QUEENSLAND COURTS

GAYNDAH CORONER

FINDING OF INQUEST

CITATION: Inquest into the death of **GEOFFREY THORPE**

TITLE OF COURT: Coroner's Court

JURISDICTION: Kingaroy

FILE NO(s): COR 2257/04TY(1)

DELIVERED ON: 18 April 2007

DELIVERED AT: Gayndah

HEARING DATE(s): 7 February 2007 and 8 February 2007

FINDINGS OF: S D Guttridge Coroner

REPRESENTATION:

Appearances:

Counsel Assisting:	Mr John Tate of Crown Law.
For Gayndah Packers Co-op:	Mr Simon Burgess of counsel instructed by Payne, Butler and Lang.
For the Family:	Ms Jeanette Thorpe (sister of the deceased) granted leave to appear.

CORONERS FINDINGS

This is the inquest into the death and circumstances of the death of **Geoffrey Thorpe.**

As the deceased died on 13 September 2004, I must deliver my findings pursuant to the provisions of the *Coroners Act 2003,* which came into force on 1 December 2003 and applies to all reportable deaths[1] after that date.

The purpose of this inquest, is to establish, as far as practicable[2] –

Who the deceased person is; and
How the person died; and
When the person died; and
Where the person died; and
What caused the person to die.

A coroner must not include in the findings any statement that a person is or may be guilty of an offence or civilly liable for something[3].

A coroner may comment on anything connected with a death investigated that relates to public safety or the administration of justice or ways to prevent deaths from happening in similar circumstances in the future[4]

A coroner is not bound by the rules of evidence but may inform himself or herself in any way considered appropriate[5]. However, the coroner must have regard to the rules of Natural Justice and Procedural Fairness.

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[1] Coroners Act 2003, section 7, as to duty to report, and section 8, as to definition of reportable death.
[2] Coroners Act 2003, section 45(2)
[3] Coroners Act 2003, section 45(5); See also R V Shan Eve Tennent; Ex parte Jager – BC200003284
[4] Coroners Act 2003, section 46
[5] Coroners Act 2003, section 37

History of investigation after death.

Mr Geoffrey Thorpe died at Gayndah on 13 September 2004. This inquest has been held at the direction of the State Coroner pursuant to section 30(7) of the Coroners Act 2003 at the request of the deceased's sister, Ms Jeanette Thorpe.

It is appropriate for inquests to be held in circumstances where there is an uncertainty as to the cause of death, as it is the duty of the coroner to determine the actual cause of death.

In this case, Mr Thorpe was employed by Gayndah Packers Co-operative as a fitter. He had been checking solenoids which required him to utilise a device that was plugged into a 240 volt power point. This device contained a transformer which reduced the power to 24 volts. While testing the solenoids, using this device, Mr Thorpe collapsed and died.

The first thing the other people in the area thought was that Mr Thorpe had been electrocuted and, in all of the surrounding circumstances, this would appear to be the assumption that most people would have come to at first instance.

The real purpose of holding the inquiry into the death of Geoffrey Thorpe is to ascertain whether the cause of death was by electrocution or whether it was as a result of a heart condition. The next purpose is to ascertain whether future deaths can be prevented.

Ms Jeanette Thorpe, who was granted leave to represent the family, found it difficult to believe that her brother, a person with no history of heart trouble, could suddenly collapse and die. Mr Thorpe was a fit and healthy person who had just built a huge shed on his property, painted it, was dancing on the Friday before his death (his death occurred on a Monday) and was generally a hard working individual who did not seek assistance from others in undertaking tasks on his property. In those circumstances, it would seem difficult to believe that he would suddenly collapse and die from a heart condition.

A pre inquest conference was held on 10 November 2006 and the inquest itself was held over two days on the 7th and 8th of February 2007.

There was a viewing of the location of the death and Gayndah Packers Co-operative provided great assistance in making the premises available and explaining the operation of the machinery and detailing the location of the area in which Mr Thorpe passed away.

There were a number of witnesses called and these can be readily defined as being in three categories. First, the witnesses who were at the scene of the incident where Mr Thorpe died; second, the technical witnesses who conducted tests on various items that were a cause of possible concern; and third were the medical witnesses. For the sake of clarity I intend to deal with the categories of witnesses in that order.

