QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Stephen Leonard Viner**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2017/565
DELIVERED ON:	8 August 2019
DELIVERED AT:	Brisbane
HEARING DATE(s):	30 April 2019, 11 to 13 June 2019, 24 June 2019
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, workplace death, undetermined cause of death, electrocution or natural causes.

REPRESENTATION:

Counsel Assisting:	Ms M Jarvis
Counsel for the Viner family:	Mr M Clarke i/b Caxton Legal Centre
Counsel for Office of Industrial Relations:	Miss E Cooper i/b Crown Law
Counsel for Constantinos Kouzoukas:	Ms Kristi Riedel i/b Gadens Lawyers

Contents

Introduction

1. Stephen Leonard Viner was 57 years old when on 6 February 2017 he was found deceased floating on his back partly submerged in approximately 30 cm of water in the basement of a commercial premises at 36 Palmerston Street, Annerley in Brisbane.
2. Mr Viner was performing maintenance work on bilge pumps to remove water from the basement. At one point he plugged an extension lead into a wall socket located inside the loading bay section of the complex and then proceeded down the stairs to the basement with the extension cord and light to conduct the maintenance work.
3. A short time later a worker standing in the vicinity of the power socket heard a loud crack and initially it was reported she had seen sparks flying from the extension lead. The worker reported this event to other workers and on entering the basement area, Mr Viner was found lying partly submerged in the water within the basement.
4. Emergency services were contacted. The extension cord was removed from the socket and other workers switched off electricity sources. The area was rendered safe by Energex. Queensland Ambulance Service officers then were able to enter the basement and found that Mr Viner was already deceased.
5. At autopsy, there were no findings to explain Mr Viner's cause of death. The forensic pathologist noted whilst there were no injuries or other marks on Mr Viner's body to suggest electrocution as a cause of death, given the circumstances of the death (including the description of someone having observed electrical sparking from a power point and electrical extension cord being used by Mr Viner around the time of his death) electrocution was considered a strong possibility. The pathologist also noted some natural disease present including a moderate degree of atherosclerosis and a mildly enlarged heart with focal scarring. He stated whilst the degree of atherosclerosis was insufficient to account for death independently, a sudden abnormal heart rhythm leading to collapse and death could not be entirely excluded.
6. The forensic pathologist stated in his opinion the medical cause of death was "not determined".
7. The incident was investigated by the Office of Industrial Relations (OIR) including officers from the Electrical Safety Office (ESO). The investigation found the cause of Mr Viner's death could not be determined and 'all indications are that the cause of his death may never be determined'.
8. Subsequent to that report, the Office of Industrial Relations engaged an expert, Associate Professor Chris Andrews who reached a similar conclusion to Office of

Industrial Relations, namely, that whilst there were a number of possible causes of death, the evidence to support one over another was not available and, as such, the actual cause of Mr Viner's death could not be determined with any certainty.

Issues for the Inquest

9. Given the considerable uncertainties regarding the medical cause of death and the circumstances as to how the death occurred, a decision was made to hold an inquest. The issues for the inquest were determined at a pre-inquest conference as follows:

    i. The findings required by s. 45(2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how he died and what caused his death (and, in particular, whether the death was from electrocution).

    ii. The circumstances surrounding the death of Stephen Leonard Viner on 6 February 2017.

    iii. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the *Coroners Act 2003*, particularly from a work health and safety perspective.

10. It was further determined after hearing from the legal representatives of the family of Mr Viner that two further sub-issues be explored, namely:

    iv. Whether or not the qualifications of the deceased contributed to his death in any way;

    v. Whether or not ongoing defect management of the property contributed to the death of the deceased in any way.

11. The following witnesses were called to give evidence;

    - Joshua Richardson, production manager for Zen Catering
    - Agnes Dela Cruz, kitchen hand
    - Stephen Underwood, Principal Investigator, Office of Industrial Relations
    - Reg Neil, Senior Equipment Safety Advisor, Equipment Section, Electrical Safety Office, Office of Industrial Relations
    - Kevin Sparkes, Principal Electrical Safety Inspector, Electrical Safety Office, Office of Industrial Relations
    - Associate Professor Chris Andrews, expert witness
    - Alan Parker, tenant in the premises
    - Dr Christopher Day, forensic pathologist
    - Mr Constaninos Kouzoukas, owner of premises

Autopsy results

12. Dr Christopher Day, Forensic Pathologist conducted a post-mortem examination. Post-mortem scans showed calcification of the coronary arteries. There was no evidence of injury. External examination found several minor healing abrasions to the left hand and right leg. There were no injuries to indicate recent significant trauma. There was no evidence of an electrical burn or thermal injury to the body surface to confirm electrocution.
13. There were no objective findings of drowning. This indicates Mr Viner had already died as he hit the water.
14. An internal examination showed a mildly enlarged heart with moderate coronary atherosclerosis. The narrowing was between 40 to 60%, which is at the upper limit of the moderate range. There was also a very small area of focal scarring or fibrosis in the heart, which could have been due to an infection (myocarditis) or a previous heart attack. This may have resulted in minor chest pain at some stage but there may have been no symptoms.
15. The lungs were heavy and congested consistent with tobacco smoking. There was also a history of diabetes, which are both risk factors amongst his age and gender for development of heart disease.
16. Toxicology testing found a non-toxic level of the antidepressant drug Doxepin. There was no evidence of an acute diabetic-related complication.
17. The forensic pathologist stated that whilst the degree of coronary atherosclerosis is considered insufficient to account for death independently, a sudden abnormal rhythm leading to collapse and death cannot be entirely excluded. In evidence he stated the condition of coronary atherosclerosis is a common one as we age.
18. Whilst objective findings of electrocution were not identified, their absence does not preclude it being a cause of death, and given the circumstances as outlined, electrocution was considered a strong possibility. In evidence Dr Day was asked to comment on the scenario of receiving an electric shock below the level of the heart and at a lower voltage. Dr Day agreed that potentially Mr Viner's heart condition could make his heart more susceptible to succumb to such an insult.
19. Dr Day stated that electrocution fatalities in bodies of water may not show evidence of typical thermal injuries or sites of entry or exit of current, as the potential surface area of skin exposed to electricity is potentially large making a focal entry point or burn less likely.

Evidence on the Issues

Personal History

20. Mr Viner's family provided some brief reflection on his life and character given they said he was larger than life and impossible to sum up. He was said to be generous with a giving nature, down to earth, loyal and funny, respectful of all people. He was a tremendous husband, father and friend and is significantly missed.
21. These sentiments are also reflected in some of the comments of witnesses about Mr Viner in respect to his regular attendances at the premises in his capacity as a maintenance man. He appeared to have been regarded fondly by those people.
22. Mr Viner had a past medical history, which included smoking, insulin dependent diabetes, dyslipidaemia and previous episodes of bronchitis.
23. According to the statement of his son, Mr Viner had no formal trade qualifications and he was mostly self-taught. He initially worked as a truck driver until he commenced employment at a furniture store and learned how to repair broken furniture. In approximately 1999 Mr Viner injured himself in a truck accident and this ultimately prevented him from returning to work in that capacity. In 2003 his father commenced to renovate their home. In approximately 2007 Mr Viner started working for Con Kouzoukas.
24. Mr Viner's son stated, and consistent with the evidence of tenants and other workers, the frequency of Mr Viner's attendances ranged from weekly to once a month depending on what maintenance needed to be done. Mr Kouzoukas also owned a number of other properties where his father would also perform maintenance work. This included tiling, building fences, fixing taps, repairing roofs, installing toilets, locating and repairing leaks, repairing roofs and walls and replacing light bulbs.

