TRANSCRIPT OF PROCEEDINGS

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CORONER'S COURT

HALLIDAY, Coroner

IN THE MATTER OF AN INQUEST INTO THE
CAUSE AND CIRCUMSTANCES SURROUNDING
THE DEATH OF SCOTT ROBERT GRIMLEY

BRISBANE

..DATE 01/09/2006

FINDINGS

CORONER: The Scope and Purpose of Inquest

The purpose of this Inquest is to establish, as far as is practicable, the fact that a person has died, the identity of the Deceased person, when, where and how death occurred, and whether any person should be charged with any of the offences referred to in section 24 of the Act.

Throughout this Inquiry, I have been mindful, amongst other things, of the observations made by his Honour Justice Toohey in Annetts v. McCann 170 CLR 596 and, in particular, the following words of his Lordship Lord Lane referred to therein.

> "Once again it should not be forgotten that an Inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an Inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial. It is simply an attempt to establish facts. It is an inquisitorial process, a process of investigation, unlike a trial where the Prosecutor accuses and the accused defends."

It may thus be noted that a Coroner's Inquest is an investigation by Inquisition in which no one has the right per se to be heard. There are no sides in the sense of adversary proceedings. Although a Coronial Inquiry is not a judicial proceeding, in the traditional sense, the rules of natural justice and procedural fairness are applicable and must be applied. The contents of such rules to be so applied, depending upon the particular facts of the case in question.

In making my findings I am not permitted by the legislation to express any opinion on any matter which is outside the scope of this Inquest, except in the form of a rider or recommendation, and I should also make it quite clear, and abundantly clear, that any findings that I do make in these proceedings are not to be framed in any way which may determine or influence any question or issue of liability which may fall to be determined in another place, or which might suggest that any person should be found guilty or otherwise in any such other proceedings.

I have referred, in the broadest of terms, to the function and role of the Coroner and of this Court, as there is perceived by some within the community a belief that a Coronial Inquiry and Inquest is an ongoing Royal Commission with unlimited terms of reference and unlimited resources and finances. I so comment as there has been some observations made within this Inquiry as to what is perceived to be the function of this Inquiry and the supposed or expected outcome.

All proceedings before this Court, unfortunately, are sad proceedings because they involve the death of a human person and of a loved one. And before I go any further, I express the condolences of my Court to the family of the Deceased in their sad loss in the sudden and tragic death of their son, Scott Robert GRIMLEY.

I want to set out in a little more detail the statutory functions of this Coronial Inquest so that they may be better and fully understood. The jurisdiction and function of the Coroner's Court are to be found within section 43 of the Coroner's Act which provides:

> "After considering all the evidence before the Coroner at the Inquest, the Coroner shall give the Coroner's findings in open Court. Where the Inquest concerns the death of any person, the finding shall set forth -
>
> (a) So far as has been proved -
> (i) who the Deceased was;
> (ii) when, where and how the Deceased came to his or her death; and
> (b) the persons (if any) who should be committed for trial."

The jurisdiction of this inquiry is limited by the statute to which I have just referred.

The word "how" the Deceased came by his death has been judicially defined in this State in the recent decision of the Court of Appeal in Atkinson v. Morrow [2005] 13 Court of Appeal, where it was determined that the word "how" means, "by what means and in what circumstances the relevant death occurred."

The Justice at nisi prius, Justice Mullins, whose decision, as I appreciate it, was upheld on appeal, said this:

> "How the death occurred should not be given the unduly restricted meaning of 'by what means the death occurred' but should be given the broad construction of 'by what means and in what circumstances the death occurred'." (2005 QSC at 11)

Now, that is the type and the extent, the breadth and the depth of what this Inquiry is all about. It is not an ongoing, far reaching Royal Commission with unlimited terms of reference.

The Inquest arrives at its decision by having regard to the evidence which has been adduced before it.