In relation to the witnesses at the scene, these comprised mostly work colleagues who have been significantly affected, in varying degrees, as a result of Mr Thorpe's death.

Ms Sharon Thompson said that on Monday 13 September 2004 at about 5.50am she noticed some of the solenoids on the ten lane grader were not working and she asked Mr Thorpe to check and replace them. At about 6.10am she saw Mr Thorpe was fitting a solenoid into place. She said that Mr Thorpe looked extremely pale and she was concerned that as he was leaning forward to fit the solenoid that he might fall. She then said that Mr Gillis spoke to Mr Thorpe and she left to perform other duties. A short time later she heard people shouting and said that Mr Thorpe was flat on his back.

Mr Gillis saw Mr Thorpe on the platform trolley working on solenoids and he greeted him and had a brief conversation with him. He said he knew Mr Thorpe well and he said that he was not really paying attention to how Mr Thorpe looked. He said that he was not taking much notice but believed Mr Thorpe would have said something if he was feeling unwell. He agreed that he had visited Mr Thorpe's premises out of hours and that he was aware that Mr Thorpe had built a

big three bay steel shed by himself and had painted it. It was not long after Mr Gillis saw Mr Thorpe on the platform trolley that he became aware that Mr Thorpe had collapsed on the lower area of the factory.

Mr Scott gave evidence that at about 6.30am on 13 September 2004 he was on his way to the platform area where the sorter is located and he saw Mr Thorpe coming down from that area. Mr Scott asked Mr Thorpe how he was and he replied he was okay. At that time Mr Scott noted that Mr Thorpe did not look very well and he made a mental note to check to see if he was okay. He intended to do this after checking on some machinery. He then heard someone saying to call an ambulance as there had been an accident and Mr Thorpe had been electrocuted. This was at about 6.40am.

Mr Scott then saw Mr Thorpe lying on the ground in what he described as a "not quite foetal" position. He checked to see if the electricity leads were disconnected and then saw someone turn Mr Thorpe onto his back and commence CPR. He called the QAS and then arranged for some palates of boxes to be removed so the ambulance would have clear access. He also told the people who came to see what had happened to stand back. Police and ambulance were called and Mr Thorpe was taken to hospital.

Mr Scott described Mr Thorpe as a person with a strong work ethic who was unlikely to take sick leave. He said that Mr Thorpe looked different to how he usually looked and described him as looking unwell and as being "ashen grey". He also stated that he had never seen Mr Thorpe look this unwell before and that Mr Thorpe had never complained about any health problems.

Mr Beasley stated that he and Michael Lockery were at the box making machine and that Mr Thorpe said to him that he would be working behind him. The two operators of the box making machine face each other and, on this occasion, Mr Beasley had his back to Mr Thorpe while Mr Lockery was facing in Mr Thorpe's direction.

Mr Beasley stated that Mr Thorpe was kneeling down testing the solenoid. A few seconds later he looked around and Mr Thorpe was lying on the ground. He thought that Mr Thorpe might have been electrocuted on the basis that he had been using electrical equipment. He did not see any flashes or hear any noises that would confirm his assumption. Despite this, in my view, the assumption made by Mr Beasley seems perfectly reasonable in all of the circumstances.

Mr Lockery saw Mr Thorpe checking the solenoids and he thought this was strange as they were usually tested in the workshop. He was speaking to Mr Beasley when he noticed Mr Thorpe was on the ground. He said immediately prior to Mr Thorpe collapsing in the ground he could hear the solenoid being tested but he did not hear any other noise such as Mr Thorpe yelling or hitting the stapling machine.

Mr Lockery described Mr Thorpe as being on his haunches prior to his collapse. He also said that Mr Thorpe looked paler than his usual self at the time. When he saw Mr Thorpe on the ground if he asked him if he was okay but there was no reply. He said that Mr Thorpe was in a foetal type position with his arms up towards his chest and his hands between his chest and chin. He did not see anything in Mr Thorpe's hands but believed that he had been electrocuted. Again I reiterate, in the circumstances, this was not an unreasonable assumption to reach.