Circumstances leading to death

25. According to information provided to OIR, Mr Viner was related to the owners of the building through marriage. It was stated he was a part time worker employed by the owners on a casual basis to do odd jobs and fix things at the premises as required. Mr Viner had attended the premises that morning, to help with some flooding that had occurred in the basement area, which had been noticed by tenants about a week prior.
26. Mr Viner had previously worked to install two submersible water pumps in the basement, which was prone to flooding at times from what was believed to be rising groundwater. For reasons that were uncertain at the time it appears the pumps had not been effective in preventing the flooding on this occasion.

27. The premises were owned by Constantinos Kouzoukas and his wife and part of the building was leased to a catering company, Zen Catering. Workers of the catering company recall Mr Viner arriving at 8:15 am and he borrowed a power cord, which was plugged into a power point upstairs. The cord had been tagged and tested recently. The basement had previously filled with water after rain but according to staff there had been no loss of power in previous incidents.
28. When Mr Viner arrived that morning he spoke briefly with staff from the catering business who were working in the kitchen areas close to the basement. He asked one of those staff, Agnes Dela Cruz, if he could borrow an electrical extension cord, which he plugged into a power point in one of the kitchen areas. Mr Viner was then seen carrying the extension cord and a portable hand-held work light, and he took them down to the basement area.
29. Joshua Richardson is the Production Manager for Zen Catering. He said he had been down to the basement once or twice in two-three years, because there was "stuff" down there they had to take out and scrap. He knew Mr Viner as a handyman through the landlord. Mr Richardson said Mr Viner came regularly to do general maintenance but there were other tradesmen who came if the work was outside his scope.
30. A couple of weeks previously Mr Richardson let Mr Viner know there was water in the basement. He said in the previous week 'a guy' turned up and drained most of the water out. This person is likely to be Alan Joseph Parker who had a mechanical workshop and car wash on the same block.
31. Mr Parker told OIR he had attended the week prior with a submersible pump and drained the water out into the council drain. He was able to access the basement because the gate to the basement is never locked. He decided to do this because of the stench. He did not go into the water, and just 'threw' his submersible pump into the water. He plugged it in using a power cord out of the back of the catering place. His submersible pump has a very long electrical lead, which was water tight, so he did not need to go down to the basement to plug it in down there.
32. Mr Parker was not present at time of the incident when Mr Viner died, but attended afterwards (after police and QAS arrived and on being told about the incident by the owner Con Kouzoukas). He assumed Mr Viner had been called to look at the pumps and believes the pumps had stopped and stated 'it actually had filled up a fair bit under there'.
33. Mr Richardson was not aware Mr Viner was coming. He understands Mr Viner grabbed a power cord, he thinks from a chef Mr Antoni Bozin, but he was not involved and did not see that.

34. Agnes Dela Cruz had worked with Zen Catering for around 14 months. She was aware of the "test and tag" processes for electrical equipment and was not aware of any other electrical issues.
35. She saw Mr Viner go down to the basement carrying a light and a cord. She was in the kitchen cleaning dishes. She then heard some sparking on the wall in the kitchen, smelt burning, and in her interview with OIR said she saw sparks coming out of the power point where the extension cord was.
36. In giving evidence at the inquest, it became clear Ms Dela Cruz was washing dishes at a sink where she had no direct view of the power point where the extension cord was plugged into. She said in evidence she heard sparking, explaining it was like "rocks hitting" and she then smelt a burning, which was different to kitchen smells and described it as "burning electricity". She stated this was similar to a burning smell that had come from kitchen appliances like a meat slicer. She then went around the corner to the powerpoint and saw smoke, which was grey in colour. Importantly she said she did not see any sparking just the sound and the smell and the smoke. She believes she may have told the chef Antoni Bozin she heard some sparking.
37. The inconsistency in Ms Dela Cruz's evidence concerning whether she saw actual sparks or not can perhaps be explained on the basis that English is clearly not her first language and perhaps due to the manner in which this evidence was adduced through some leading questions. In the interview with Mr Underwood, the following exchange occurs:

> *Ms Dela Cruz --I am just standing there and I heard some, like, sparking on the wall on the kitchen.*
>
> *Mr Underwood--so what did you actually hear?*
>
> *Ms Dela Cruz--It is like, sparking thing, like I saw, what you call that, it is like, if something like you plug something on the wall it is going to explode, something like that and I can smell the burning of the—*
>
> *Mr Underwood-- okay. You could smell burning?*
>
> *Ms Dela Cruz-- Yeah I smell*
>
> *Mr Underwood--smell burning and you could hear, ah, electrical*
>
> *Ms Dela Cruz-- yeah I just hear*
>
> *Mr Underwood --electrical noise?*
>
> *Ms Dela Cruz--that the one, I heard the electrical*
>
> *Mr Underwood—noise. Did you see any sparks?*
>
> *Ms Dela Cruz--Yes*

Mr Underwood--saw sparks?

Ms Dela Cruz--Yeah

Mr Underwood--where were the sparks?

Ms Dela Cruz-- Oh, and the- not on the extension, the plug

Mr Underwood— so on the wall.

Ms Dela Cruz--Yeah

38. Ms Dela Cruz says she then went to the top of stairs and called out to Mr Viner, with no answer. She then told the chef Antoni Bozin and they both went to the top of the stairs and called out again with no response. She said in evidence after a few minutes she spoke to Joshua Richardson.
39. In his interview Mr Bozin told OIR he had had worked for the catering company for nine years and had known Mr Viner as the handyman (little fix it guy) for the premises for all of that time. Mr Bozin was asked what Mr Viner fixed and replied that it was whatever needed fixing such as leaking taps, plumbing, replacing damaged panelling from termites and whatever he could do that was "not out of his league".
40. On the day of the incident Mr Bozin stated Mr Viner asked for an extension cord and then went downstairs to the basement. After about ten minutes the kitchen hand told him she saw sparks come from the power point. He then went to the top of the stairs to the basement and called out Mr Viner's name and did not get a response.
41. Mr Richardson stated he came up from the office, and Mr Bozin told him that Agnes the kitchen hand had seen sparks from the power point. Mr Richardson says he spoke to Agnes and she said she saw sparks and could smell burning electricity. Mr Richardson says the business did not lose electricity. Ms Dela Cruz also recalls the lights remained on and the chefs were upstairs and none said the power went off.
42. Mr Richardson went downstairs to tell Mr Viner about the sparks. Mr Richardson does not think there was any artificial light and the area was not lit up at all. He went to the bottom step and called out his name. He looked around and saw Mr Viner near a blue refrigeration unit and a metre or so from a large pedestal fan under the water. He called triple zero. He saw the extension cord going down the stairs and knows it was plugged in up the top. After he called the ambulance, he ran to the switchboards and switched everything off. Mr Bozin pulled the cord from the wall. Mr Richardson stated all equipment being used had remained on. He stated none of the switches were in the "off" position but he does not have a clear recollection if all were in the "on" position. The workers sensibly and reasonably

resisted entering the water to assist Mr Viner because they were concerned they could be electrocuted. It is now known Mr Viner was probably deceased by the time he hit the water.