At arriving at any finding of fact, this Court is required to be satisfied to the requisite standard and that standard, as in all Coronial matters, is the civil standard of proof; that is, on the balance of probabilities. So that a fact is proved, if the Inquiry is reasonably satisfied of it. The degree of persuasion necessary to establish a fact, on the balance of probability, varies according to the seriousness of the issues involved and in such regard I refer to Briginshaw v. Briginshaw 60 CLR 336 per Dixon J at 362; and to the succinct statement of his Lordship Lord Denning in Hornall v. Neuberger Products Ltd [1957] 1 QB 247 at 258:

> "The more serious the allegation the higher the degree of probability that is required."

In arriving at my determination herein I have had regard to all evidence adduced, written and viva voce and to the various submissions made on behalf of all interested parties.

Circumstances Giving Rise to This Inquest

The facts in this particular case fall within a fairly small compass and I do not intend to refer to them at any great length.

The Deceased, Scott Robert GRIMLEY, was born on the 5th of February 1969. He qualified as an electrical fitter/electrical mechanic on 13 August 1991 after his completion of an apprenticeship with SEQEB. He was the holder of a licence in relation to both of those capacities.

In January of 1998, he was employed by Johns Electrical Services in the task of performing maintenance work upon domestic electrical service lines. On the 21st of January 1998 the Deceased was performing his employment duties as an electrical fitter/mechanic working within an elevated work platform upon an electrical pole in the vicinity of premises situate at 19 Girraman Street, Chermside West.

During the course of such employment on that day an incident occurred whereby the Deceased received an electric shock when he came into contact with overhead power lines and as a

consequence of which the Deceased was conveyed by ambulance to the Prince Charles Hospital. Following admission to the John Tonge Centre where a post mortem examination was performed by Dr S Ashby, a medical cause of death by electrocution was expressed as being the opinion as to the cause of death of the Deceased.

The father of the Deceased, Mr Bob GRIMLEY Senior, has, since the death of his son, actively, if I may say so, with all due respect, sought a thorough investigation into not only the death of his son, but also other persons who have found their demise within what I may call and refer to as "the live wire electrical industry", and such personal commitment of Mr Grimley and his enthusiasm in such regard can be fully appreciated and commended.

It was clear at the outset and following inquiry made by Mr Grimley that the initial and subsequent investigation and inquiry by those entrusted with the regulation of the electrical industry and the safety of its members and by the Queensland Police Service into the circumstances of the death of the Deceased was flawed from the very beginning. In fact, some may well say that there was no such investigation and inquiry at all.

As a consequence of the endeavours of Mr Grimley Senior and an application made by him to the Queensland Ombudsman, an investigation was undertaken, not only into the circumstances surrounding the death of the Deceased, but also into the deaths of certain other persons who had died as a consequence of electrocution.

The investigation by the Ombudsman, in my view, has been most thorough and the report and recommendations following concerning the death of the Deceased has been placed into evidence in this Inquiry. As I said, it is my view that the investigation by the Ombudsman, with all due respect, has been thorough in the extreme. I have no hesitation whatsoever in formally accepting the findings and the recommendations contained within that report and adopting and incorporating the same herein by reference.

In the course of this Inquiry there has been suggested various hypotheses as to how the Deceased came to his demise. What is clear is that whilst the Deceased was working upon the overhead electrical wires, he came into contact with them and as a consequence was electrocuted. No one saw the incident occur. All that was seen was what occurred shortly after the Deceased came into contact with the wires.

The Court and this Inquiry is unable to speculate or surmise as to how an incident or a death occurred. The Court must be satisfied by cogent, reliable evidence as to what, in fact, occurred. I am satisfied, on the evidence that has been placed before me, that the Deceased came into contact with overhead wires whilst he was within the elevated work platform in question.

Speculation has also been expressed as to whether the Deceased was still in the process of work or whether he had, in fact, completed his work at the time of the incident. On the evidence that has been placed before me there is no evidence to suggest that he had so finished or that he was otherwise not engaged in his work. Further, there is no evidence to suggest that there was any malfunction of the elevated work platform and the evidence suggests that subsequent to the incident there was found to be no defect within its operation. Furthermore, there is no evidence to suggest that there was any deliberate intent on the part of the Deceased to come into contact with the power lines. Rather, having regard to the limited experience the Deceased had in operation of an elevated work platform, I am reasonably satisfied that the incident occurred in the manner in which the platform was operated by the Deceased whilst in close proximity to the wires.