Mr Brown was significantly affected by the death of Mr Thorpe and stated that he has tried to block it out of his mind. He stated that this was the first time he had seen anyone die before. He recalled that he was called to come and help Mr Thorpe and that he focussed on performing CPR. He said that he felt a failure when it was unsuccessful. There is no doubt that Mr Brown, and others at the factory did everything that could reasonably be done and, despite the tragedy of Mr Thorpe's death, no-one, in my view, has anything to feel guilty about.

Basically, the evidence of the first category of witnesses is that Mr Thorpe may have looked a little unwell but he was performing his duties in a conscientious and normal manner. All staff were shocked at Mr Thorpe collapsing and they

rendered immediate aid and assistance as best they could until the ambulance arrived. There is no doubt that most of the witnesses assumed that Mr Thorpe had been electrocuted on the basis that he was using electrical equipment immediately prior to his collapse and such an assumption was reasonable.

The next category of witnesses was the technical experts. I am not going to go through their evidence in any detail but it was clear that the electrical equipment being used by Mr Thorpe immediately prior to his collapse was not in any way defective. In particular, the solenoid tester, was tested on three occasions and there was no leakage of electricity. Moreover, the device is such that it has an inlet of 240 volts from an AC power source, it goes through a transformer that limits the voltage output to a 24 volt DC current.

Mr Pavey, the Senior Electrical Safety Inspector, stated in his evidence as follows:

> "To summarise your evidence, Inspector Pavey, would it be fair to say that you left no stone unturned here? – I feel very confident that all aspects of that installation were checked and re-checked. I've had a lot of experience with fault finding and I could not find a fault on that day.
>
> And your opinion is and remains that it was just not possible for Geoffrey to have received an electric shock in this particular case?—That is my opinion." (pages 142 – 143 Transcript)

Mr Couch stated in his evidence that even if there was a leakage of electricity that he did not believe that it could be fatal. This question was in response to a worst case scenario if Mr Thorpe formed a conduit with the 24 volts passing through his body. This would require him to have a direct contact with the plug wires and to depress the button on the tester at the same time, which, in consideration of the evidence, is virtually impossible.

I also point out that the solenoid tester used by Mr Thorpe was returned to Gayndah Packers Co-operative and was in use before it was again taken for the purposes of this inquiry. There were no known problems with the solenoid tester

prior to Mr Thorpe's death, it was properly tested and determined not to be dangerous in any way and was subsequently used by others at the factory.

Professor Birtwhistle also gave evidence than on that worst case scenario, being exposed to 24 volts was not hazardous. Moreover, he opined that it was extremely unlikely that Mr Thorpe's death was caused by any failure connected with the main 240 volt electricity supply system at Gayndah Packers.

The equipment surrounding the area was also tested and all found to be in safe operating order with no leakage of electricity and no danger of exposure to being fatally electrocuted.

In all of the circumstances and on all of the evidence I am satisfied that the solenoid tester was not defective and could not have caused the death of Mr Thorpe by electrocution.

I am also satisfied that there was no other equipment failure or electrical defect that could have caused the death of Mr Thorpe by electrocution.

The final category of witnesses are the medical experts.

Dr Ung is a GP who attended on Mr Thorpe prior to his death for unrelated matters for which Mr Thorpe was prescribed Zoloft medication.

Dr Ung said that on the day of Mr Thorpe's death he examined and attempted to resuscitate Mr Thorpe but the efforts were futile.

He said that he was informed that it could have been a death by electrocution but he saw no obvious signs of such. He said that the enlarged heart condition is one where death can occur suddenly and without any warning. He did not find it surprising that Mr Thorpe had been out having a good time the Friday before his death. He said that the nature of the problem is that it can attack out of the blue without warning and that the total absence of symptoms is common.

Dr Anderson performed the first post mortem on Mr Thorpe on the 14th of September 2004 and he was specifically looking for signs of death by electrocution and could not find any such signs.

The only pathology Dr Anderson could find was chronic obstructive airways disease in the lungs and a heart which appeared flabby to palpation. He did not determine a cause of death at the time of the autopsy and intended to issue an autopsy certificate when the histological examination results were returned from the John Tonge Centre.

Dr Lampe performed a second post mortem on 24 September 2004.

Before going into Dr Lampe's evidence I intend to quote the entirety of the summary and interpretation from his autopsy report.