43. The Queensland Ambulance Service attended but Mr Viner was declared life extinct at the scene. Resuscitation efforts were not performed.

Evidence of Constantinos Kouzoukas

44. Constaninos Kouzoukas told OIR he has owned the building for 20 years. He said he was related to Mr Viner by marriage in that Mr Viner married his first cousin and he has known him for 30 years. He stated the equipment in the basement (condensers) was 'decommissioned' by the time he bought the building, with all electricity disconnected.
45. In his evidence he stated he purchased the property around 1994. His memory at the time was the property was vacant. He had seen the old engine room downstairs where there were condensers and cold compressors and there was a pump in the basement to pump water out. He was told the basement flooded due to underlying ground water and a pit had been purpose built to collect water and pump it out. He stated one of his concerns related to the refrigeration units as he was told they had been decommissioned and there were now replacements on the roof. He stated an electrician had been requested to ensure the equipment had been decommissioned but he was not sure the name of the electrician who performed this task over 20 years ago. Mr Kouzoukas said he was an auto electrician and mechanic by trade and he also had a quick visual inspection at the time and the equipment appeared to be disconnected.
46. Mr Kouzoukas said Mr Viner did handyman type work for him at the building in respect to smaller jobs as needed, or when he was called from the property manager. He has a builder he calls on for any big works. Mr Viner just did 'little odds and ends'.
47. He stated the current property manager is 'First Asset Management'. They have never raised any electrical issues with him. They have issued him with a report of things that needed to be done around the place (eg white ants, infected wood etc).
48. Mr Kouzoukas told OIR he had only been down in the basement 'a handful of times'. The basement was not used for storage or anything and so there was no reason to go down there, other than to tend to the pumps. It was kept locked with an iron gate across. Mr Kouzoukas said he was involved in pumping out the water back in June 2016, using an external pump and a hose. Mr Viner was the person who bought the current pumps from Bunnings. He still has the invoices.

49. Mr Kouzoukas stated in evidence he had been down in the basement previously and had carried out inspections when the pumps were not working, as they had a lifespan of 5-7 years. In June of 2016 the basement was flooded for about the third time since he has owned the building (when it rains, stormwater rises from below the ground, into a pit/tank in the corner of the basement, and can spill over onto the concrete slab). On the occasion in 2016 the pumps for evacuating the water had stopped working. He used his own pump to dewater the basement, and he arranged for Mr Viner to purchase two new pumps, one for in the pit/tank and one for on the concrete slab as a backup. The pumps were plugged into a power point up on the wall. Mr Kouzoukas stated his recollection of how high the water had ever got was about a metre. He could not recall when this occurred but the recalls the water was over the height of the compressors. When the OIR Inspector Underwood described to Mr Kouzoukas the water when they went down was about a metre high with all the compressors and everything under water, he replied that height would be the highest he has ever seen it. He denied the water had ever got to ceiling height.
50. Mr Kouzoukas also said he has never had any electrical problems with the basement in the 20 years he has owned the building. This is the fourth time he has had to replace the pumps (ie when he replaced them after the fatal incident). Mr Kouzoukas stated the only live electricity in the basement was the power point and maybe a switch for a ceiling light (he was not sure if it was working at the time, but it had worked at one stage).
51. The then property managers (Tegan from First Asset Management) contacted him about water being downstairs, and he rang Alan Parker from the mechanical shop next door to ask him to check for him. Mr Parker called back and confirmed there was water and Mr Parker told him he would take care of it with a pump he had.
52. Mr Kouzoukas then called Mr Viner and asked him to investigate the water issue. Mr Viner agreed but said he could not get there until the following Monday 6 February 2017.
53. Mr Kouzoukas stated this was the first time he had become aware of any problems with those pumps (that is, that they might not be working given the water that was reported to be present and pumped out by Mr Parker).In his evidence he said he was surprised both pumps had failed and stated it could have been due to the power point being switched off as he recalls on one occasion someone had broken into the basement and the power point was switched off. This incident was not reported to the police and he does not recall when this occurred. He understood

people may have entered the basement to steal any copper wiring and pipes from the compressors.

54. Mr Kouzoukas stated he had not given any direction to Mr Viner as to how to fix the problem. He was not aware of any issues with the power outlets in the basement. He does not know why Mr Viner used the extension lead plugged into an outlet upstairs to power the pumps.

Maintenance of Building

55. The records indicate at the time of the incident the premises were managed by First Asset Management. They had only been managers for a period of seven weeks from February 2017. Angelo Efstathis told OIR the owner was difficult to deal with and their company really only ensured the rent was paid up on time or chasing any arrears. The owner would organise his own tradesmen to attend to any maintenance issues. They were not aware of any issues in the basement and did not know, until after the event, that Mr Viner had attended the property. They had never been advised of any electrical problems or issues at the property.
56. The previous property managers were Net Rent Commercial. OIR had spoken to Thor Harrison who stated they had been managing the property from mid-2005. He stated the owner organised his own people to attend to any maintenance issues and they only ensured that rent were paid. He stated this was often a full-time job as various tenants were often late with payments. He was never made aware of any electrical issues at the property.
57. It is evident from statements from a number of witnesses who were either tenants or employees of tenants that Mr Viner was frequently at the premises performing maintenance work for the owner.
58. It was also understood that in the year prior to his death Mr Viner was also contacted directly by the real estate agent who managed the Ipswich Road property on a number of occasions to undertake repairs or maintenance. According to his son, Mr Viner was paid cash in hand by Con Kouzoukas.
59. Mr Kouzoukas also said he and Mr Viner would do contra deals (eg Mr Kouzoukas would fix Mr Viner's vehicles) and sometimes there was no charge. Mr Kouzoukas stated any invoices he received he paid and never questioned the amount as he trusted Mr Viner. Invoices invariably ranged in the hundreds and not thousands of dollars.
60. Mr Kouzoukas told OIR he has used the same electrician for the last three or four years. The property manager tells him of any problems, and he acts on it (by

engaging the electrician). He was not aware of anybody having received an electric shock at the property.

61. In relation to submersible pumps in question he stated there was no hard wiring and they just needed to be plugged into a powerpoint and an electrician is not needed.

