or not a safety switch was installed. Upon settlement the new owner has an obligation to ensure one is installed within 3 months. Clearly the presence or absence of an RCD can be a selling point. He and his partner decided to engage an electrical contractor to install it. He does not recall who it was other than it was someone out of the local paper. He has no paperwork on who installed it. He paid cash of around \$185 to \$190. This occurred sometime around 6 weeks before the settlement of the sale.
33. Ms Linnegar has a slightly different recollection to the extent that she does not recall it was a condition of the first contract but recalls that it was installed some 6/8 weeks before settlement and that Mr Thorpe organised it. She gives evidence in substantially the same terms as Mr Thorpe but relies on what he told her happened.
34. Neither of them recall any incidents involving the RCD activating or tripping. Mr Thorpe denies that he installed or modified the RCD and Ms Linnegar denies any knowledge of that happening.
35. Mr Thorpe admits that he moved power points and switches during his occupation when they gyprocked the walls but did not disconnect the switches. He turned the electricity off at the Mains Switch board when he did this. He performed no other electrical work.

36. This evidence is corroborated by the owner of the house and his then partner Tania Linnegar. They are now separated.

The Autopsy

37. Dr Nathan Milne performed an autopsy examination on 24 May 2005. This revealed electrical type injuries on both hands and the chest. There was a single injury on the right hand which appeared to be a contact site. There were numerous injuries on the left hand which appeared to be exit sites. There was no other evidence of injury or significant natural disease. Histology showed changes of electrocution in the skin of the right second finger, left hand and right side of chest. He opined that the most likely path of electricity was from the right to left hand, which is likely to pass through the heart and therefore causing death. Toxicology showed no alcohol or drugs in the blood or urine

Findings required by s45

38. I accept that the evidence supports a finding that the RCD was installed on the premises some short time before the house was sold to Mr O'Connell. There is no evidence that this was installed by Mr Thorpe. The relatively short time between installation and the handing over of possession would discount the possibility that Mr Thorpe or someone on his behalf then modified the RCD to take off circuit 5. There would be no reason to do so.

39. There is no evidence of later problems with the circuits from what Mrs O'Connell says so it is difficult to surmise why anyone else, including Mr O'Connell or someone on his behalf would want to modify the unit by removing circuit 5 from protection.

40. One inference that could be drawn from all of the evidence is that it is possible that circuits 4, 5 and 8 were isolated to the safety side of the RCD at one stage, probably at installation. It was then later modified by persons unknown by moving the circuit 5 wire from the protected side and putting it at the top of the RCD, effectively leaving it unprotected by the device. The looping of the wire gives some support for that inference. Also, as Mr Poynting said, if the installer wanted to deliberately leave circuit 5 unprotected that could have been done by simply leaving it as is and in the same manner as circuits 6, 7 and 8.

41. The other possibility or inference is that the installer, whoever that may be, deliberately or negligently wired the RCD so that circuit 5 was not protected. There is more evidence pointing to the first inference but unfortunately I am not able to be so satisfied on the balance of probabilities that I can make a definitive finding to that effect one way or the other.

42. What is known is that circuit 5 was not protected by the RCD on 22 May 2005 and there is no doubt, that if it was, then this death would most

likely have been prevented. Prevention also would have occurred if the Mains Power was turned off or if Mr O'Connell had testing equipment in the ceiling which would have shown that power was running through the wiring he was working on. He clearly thought that when certain equipment in the kitchen was not working that the circuit he was intending to work on was inactive. Clearly it was not or some other mistake has been made bringing about this tragic death.

43. I am required to find, as far as is possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with the last of these issues, being the circumstances of Mr O'Connell's death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other aspects of the death.

- (a) The identity of the deceased was Martin John O'Connell
- (b) The place of death was 305 Colburn Avenue, Victoria Point, Brisbane, Queensland.
- (c) The date of death was 22 May 2005.
- (d) The formal cause of death was:
 - 1(a) Electrocution.

Concerns, comments and recommendations

44. Section 46 of the Act provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. The state of the evidence is such that no such comments or recommendations can be made. The legislative framework under the Electrical Safety Act is quite clear and appropriate.

To the family of Martin O'Connell, I again offer my condolences.

I close this inquest.

John Lock
Brisbane Coroner
6 June 2008