> "SUMMARY AND INTERPRETATION
> According to the Form 1 history, this man was at work testing solenoids which were believed to be faulty. When last seen alive, he was checking the boards. Soon after, he was seen lying on the floor. When checked on by his work colleagues, he did not respond and was frothing at the mouth. Despite all efforts by his colleagues and the QAS, he could not be resuscitated. Despite inspection at the local hospital and an initial autopsy performed by a Government Medical Officer (GMO), no cause of death was initially identified. Furthermore, no electrocution injury was identified. His family requested that a second autopsy be performed, and the body was transported to Brisbane for this to occur. The body arrived in Brisbane 10 days after death, and the second autopsy was performed 11 days after death.
>
> The second autopsy again was not able to determine a definite cause of death initially that was obvious to the naked eye. The quality of the initial internal autopsy examination was, in my opinion, to the standard expected of a GMO.

Microscopic examination of tissues from both autopsies showed a presence of a minor degree of inflammation of the heart muscle. The lesion at the base of the right thumb **was not an electrocution injury.** No other significant pathology was identified.

Toxicology testing revealed no alcohol to be present. Sertraline (Zoloft) was essentially not detected. No other drugs were identified.

The cause of death in this case could be due to either his heart condition, or to electrocution (if the scene circumstances were appropriate). Let me consider the later option first. The Coroner should be made aware that most, but not all, electrocution injuries leave a tell-tale electrocution mark; the absence of an electrocution mark on the skin does not exclude electrocution as the cause of death. The death scene was reasonably described in the Form 1 but certain particulars were lacking, such as whether the deceased was wearing personal protective equipment and the state of the floor, etc. It is recommended that the Coroner seek an expert opinion on the workplace environment at the time of this man's death to determine if it was a safe environment in which to be working on electrical equipment. As part of this process, the electrical equipment should be thoroughly and expertly examined to determine whether or not it was faulty (as was alleged), and whether it was able to deliver an electrocution type injury to the deceased just before the time he was found unresponsive on the floor of the shed. It is certainly possible that this man may have been electrocuted to cause his death, but I am unable to prove this.

The other possibility is that this man died as a result of the inflammatory process that was identified in his heart muscle. This process is called myocarditis, and can be due to one of many factors (such as a result of a recent infection, autoimmune disease processes, drug effect [but not associated with Zoloft to my knowledge], etc). Because I have no definite evidence of electrocution, I will list myocarditis as the cause of death; however, if the Coroner has

> evidence of an unsafe work environment whereby this man may have sustained an electrical injury, then the Coroner may wish to overturn my listed cause of death and replace it with 'electrocution'. In that instance, the myocarditis could be considered as a coincidental pathology, or it may have been a contributing factor in his death by making the myocardium/heart muscle irritable and thus more susceptible to the development of an abnormal heartbeat (which is the mode of death in most electrocution injuries)."

The contents of this summary and interpretation are very important because it is clear that Dr Lampe would only accept the cause of death as being electrocution if there was a workplace that was either unsafe or if Mr Thorpe was using faulty equipment that could administer him an electric shock.

The technical evidence is clear that the workplace was thoroughly assessed and relevant equipment tested. The technical evidence, in my view, is also clear that the workplace was safe and that there was nothing that would have caused any electricity to pass through Mr Thorpe's body.

Consequently, when one identifies the concerns of Dr Lampe and sees that they are obviated by the other expert witnesses then there is no basis to believe that Mr Thorpe died from electrocution.

Dr Lampe, in his evidence, stated that if there was no evidence of potential of current passing through Mr Thorpe's body then he could not have died from electrocution.

On his initial findings Dr Lampe listed the cause of death as Myocarditis. He described this as comprising an inflammatory lesion as opposed to cardiomyopathy which he described as being an enlarged heart which would also have an element of inflammation.

Dr Lampe stated in his evidence that it was not surprising that Mr Thorpe had no symptoms of his heart condition or that he was active immediately prior to his death.

Dr Lampe also stated that it was not the worst case of myocarditis that he had seen as there was a relatively small amount of inflammation. He said it could also be determined to be cardiomyopathy but he believed that while the heart weight was a little high, it was still in acceptable limits. It was for that reason that he gave the cause of death as being Myocarditis. He said that there was no other explanation for Mr Thorpe's death if electrocution was excluded and that the decision has to be made on the information available.