The Investigations

Work Place Health and Safety Investigation

62. The incident was investigated as a 'Serious Electrical Incident' under the *Electrical Safety Act 2002* and as a workplace death under the *Work Health and Safety Act 2011*. The primary purpose of such OIR investigation is to fulfil its regulatory responsibility to determine if any duty holders had breached their obligations under the WHS Act. The Investigation Report by the Office of Industrial Relations, which reports the outcome of these investigations, states that despite those investigations (which included testing of several pieces of electrical equipment, including the portable work light, electrical extension cord and water pumps Mr Viner was working with at the time of the incident) the cause of Mr Viner's death could not be determined and 'all indications are that the cause of his death may never be determined'.
63. The WHSQ investigation was conducted by Stephen Underwood. Mr Underwood had previously been a detective for 16 years with the Queensland Police Service and had diploma qualifications in investigations. He had conducted two or three previous electrical incidents. He relied on the Electrical Safety Office opinions relating to electrical issues.
64. The report prepared by Mr Underwood noted that Mr Viner was a part-time worker employed on a casual basis to do odd jobs and fix things at the premises as required. Mr Viner was said to be related to the owners of the building. The owners and the lessees of the building stated there had not been any previous electrical problems in the building .Mr Viner had been requested to attend in the basement to ascertain why the pumps had stopped working. There were no witnesses to the incident.

Yellow extension lead plugged into submersible pump

65. Arrangements were made with police scientific officers to take photographs and a video of the scene. Mr Underwood described the scene in the basement in that it contained water to a level of about 20 cm and covered the whole floor of the basement. There was a lot of old equipment and old electrical equipment. A yellow lead came down the concrete stairs, which was wrapped around some equipment on the wall and it did not come in contact with the water. The yellow cord was plugged into an Ozito 350W submersible pump. He saw a black mobile phone and a pair of spectacles on a piece of equipment (later described as the Blue Refrigeration unit). The mobile phone had its torch with its light engaged. Another pair of spectacles were photographed in the water nearby. Mr Viner's son gave a statement verifying both pairs of glasses belonged to his father, one for short and one for long distance.

Blue Refrigeration Unit with spectacles and mobile

66. Arrangements were made for the water to be pumped out of the basement. Later inspections and advice received from the Brisbane City Council found the water was ground water rising up from the ground after rain and there were no plumbing issues. Mr Underwood's report noted new pumps were installed in June 2016 by Mr Viner after a previous incident of water being found in the basement. One pump was placed in a pit and one pump was on the concrete. They were plugged into a power point on the wall. The owner stated all the other equipment in the basement had been decommissioned before he bought the property and the only thing live in the basement was the power point on the wall above the pumps. Mr Underwood stated he is aware from the findings of the ESO that electrical supply to fuses in the basement and the Blue Refrigeration unit was present but no shock path was identified. Since the incident the basement electrical system has been isolated completely.
67. A number of items were identified for testing by ESO officers and taken from the scene.
68. WHSQ concluded the cause of death has not been determined and there was insufficient evidence to commence a prosecution.

Electrical Safety Officers report and findings

Equipment Inspection – report of Reg Neil

69. Inspectors from the Electrical Safety Office attended at the premises on 6 February 2017. 10 items of electrical equipment were collected from the scene and sent to

the equipment section of the ESO for further analysis. Reg Neil is the Senior Equipment Safety Advisor and was responsible for the testing of this equipment. The equipment had been collected by Kevin Sparkes.

70. The 10 items of equipment were a Merlin Gerin RCBO or safety switch; four Rewireable porcelain fuses; a double wall socket outlet; a cord extension set; a submersible pump; a portable work light; and a double adapter.
71. According to the report of Mr Neil the purpose of the examination of these electrical items was to determine if a shock path existed and if there was indication of any obvious and pertinent non-compliance to the relevant equipment safety standard. The examinations comprised of visual inspections and limited tests generally in accordance with Australian electrical safety standards relevant to the type of equipment.
72. In respect to the RCBO safety switch this worked when depressing the test button. An injection of current caused the safety switch to trip. The safety switch was found to be operating correctly and within limits of the relevant safety standards.
73. In respect to the rewireable fuses these were examined and upon initial examination one fuse was found to have operated. This blown fuse was likely to be due to an overload condition of the circuit protector.
74. A visual inspection of the double wall socket outlet revealed no signs of external damage to the installation or the terminal connections.
75. The 20 metre cord extension set passed insulation resistance tests between live parts and the external sheath of the cord, including after being immersed in a saline solution for 24 hours. The insulation system of the cord set providing protection against electric shock and the connections of the cord extension set were shown to be functional. No electric shock path was identified. If the extension cord had been in contact with water such a scenario may create a shock path. However, there was no evidence of the socket outlet of the cord extension set having been submerged in water and it was considered unlikely as a source of a shock path. It was noted the socket outlet was not found submerged in water.
76. With respect to the submersible pump it passed an insulation resistance test from live parts to accessible metal parts (4 metal screw heads). It also passed continuity tests on its disconnection. The pump as supplied, and again after operating in water for 45 minutes showed no change in the result. The insulation against electric shock and the protective earthing of the pump was shown to be operating correctly. No electric shock path was identified.
77. A visual inspection of the double adapter outlet device showed no signs of external damage. An internal examination showed no evidence of water ingress, humidity

or corrosion. No electric shock path was identified. This equipment was also eliminated as a possible scenario.

78. A visual external inspection of the work light showed no damage and there were no exposed live parts accessible to the standard test finger. There was no evidence it had been submerged in water. No electric shock path due to an equipment fault was identified. There was no evidence to suggest it had been submerged in water and this was considered unlikely.
79. In summary, Mr Neil found there was no clear evidence of a shock path from the equipment supplied. Some live parts such as plugged pins, which are not weather proof rated, if in contact with water may create a shock path, however, there was no evidence to show this scenario was likely.
80. Mr Neil reported the presence of potential shock paths from any failure or electrical faults in the pump or cord extension set can be eliminated after consideration of the examination findings.
81. There was no evidence of the work light or double adapter being recently immersed in water and no evidence these items were connected to electrical supply at the time of the incident. These items were eliminated as having potential shock paths.
82. Mr Neil opined the only foreseeable potential shock path could be from the immersion of the pump's plug in connection to the cord extension set socket in water. In this circumstance there would be no effective insulation from live parts and the water. This scenario is unlikely as there was no evidence the plug or cord extension socket were immersed in water. This is in addition to the cord extension set and the socket outlet that were reportedly found located above the water level at the time of the incident. It would also have been likely in the event of the plug/sockets immersion in water that the RCBO would have operated, isolating the mains supply to the cord extension set (the RCBO was in operational order). No shock paths could be identified from the equipment examined.
83. The protection from electrical shock through both the insulation system and protective earth system in the pump and cord extension set appeared to be effective. These items can be eliminated as sources of potential shock paths.
84. The safety switch (RCBO) was confirmed to operate correctly. The safety switch was not considered as a possible source of a shock path.
85. Close visual examination of the work light, double adapter, the plug for the pump and the plug and socket outlet in the cord extension set failed to show any evidence of immersion in water. These items could also be eliminated as potential shock paths.