Much time and discussion took place during the Inquest as to the meaning to be given to the relevant legislation and in particular as to whether the Deceased was qualified or competent to do the work that he was so doing at the time of the incident and whether there was any need for him to have been supervised in the course of that work. I am satisfied, on the evidence that has been placed before me, that the Deceased by his training in relation to the use of the platform was not sufficiently competent to so operate such platform without qualified supervision.

The training of the Deceased in that regard consisted of a few hours instruction in the use and operation of such a platform on what has been referred to as a "dead pole". There was no training, or if there was, there is no evidence which has been adduced before this Inquiry as to what work or training the Deceased had had in and around live electrical lines.

This Inquiry has been provided with certain legal opinion from the Crown Solicitor. Such legal advice came to light very late in the piece and is in relation to the need, or the requirement, for a person in the position of the Deceased to be either trained in a certain way or whether he was competent to perform the work that he was doing and/or whether he should have been supervised in the light of the then relevant legislation.

Furthermore, an issue arose during the Inquiry as to whether the Deceased was qualified within the relevant legislation to actually perform work upon overhead lines or whether he needed to hold an electrical line person's licence for that purpose. Much time during the Inquest was spent on such issue. In the light of the then legislation it is reasonably open to argument that such a qualification was so required. However, I agree with the submission of Counsel Assisting, Mr D Lynch of Counsel, that it is unnecessary to express a concluded view on such issue as all relevant parties, including apparently the Deceased himself, believed the Deceased to be sufficiently qualified to perform the work he was so undertaking.

In summary, I am reasonably satisfied on the whole of the evidence, and so find, the Deceased, although possessing qualifications and licensing referable to an electrical fitter/electrical mechanic, was not experienced either from his work experience or training to perform the type and the extent of the work that he was engaged upon immediately prior to his death. The Deceased was not experienced in performing work upon live overhead power lines nor in operating an elevated work platform. I am also satisfied, having regard to the then relevant legislation, that there ought to have been present what has been referred to as a competent assistant/ground observer/safety observer on the ground at the base of the elevated work platform supervising

the work and the operation of the Deceased in his management of the platform whilst he was working underneath the overhead electrical power lines.

In the course of evidence during the Inquiry the importance of there being present a competent assistant at ground level was highlighted by the risk of the platform telescopically retracting and/or simultaneously raising the angle of elevation.

There was also discussion during the course of the Inquiry as to whether insulating mats should have been used and which were not. Having regard to the fact that nobody saw the particular incident occurring, one is unable to come to any conclusion as to whether the presence or otherwise of the insulating mats would have had any relationship to the prevention of the incident and the death of the Deceased. However, on balance, I am satisfied that the relevant legislation contemplates that safety apparatus such as insulating mats ought to have been present at the "site" and not locked away in the vehicle, as was indicated by the evidence.

During the course of the Inquiry an issue arose as to whether any person or persons ought to be sent for trial and in that

regard submissions were made by Counsel Assisting and by the legal representative for Peter John JANSSEN.

Evidence before the Inquiry indicated that Mr Janssen was not watching the Deceased, nor the basket of the platform at the time of the incident, but rather on the evidence of the witness Cope Mr Janssen at such time said he was either on or at the base of a ladder at premises at 19 Girraman Street.

Having regard to the injunction contained within section 43(6) of the Coroner's Act, I refrain from making any further finding of fact relating to Peter John Janssen vis a vis his statutory and/or common law obligations towards the Deceased.