On all of the available medical evidence it was clear that Drs Ung, Anderson and Lampe were all looking for signs of electrocution and there was nothing overt. Both Drs Anderson and Lampe noted a heart condition that was ultimately seen as the cause of death.

In essence, Mr Thorpe was working with electrical equipment while at work. He seemed a pale to some, but not all, of his colleagues and he was carrying out his normal duties when he suddenly collapsed. His work mates assumed Mr Thorpe was electrocuted and tried to revive him by performing CPR and calling the ambulance.

There was no overt sign of any electrocution to the body despite being specifically sought. However, there was some concern by Dr Lampe that, despite there being no obvious signs, electrocution was possible and he believed the workplace and equipment should be tested to exclude that possibility.

The workplace and equipment was assessed and tests carried out which, in my view, conclusively demonstrate that no electricity passed through the body of Mr Thorpe. Thus, his death could not be due to electrocution.

All the Drs agree that death by myocarditis can be sudden and without prior symptoms and that people can be active immediately beforehand. The Histology

report stated that myocarditis can be considered a possible cause of death. This is consistent with the cause of death listed on the autopsy report of Dr Lampe.

I make the following findings:

(a) The identity of the deceased was **Geoffrey Thorpe**.

(b) His date of birth was **13 November 1956.**

(c) The date of death was **13 September 2004**.

(d) The place of death was
Gayndah Packers Co-operative
37 Bridge Street
GAYNDAH Q 4625

(e) Mr Thorpe died after collapsing while performing tests on some solenoids at his place of employment.

(f) The formal cause of death was **Myocarditis**.

CORONERS COMMENTS

Pursuant to section 46 of the Act, a Coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to –

(a) public health or safety; or

(b) the administration of justice; or

(c) ways to prevent deaths from happening in similar circumstances in the future.

I make the following comments:

In this case I am of the view that the death of Mr Thorpe was unforeseen and, on the evidence, not preventable. However, there was evidence in relation to practices and procedures that need addressing.

First, there was evidence that while there are two persons with first aid certificates on duty in each shift to enable first aid and, if necessary, CPR to be carried out, there was no evidence of any formalised system to ensure that such persons were on duty. Consequently, I am of the view that such a process should be formalised. I note in this case that someone was on duty and CPR was performed.

Second, the persons giving evidence all acknowledged a basic induction training in workplace health and safety issues but there seemed to be no ongoing training that is formalised. There were no formal risk assessments or job safety analyses and training being carried out. The fact that the employer may employ a number of transients or casual workers will not exempt it from its obligations of ensuring a safe workplace. This requires ongoing risk assessments, job safety analyses and training to be carried out.

On the evidence before me, there appeared to be formal induction training and then an ad hoc approach to dealing with these issues. The issues of risk assessment, job safety analysis and training need to be formalised.

Finally, there was some evidence that a defibrillator could increase the prospects of a successful resuscitation of someone suffering from cardiac arrest. It would be beneficial if one was purchased by Gayndah Packers Co-operative and that appropriate training be given in its use and ensuring that on each shift there is someone with the ability to operate the device.

In light of my comments I make the following recommendations:

1. That a formalised procedure be developed to ensure that there are two persons trained in first aid and CPR on each shift.

2. That a formalised procedure be developed to ensure that there is proper and appropriate risk assessment procedure in place.

3. That a formalised procedure be developed to ensure that there is proper and appropriate job risk analysis procedure in place.

4. That formalised job safety training is carried out.

5. That a defibrillator is purchased.

6. That proper training in the use of the defibrillator be given to appropriate employees.

7. That trained defibrillator operators are on duty in each shift.

In accordance with sections 45(4) and 46(2) of the Coroners Act 2003 I direct that a copy of my findings and comments be provided to Ms Thorpe who has appeared for the family, Mr Burgess who has represented Gayndah Packer's Co-operative and to the State Coroner.

In conclusion, I thank Ms Thorpe for her participation in the inquest. It has no doubt been a difficult time for you. I wish to express my condolences to you and all other members of Geoffrey's family.

I thank Gayndah Packers for making the view possible and I thank Mr Burgess and counsel assisting, Mr Tate, for their sensitive participation in this inquest.

The inquest is now closed.

S D Guttridge
Coroner Gayndah