86. There were no indications of any pertinent non-compliance to the relevant equipment safety standard for any of the equipment.
87. A second submersible pump from the incident site was examined by Mr Neil almost a year later. This pump had been immersed in water at the site for an extended period. The pump appeared to be working normally when examined. No clear evidence of any shock path could be identified from the equipment supplied for examination.
88. Mr Neil confirmed in relation to the cord extension that one of the pins was slightly bent. He was asked what explanation could be given to a witness spelling a burning odour and hearing a “sparking” noise at the power outlet. He stated normally this could be a sign of bad contact but he could see no signs of any melting or of heat. There was no signs of water ingress or evidence of arcing on the pins. Normally if there is some transverse contact you would normally see some signs such as arcing or an “Ozone” smell. He agreed it was theoretically possible if there was some movement of the plug it could contribute to an electrical activity and a smell. He stated that in relation to a smoke smell this would be a sign of excessive current and the safety circuit should have tripped.

Report of Kevin Sparkes

89. Kevin Sparkes was the lead ESO inspector who conducted all of the tests of the electrical installations and equipment within the site after the incident. He had attended the scene on 6 February 2017.
90. When he arrived the electrical cord had been unplugged from the power socket in the loading bay upstairs. He was told it had been found plugged into the socket but was unplugged during the rescue.
91. Mr Sparkes took a number of photographs of equipment and power outlets and sockets and other equipment.
92. The Safety Switch (RCBO) was off when he inspected it. It could have tripped or been switched off manually.
93. Mr Sparkes tested insulation resistance of the extension lead while the submersible pump was still plugged in and found no faults with the insulation of the active and neutral conductors of this equipment. The next day he inspected the socket outlet and found no evidence of arcing or damage.
94. He also plugged the male end of the yellow extension lead into the socket outlet where he had been told it was plugged into at the time of the incident. He had to pull the extension lead tight so it would reach the socket outlet, but it just reached.

The test result indicated no insulation fault with the active and neutral conductors of this equipment.

95. Mr Sparkes examined the extension lead where it ran from the car park into the basement to where it was coiled over an old wall mounted basement sump pump that was not plugged in. The female socket end of the extension lead was located near where the lead was coiled on the pump motor. The extension lead was strung above the water.
96. Mr Sparkes saw the submersible water pump was plugged into the extension lead. His testing indicated there was no fault from the active and neutral conductors of the pump to the water in the basement.
97. One issue that was tested in examination of witnesses at inquest related to the description of the "sparking" incident as described by Ms Dela Cruz. It can be accepted, based on the findings of Mr Sparkes, that any such adverse incident would not have adversely affected Mr Viner in the basement. Mr Sparkes gave evidence at the inquest that the drawing of a larger amount of current at the time of the motor starting would provide one possible explanation for the adverse electrical activity described by the Ms Dela Cruz. Mr Sparkes also agreed there were other factors that may have contributed to a poor connection between live conductive parts at the upstairs power point, including the bent pin at the plug end of the cord extension set, the cord extension set being set up in a way that there was some tension along the cord length causing the plug end to pull away from the power point, and the power point itself being older and showing signs of wear indicating possible heavy use which can loosen connections inside.
98. There was another pump in the sump pit but it was not found plugged into any socket and accordingly no other testing of this pump was initially considered necessary.
99. Mr Sparkes then commenced testing insulation of the whole electrical installation, starting at the main switchboard. He found three final sub-circuits tested below the minimum insulation resistance required by the Australian Standards.
100. Two of these sub-circuits, although testing lower than the minimum required standard, did not indicate any likely immediate electrical risk with these sub-circuits. He also concluded from the location of the switchboards and the labelling of the circuits they were likely upstairs lighting circuits.
101. Of significance the third sub-circuit that measured a low insulation test was a power final sub-circuit originating at the basement switchboard. He identified a re-wireable fuse on the circuit located on the right side of the switchboards and marked "Power"

on the panel. The fuse element was found blown and he was unable to determine when this may have occurred.

102. The basement switchboard appeared to be very old, all of the circuit protective devices were rewireable fuses and there were no safety switches installed at this switchboard. He saw several old belt driven abandoned refrigeration pumps and that the wiring to these pumps had been disconnected from the switchboard.

103. He noted a fused base marked “lights” but found no rewireable fuse wedge inserted in the fuse base. This explained why the light to basement was not operable.

104. There was a newer blue coloured commercial refrigeration unit located in the middle of the room, which did not appear to be in working order due to the evidence of corrosion from previous flooding in the basement. On inspecting the wiring he saw that it ran out of the switchboard, across the ceiling of the basement to the dividing wall in the middle of the basement to an isolator above the blue compressor. The isolator was found in the “off” position. He verified continuity from the load side of one of the switchboard fuse bases marked “COLD ROOM” to one of the terminals on the line side of the isolator. He saw the three phase active conductors running in conduit from the load side of the isolator were connected to the top row of terminals of the contactor. This meant that even if the contactor was in the “off” position there could be live conductors not switched by the contactor running to the compressor, when the isolator located just above was switched “on”.

Isolator Switch to activate Blue Refrigeration unit

105. Mr Sparkes switched on the wall isolator for the blue refrigeration compressor and verified continuity from the load side of the middle cold room fuse base at the switchboard to one of the terminals of the terminal strip at the Blue Refrigeration compressor.

106. Mr Sparkes also tested continuity from the main earth and the main switchboard to the metal frame of the Blue Refrigeration pump to the sub-main earth conductor inside the basement switchboard. These tests indicated there was a high resistance fault in the earthing conductor. He tested earthing continuity to the metal post and this recorded the post was not earthed.
107. Mr Sparkes stated the testing revealed the basement power and cold room circuits were not effectively earthed and this was a potentially immediate electrical risk defect because if a fault occurred from a live conductor to an exposed conductive part requiring effective earthing, a person potentially might receive a fatal electric shock from contacting the exposed conductive part.
108. However, Mr Sparkes stated although the circuits were not disconnected, he found any electrical equipment connected to the circuits requiring earthing were not likely energised at the time of the incident as the basement power circuit fuse was found blown and the refrigeration compressor wall isolator was switched “off”.
109. In his summary, Mr Sparkes stated he found no defects with the submersible water pumps, the extension lead and the power circuit he was informed was being used by Mr Viner at the time of the incident. He stated there was an increased risk of electric shock of anyone entering the basement while it was flooded and the electrical installation was energised as the electrical installation in the basement was not electrically safe due to serious defects. However, he did not find evidence of the required circumstances to be in place for a person to receive an electric shock because the blue coloured refrigeration unit was found switched off at the wall, the basement power circuit rewireable fuse was blown, and the basement lighting circuit rewireable fuse was not inserted. He found no serious insulation resistance fault with the parts of the electrical installation that would have been energised according to how he found the incident scene. He concluded the only probable cause of a fatal electric shock was the exposed terminals of the rewireable fuses at the basement switch board that a person could directly contact. The rewireable fuse bases appeared to be typical of electrical industry standards when this equipment was permitted to be installed. It was noted the fuse board was some metres away from where Mr Viner was found in the water.
110. Mr Sparkes issued Improvement notices in relation to the defects and his understanding is the notices were complied with.
111. Mr Sparkes agreed there was a potentially unsafe situation if someone was standing near the Blue Refrigeration unit if it was switched on. He agreed the metal post to the unit was not earthed and was an open circuit. Some other parts were partly earthed. The cold room power circuit was 3 phase with one fuse missing.