I accept the submissions of Counsel Assisting as referred to in paragraphs 3(iii) and 4 of his written submissions and, on all of the evidence which has been placed before this Inquiry, both documentary and viva voce, I am satisfied, and so find and determine, that in accordance with the provisions of section 24(1)(d) of the Coroner's Act that there is evidence sufficient to put a person on trial for an indictable offence. In so determining, I am mindful of the relevant test to be applied by this Court in determining whether a person ought to be committed for trial or not. Such test, in broad terms, is whether there is evidence which if placed before a jury and which if a jury is properly instructed as to the law could, as

opposed to would, return a guilty verdict. (Vive inter alia May v. O'Sullivan 92 CLR 654.)

It is therefore determined that Peter John Janssen be committed for trial on a charge of manslaughter and he is so committed on the following charge, namely:

> "That on the 21st day of January 1998 at Brisbane in the State of Queensland Peter John Janssen unlawfully killed one Scott Robert Grimley."

Formal Findings

I make the following formal findings.

The Identity of the Deceased Person

The identity of the Deceased person was Scott Robert GRIMLEY, who was born on the 5th of February 1969, and who, at the time of his death, was residing at 25 Tanderra Street, Bracken Ridge.

I further find that the occupation of the Deceased was electrical fitter/mechanic.

Date and Place of Death

I find that the Deceased died at Brisbane in the State of Queensland on the 21st of January 1998.

Medical Cause of Death

I further find that the medical cause of death of the Deceased person was by means of electrocution. I further find that there is no evidence which would reasonably suggest that the cause of death of the Deceased was other than by accident.

Recommendations

It is a further requirement of an Inquest in appropriate cases to make recommendations which may prevent the occurrence of a similar event in the future.

It has been said that the paramount duty of any State is to protect the lives of its citizens. To this end it is important that the Coronial system monitor all deaths and in particular that it provides to the community a review of the circumstances surrounding deaths that may appear to be preventable and every effort should be made to obtain recommendations which might prevent similar deaths in the future. It is the role of an Inquest, as it has been said, to speak for the dead in order to protect the living.

This is a case, in my determination, in which the death of the Deceased could well have been prevented. It was an unnecessary death and one that could have been prevented in the prevailing circumstances.

It has been suggested by way of submission by Mr Grimley Senior that there be wide-ranging recommendations made in relation to the training and supervision of those engaged in the electrical maintenance industry. There have also been

submissions made in relation to the relevant legislation, both past and the present. Relevant legislation has been amended and the present legislation is not that which was in existence at the time of the unfortunate death of the Deceased.

Those whose task it is to govern and regulate the electrical industry and workplace health and safety in this State have seen fit to pass the present legislation concerning electricity and also in relation to Workplace Health and Safety. It is debatable, in some quarters, as to whether the present legislation is sufficient to protect those engaged in the electrical maintenance industry. In my view, the present legislation is adequate in that regard, so long as it is vigorously supervised and enforced.

However, it is determined that there be the following recommendations made:

Firstly, that there be introduced by the relevant statutory authority a course of regulated training for and licensing of persons before they are permitted to operate an elevated work platform, and such to include specific relevance to working in close proximity to overhead electrical wires; and

Secondly, that there be introduced guidelines as to the supervision of such licensees before they are permitted to operate elevated work platforms solely or on their own.

The Standard of Investigation

(a)The Ombudsman Workforce Electrocution Project has identified serious flaws referable to the investigation carried out by officers of the Workplace Health and Safety and of the Electrical Safety Office and it is now evident that steps have been taken to address and remedy the problems which were so identified. In such premises it is not proposed to make any recommendation in relation to investigations by such agencies.

(b) In respect to investigation of the incident by the Queensland Police Service it is apparent that the incident was treated as a technical matter best left to those more competent to deal with it. It was submitted in the course of the Inquiry that the Queensland Police Service should have engaged its own expert opinion concerning issues of a technical nature and ought to have sought specialist legal opinion as to whether there was sufficient evidence to justify the charging of any offences.

It is recommended that in cases such as the present, as in all cases, the Queensland Police Service ensure that all necessary investigations are duly undertaken by appropriate personnel and that all relevant prosecutions are commenced in a timely fashion so as not to permit any relevant period of limitation to expire.

The Inquest is closed.