This meant there would be power to the unit but it would not work. He said in evidence you might hear a humming sound.

112. Mr Sparkes was asked to accept a scenario that if Mr Viner was near the unit, the fuse had not blown and water was in contact with the unit and the isolator switch was turned on, as to what Mr Viner may have felt. He referred to it being a non-fatal level of current and a “tingling” feeling.

113. The isolator switch was described by Mr Sparkes at inquest as a *lever-type switch* and he stated that to turn the isolator switch on and off would require a push down or push up movement and would only require ‘a little bit’ of force, ‘not much’.

Report of Dr Chris Andrews

114. WHSQ commissioned a report from Dr Chris Andrews who has both medical and engineering qualifications. He agreed with the conclusion of WHSQ that there are a number of possible causes of death but the evidence to support one over the other is not available.

115. He opined that for a person to sustain an electric shock, the body requires to be in contact with two points, one being a source of current, and one effectively being an earth.

116. In this case there were two possibilities to achieve this. Firstly, the water becomes one contact area if there was some fault injecting electric current into the water with something touched by the victim becoming the other (like a metal earth or similar).

117. The second possibility was some active item is touched and the water becomes the earth.

118. Dr Andrews rejected the first option. This was because Mr Viner had entered the water and walked a distance to a table and was able to put at least two items of equipment on the table. This was not consistent with the water being energised, thus eliminating this scenario.

119. Dr Andrews was unable to consider where any current would have come from, as both the lead and the pump was tested as satisfactory as well as the double adapter.

120. Dr Andrews considered a third possibility was for Mr Viner to be standing at the Blue Refrigeration Unit with his thighs in contact with its metal, leaning over the unit to reach to the apparatus in the archway control switches. The switches, or the metal table, in the presence of the wet connection block, could then become one source of current, and the water via the table legs, the other. He considered that

testing showed the switch gear was isolated and turned off, negating this possibility.

121. Dr Andrews postulated an alternative might be that Mr Viner operated a switch on the archway control apparatus and this could possibly have provided a source of current to him by the control apparatus. He stated you would also have to postulate that in consequence of the shock, Mr Viner flicked the switch back to "off" prior to collapse. He stated this does not seem possible with the switch gear seen by him, as it was rotary operated, and the return operation would not seem possible in the time available during a collapse. He also stated a lever styles isolator might have been more likely to be operated in this way, but he did not recall this and considered it may have been removed prior to his viewing.

122. In relation to the autopsy findings, Professor Andrews noted 'the almost universal cause of death by electric shock is a 'cardiac arrhythmia' and, in that event, there will be no sign at autopsy in the examination of the heart to indicate this event. He further noted there were no findings at autopsy to either rule out or rule in an electric shock as Mr Viner's cause of death.

123. Professor Andrews inspected the basement and also examined the relevant electrical safety and work health and safety reports. Professor Andrews ruled out the possibility the water in the flooded basement was energised, given Mr Viner had been able to enter the water and walk at least some distance to a table where he placed two items, namely a mobile phone and a pair of spectacles. Professor Andrews then considered whether some item or piece of electrical equipment Mr Viner had come into contact with was a source of the electric shock, but on the basis of tests carried out by electrical safety officers, which found those items were either not active or were active but with no signs of fault, Professor Andrews was unable to arrive at any particular scenario as a likely or even possible cause of Mr Viner's death.

124. Finally, Professor Andrews noted other possible causes of death unrelated to electrical shock, including natural disease or illness of some sort causing a collapse or heart attack, or perhaps some type of insect bite or anaphylactic reaction, but concluded those could be eliminated as inconsistent with the autopsy findings.

Conclusions on the issues

125. In reaching my conclusions it should be kept in mind the *Coroners Act 2003* provides that a coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something. 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.

126. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw*[1] sliding scale is applicable. This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, then the clearer and more persuasive the evidence needs to be for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.

127. With respect to the *Briginshaw* sliding scale it has been held that it does not require a tribunal of fact to treat hypotheses that are reasonably available on the evidence as precluding it from reaching the conclusion that a particular fact is more probable than not.

The circumstances surrounding the death of Stephen Leonard Viner on 6 February 2017 and how and what caused his death

128. On the morning of 6 February 2017 Stephen Leonard Viner attended at the basement of the premises to address some flooding that had been noticed. Mr Viner had been requested to do so by the owner of the premises. Mr Viner had for a number of years acted as a maintenance handyman for the owner in relation to his commercial rental properties. This was not the first time that such flooding had occurred and Mr Viner had previously installed two submersible pumps in the basement.

129. The two submersible pumps had a supply power cord attached to them and which could be inserted into a normal domestic power outlet. One of the pumps was placed in a sump pit with the other on the ground of the basement floor as a back-up. These had been plugged into a single wall socket outlet. It is likely the double adapter outlet device that was found nearby had been utilised for the purpose of connecting the two pumps to the power circuit.

130. It is evident the pumps were not working because water had accumulated in the basement. A few days earlier Mr Alan Parker had used his own submersible pump to pump out some of the water, but he used a power source from another part of the premises and not the basement.

131. Although there are no direct witnesses as to what occurred after Mr Viner entered the basement, a number of inferences can be drawn.

[1] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361

132. Mr Viner would have noted there was no artificial light in the basement. It is accepted there was some natural light available from windows. There was a ceiling light but a number of witnesses recall the ceiling light did not work. It is now known this was not working because the rewireable fuse wedge for this light circuit had been removed from the switch/fuse board in the basement. It is unknown when that occurred but it is likely it had been that way for some time.

133. Mr Viner had a portable electric light, which required to be connected to electric power. It is known Mr Viner requested of one of the tenants the use of an extension cord, which he then plugged into a power outlet socket upstairs from the basement. Mr Viner was seen with the extension cord, which was plugged into the upstairs power outlet socket and with the portable light. It can be inferred he used this light as a light source when he entered the basement.

134. When Mr Viner entered the basement he would have seen the accumulated water and would have seen the two submersible water pumps were not working. There were only two possibilities as to why this was the case. Either both of the pumps had failed or power supply to the pumps had failed.

135. Mr Viner had been careful to keep the extension cord out of the water. It can be seen draped over an old wall mounted pump. It can be inferred Mr Viner decided to connect the extension cord to one of the pumps to test if it was the pump that was a problem or the power source. To do so he disconnected the portable light (it was found nearby on a table) and plugged the pump in the sump pit into the extension cord leading upstairs. This is how the extension cord was found by investigators later and can be seen on scene photographs.

136. The pump would have commenced working. This is known because later testing by ESO officers concluded the pump (in fact both pumps) worked when connected to power and ESO investigators were able to confirm the power circuit from the upstairs outlet also worked.

137. It is likely at the time Mr Viner plugged the pump lead into the extension cord that the kitchen hand working upstairs heard a sparking noise and smelt electrical burning and on inspection saw some smoke coming from the power outlet into which the extension cord was plugged.

138. It is accepted that on inspection of the extension lead and the power point upstairs there was no direct evidence of adverse electrical activity. Mr Sparkes and Professor Andrews had some doubts about whether this incident occurred. However, there is no reason to doubt the credibility of Ms Dela Cruz in her description of what she saw and heard. This is particularly because there is no reason why she would give a false account of adverse electrical activity at the

power point. She immediately told her workplace superiors at a point in time when she would not have known Mr Viner was going to be found deceased in the basement, but brought it to their attention because she was concerned about what she saw and his well-being. It is accepted she was reported as saying to her fellow workers and to WHSQ investigators she saw "sparks" coming from the power point, but in her evidence at the inquest she clarified this. This contradiction can be explained on the basis English was clearly not her first language and she was giving an account to people in authority at a stressful time about the death of a person with whom she had been friendly with on a work basis for some time. I find her evidence credible and was given truthfully.

139. An explanation for this "sparking" event is, as conceded as possible by Mr Sparkes, due to a combination of a slightly loose connection of the lead into the power point (as it was noted by Mr Sparkes when he tested it as being tight to plug in); a bent pin and it being an older extension cord; and the pump motor drawing a larger than usual amount of current as it commenced operating.

140. Mr Viner would not have been affected by what occurred upstairs and may not have even known about it. This incident was not causally related to why Mr Viner died. This can be inferred from the evidence of Mr Sparkes that such electrical activity would not affect someone downstairs as well as the location of Mr Viner's body when he was discovered deceased, which was approximately three metres away from the wall on which the cord extension set and submersible pump power supply cord were attached.

141. Because there was only one known power outlet source in the basement it can be inferred Mr Viner would have therefore reasonably concluded the power outlet to which the pumps must have been connected, may be the problem. We now know the power point outlet in the basement was not working because the testing by the ESO confirmed the power sub-circuit involving the basement power point had a blown rewireable fuse. It is unknown when or why the fuse had blown but clearly this was the source of the problem as to why the pumps were not working and why water had accumulated in the basement.

142. It can then be inferred Mr Viner must have then decided to investigate if there was a reason for the power failure to the power outlet. He no longer had the use of the portable light as the lead was being used to power the pumps and he turned on the torch light function of his mobile phone.

143. It cannot be said exactly what Mr Viner did to investigate, but it is evident he was in the moments before his death in the immediate proximity of the Blue Refrigeration unit. His glasses and mobile phone (with the torch light on) were

found there and his body was nearby. It can be accepted from the evidence of the ESO investigators it was possible for the Blue Refrigeration unit to have a live circuit if the isolator switch was turned “on” and a person came into contact with earthed conductive parts such as the metal post the terminal enclosure was mounted on. If, as I find likely, Mr Viner leaned across the Blue Refrigeration compressor unit to reach and turn on the isolator switch or to turn it off and at the same time came into contact with one or more of the exposed conductive parts of the Blue Refrigeration, then Mr Viner would have received an electric shock.

144. The electric shock was not one that was inevitably fatal given only two phases of the three phases of the equipment were enlivened. Mr Sparkes was asked what could have been felt by a person if that scenario was accepted and described it as a “tingling” feeling.

145. Dr Andrews discounted this possibility but one of the reasons for this was he mistakenly described the switch that he believed isolated the electricity to the unit as rotary operated and believed it would not be possible to turn a rotary operated switch off in the time available during a collapse. Dr Andrews did state that a lever style switch might have been a little more likely to be operated in this way. It is evident in this case the isolator switch is in fact a lever style operation and not a rotary operation. Mr Sparkes also clarified in his evidence that to turn the isolator switch on and off would require a push down or push up movement and would only require only a little force.

146. It is therefore likely and I find, Mr Viner could have switched on the isolator switch, felt a “tingling sensation, and then switched the isolator switch off but then collapsed. The alternative scenario as submitted by Counsel for the family, is after turning the isolator on (and perhaps hearing a humming sound from the Blue Refrigeration unit as described by Mr Sparkes), Mr Viner leaned over to switch it “off” and in so doing came into contact with the exposed conductive parts of the Blue Refrigeration unit. In either scenario he would have received an electric shock and I find it is likely on the balance of probabilities, it was at this moment he collapsed into the water. One pair of his spectacles dropped on the Blue Refrigeration unit together with his mobile. It can be inferred he had the mobile in his hand using it for its torch light purpose and it fell. The mobile was found with the torch light facing into the side of the unit. It is unlikely he would have placed it that way as this would have negated the utility of the light function. Mr Viner’s other pair of spectacles were found near his body in the water and were probably on his head at the time.

147. Mr Viner had an underlying heart condition, which on its own was not likely to cause sudden death, although Dr Day said this could not be absolutely excluded. Dr Day confirmed at inquest that a non-fatal electric shock could nevertheless trigger an abnormal heart rhythm, particularly in someone who had pre-existing coronary atherosclerosis. It cannot now be retrospectively established to what extent the underlying heart condition contributed but I do find Mr Viner suffered an electric shock sufficient to trigger an abnormal heart rhythm causing his death.

Whether or not the qualifications of the deceased contributed to his death in any way

148. The tasks being performed by Mr Viner at the time included investigating the flooded basement and checking on the operation of two submersible pumps. None of those tasks required formal qualifications or training as the submersible pumps were of a type that did not require electrical expertise. As such, there is no evidence his qualifications and training as a handyman contributed to his death on the basis he limited himself to that task.

149. Mr Kouzoukas stated he had not given any directions to Mr Viner in respect to the task at hand. In his evidence Mr Kouzoukas said he was surprised both pumps had failed and stated that it could have been due to the power point being switched off as he recalls that on one occasion someone had broken into the basement and the power point was switched off. Accordingly it can be inferred the issue of the power point operation was a matter Mr Kouzoukas was concerned about and therefor was an issue he may have considered a matter for investigation. Mr Viner would have known of this issue given his long and close relationship with Mr Kouzoukas and clearly decided to investigate this issue.

150. In hindsight, given the presence of water in a dark basement and obviously there being an electrical issue with the power point, it might be considered this decision to investigate was an unwise decision on the part of Mr Viner and he should have left this to electrical experts. It is not possible to now know Mr Viner's state of mind or knowledge at the time but there can be some inferences made. Mr Viner had some familiarity of the basement area and its problems, having installed pumps previously. As well, Mr Kouzoukas believed the equipment downstairs had been decommissioned many years previously, which knowledge and belief I can infer had been passed on to Mr Viner, given their long and close relationship. It was in those circumstances reasonable of Mr Viner to believe

none of the equipment downstairs was capable of being electrically enlivened and it was therefore safe to proceed to investigate.

151. It was argued by the family in submissions that someone with appropriate training, experience, expertise, knowledge and/or qualifications would likely have identified the dangers and risks associated with the tasks and would likely not have approached the task in the same manner as Mr Viner did. They submit Mr Kouzoukas ought to have engaged a qualified electrician rather than Mr Viner. However, Mr Kouzoukas said he believed the equipment downstairs had been decommissioned and therefore there was no electrical risk associated with being in the basement, checking the pumps and checking if the power point was working. As well there is no evidence to suggest Mr Viner had attempted to perform any electrical work beyond his handyman tasks in the past. In this case after noting the power point was not working, he unfortunately turned on the isolator switch not knowing it would enliven the Blue Refrigeration unit. His death is no related to his lack of experience or training but due to the fact not all of the electrical equipment in the basement had been decommissioned as he would have reasonably believed.

Whether or not ongoing defect management of the property contributed to the death of the deceased in any way

152. Information gathered from relevant property managers during the inquest did not reveal any evidence of defects known to either of the property managers related to the electrical installation within the basement. It is noted however that each of the property managers devoted most of their time to rent collection and maintenance issues were largely in the control of Mr Kouzoukas.

153. As noted above Mr Kouzoukas believed that all of the electrical equipment in the basement had been decommissioned before he purchased the property and was electrically safe, other than the power point on the wall above the pumps and a ceiling light was active. Mr Kouzoukas was unable to identify what steps were done 20 years previously and I do not necessarily criticise him for this lack of recall. Whether Mr Kouzoukas' belief is a reasonable one is not necessarily for me to determine, although there is no evidence to suggest or prove otherwise. What is now known is it was not the case that all electrical equipment had been decommissioned.

154. The results of the testing of electrical equipment in the basement by the ESO inspectors confirmed the majority of the old refrigeration plant had its electrical wiring removed and was incapable of being energised. However, two potential

shock paths were identified. Firstly, there was an old wall mounted switchboard incorporating old ceramic type refuses. Five of the ceramic fuse bases had their corresponding fuse wedges removed exposing small recessed brass terminals that remained live. A person touching the small brass terminals could receive an electric shock. Mr Viner was not found anywhere near the switchboard and this source can be eliminated as being the source of a shock path.

155. Secondly, and of more significance to this case, the partially submerged Blue Refrigeration Unit had faulty earthing that could be energised if the isolator switch mounted on the basement wall was turned to the 'on' position. The faulty earthing system meant that if the unit was energised, it could cause a person touching it to receive an electric shock.

156. Whatever can be said to be the reasonableness of Mr Kouzoukas' state of mind and knowledge as to the decommissioning of the basement and who was said to have performed that task, it is clear some of the electrical equipment in the basement was not electrically safe.

Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act 2003, particularly from a work health and safety perspective.

157. The Office of Industrial Relations has an investigative and regulatory role. The OIR's investigation did reveal there was electrical equipment in the flooded basement that was electrically unsafe. However the investigation conducted at the time did not consider there was evidence to identify the unsafe electrical equipment as being directly causative of Mr Viner receiving an electric shock.

158. Counsel Assisting submitted the OIR investigation did identify serious defects with the electrical installations in the basement, however given the age of those installations and the unlikelihood that further investigations would establish how those defects came about, there is insufficient evidence upon which recommendations might usefully be made for preventing such circumstances in the future. I agree, although it has to be said the ESO investigation as to a possible shock path was premised on excluding the Blue refrigeration unit as the culprit simply on the basis the isolator switch was turned "off". The inquest brings into doubt whether it was wise to exclude the Blue refrigeration unit without considering other possibilities, although there is nothing else that could have been done by way of testing to support this scenario.

159. The family submits that there are a number of issues that remain undetermined because they were not adequately investigated as there was an undue focus on

identifying the precise electrical shock pathway, to the exclusion of all else. Those issues were set out in their submission, although a resolution of those issues in my view would not have brought any further clarity to the case and in fact were unnecessary to be investigated.

160. The coronial investigation and inquest has now forensically considered all of the evidence. Based on the relevant standard of proof there are a series of inferences that can be raised, which now supports a finding that a non-fatal electrical shock likely occurred due to the unsafe electrical equipment in the basement and this was sufficient to cause Mr Viner to suffer an abnormal cardiac arrhythmia, possibly and even probably in the context of his heart disease. Whether the findings from this inquest cause the OIR to consider whether there has been any breach of the WHS Act or ESO Act that is capable of being proven to the requisite prosecution standard is a matter for OIR.

Findings required by s. 45

Identity of the deceased – Stephen Leonard Viner

How he died – Stephen Viner attended the basement of commercial premises on 6 February 2017 by prior arrangement with the owner of the premises, to address some flooding that had been noticed about a week prior. When he entered the basement he would have reasonably believed the equipment in the basement was electrically safe. He would have become aware power supply to the pumps from a power point well above water height was not operating. In the course of investigating the cause of this problem he noted a set of switches on a wall and turned one on. At the same time he came into contact with a Blue Refrigeration unit, thought to have been decommissioned, but which later testing found was capable of being enlivened due to two of the three phases of the power circuit being connected to the unit and would become live if an isolator switch mounted on the basement wall was turned to the 'on' position. As well the

partially submerged Blue Refrigeration unit had faulty earthing that could be energised in that scenario. The faulty earthing system meant that if the unit was energised, it could cause a person touching it to receive an electric shock. Stephen turned the isolator switch on and then off. In course of either switching it on or switching the isolator switch off he came into contact with an exposed conductive part of the unit resulting in him receiving an electrical shock. Stephen would have received a non-fatal electrical shock.

Stephen had some natural heart disease, which predisposed him to an abnormal heart rhythm in the event of receiving such a shock, and it is possible this heart condition contributed to his sudden death in these circumstances.

Place of death – 36 Palmerston Street ANNERLEY QLD 4103 AUSTRALIA

Date of death– 06 February 2017

Cause of death – 1(a) Abnormal cardiac arrhythmia

1(b) Electric shock

2 Coronary atherosclerosis

Comments and recommendations

161. I agree with Counsel Assisting there are no recommendations that can be considered to prevent such circumstances again. It is patently obvious the fact the plant in the basement thought to be decommissioned, was not, and this is a serious issue. Given that decommissioning occurred more than 20 years previously in circumstances which cannot be now ascertained, it is not possible to consider what recommendations could be made to prevent that occurring in the future.

I close the inquest.

John Lock
Deputy State Coroner
BRISBANE
8 August 2019