CITATION: *Inquest into the death of Mitchell Thomas* [2026] NTCC 08

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0023/2023
DELIVERED ON:	5 June 2026
DELIVERED AT:	Darwin
HEARING DATE(s):	8, 9, 10, 13, 14 October 2025; 25 and 26 February 2026
FINDING OF:	Judge Elisabeth Armitage
CATCHWORDS:	**Electrical house fire; public housing; electrical arcing in the roof space; smoke alarms; an audit of public housing for electrical safety in Alice Springs and Tennant Creek; major electrical faults; AS/NZS 3019:2022; cyclical maintenance; periodic electrical inspections; investigation of electrical fires; Electrical Safety Regulator.**

Inquest into the death of Monica Presley **[2007] NTMC 037**
Residential Tenancies Act 1999 **(NT)**
Residential Tenancies Act 1997 **(VIC)**
Fire and Emergency Act 1996 **(NT)**
Electrical Reform Act 2000 **(NT)**
Electrical Safety Act 2022 **(NT)**

REPRESENTATION:

Counsel Assisting:	Paul Morgan
Counsel for Department of Housing, Local Government and Community Development:	Michael McCarthy

Counsel for the family of the Deceased:	Jonathan Cooper, Sandra Wendlandt
Counsel for Department of Logistics and Infrastructure:	Tom Grace
Counsel for Joytech, Carey Joy, Kearne Joy and Justin Paech	Sharon Lacy SC

Judgment category classification:	A
Judgement ID number:	[2026] NTCC 08
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Number of pages:	39

IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0023/2023

In the matter of an Inquest into the death of

MITCHELL THOMAS

ON: 01 JUNE 2023
AT: ALICE SPRINGS HOSPITAL

FINDINGS

Judge Elisabeth Armitage

Introduction

1. Mitchell Thomas was born at Alice Springs Hospital on 3 December 2019, to parents Kiannah Beattie and Ethan Thomas.[1] Mitchell tragically died in a house fire at 1 Thorold Court, Larapinta on 1 June 2023, when he was just three years old. Mitchell was described by his family as a healthy,[2] lovely, three year old "who ran amok on us."[3] They said that everyone who knew him loved him.[4] Mitchell loved the film Toy Story. He would pretend to be Buzz Lightyear, jumping off the furniture with his arms out wide.[5] He loved his little brother and cuddles with his mother.[6] He brought his family much happiness.[7]

2. This death was a reportable death because it occurred in the Northern Territory and was sudden, unexpected and in circumstances where Mitchell died from injuries sustained in the fire. The home where Mitchell perished was public

[1] Brief, Folio 3, Affidavit of Identification.
[2] Brief Folio 7, Audio Statement, Kiannah Beattie, 25:00.
[3] T19.
[4] T19.
[5] Brief Folio 7, Audio Statement, Kiannah Beattie, 24:20.
[6] Brief Folio 7, Audio Statement, Kiannah Beattie, 28:30
[7] T19.

housing, owned and maintained by the Northern Territory Government (**Government**). Initial investigations suggested non-compliant electrical wiring in the roof space of the home as a possible cause of the fire.[8] In those circumstances, I exercised my discretion to hold an inquest into the death of Mitchell.

3. I heard evidence in the inquest about the devastating impact Mitchell's death had on his family.[9] I thank the family for attending the inquest, bravely giving evidence about their lovely little boy Mitchell, and sharing the impact on their lives of their immeasurable and enduring grief. I offer my sincere condolences.

4. As the initial police investigation suggested that the fire may been linked to non-compliant electrical wiring, there were concerns that there might be dangerous wiring in other public housing owned and leased by the Government. Discussions took place between the police investigator, the Coroner's office, and the Government which ultimately led to detailed electrical safety audits of a selection of public housing stock.[10] Therefore, in addition to examining the circumstances of the fire at 1 Thorold Court, this inquest also examined the results of those audits.

The events of 1 June 2023

5. Mitchell lived with his family at 1 Thorold Court, Larapinta. The home was a single storey, 3 bedroom, 1 bathroom brick residence with a corrugated iron roof.[11] It was built in 1988.[12]

6. On 1 June 2023, Mitchell's mother left the home at around 9:40am to attend an appointment. Mitchell was left in the care of BJ, Mitchell's 16 year old uncle.[13]

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[8] Brief, Additional Documents, Folio 8, 8.10 Affidavit of Michael St Clair dated 15 September 2025 para 11.
[9] Transcript, p 17-19.
[10] Brief, Additional Documents, Folio 8, 8.10 Affidavit of Michael St Clair dated 15 September 2025 paras 11-21.
[11] Brief, Additional Documents, Affidavit of Michelle Walker, para 96; Brief Additional Documents, Folio 4, QEC Report, p 13.
[12] Brief, Additional Documents, Affidavit of Michelle Walker, para 96.
[13] Brief, Folder 1, Folio 7, Audio Statement of Kiannah Beattie.

Mitchell was watching movies on the television in the living area of the home, while BJ went for a nap in a bedroom.[14]

7. Just before 10:36am a 000 call was made by a neighbour who reported that the house at 1 Thorold Court was on fire and there were people trapped inside.[15]

8. One of the first on the scene was Stephen Greenfield who was driving home from work and noticed "smoke bellowing out of the eaves of the property."[16] He stopped his car, backed up and went to investigate because there were "no fire engines…nobody there yet".[17] At about the same time a neighbour jumped the fence to assist.[18]

9. They both found BJ up pushed up against one of the windows of the house, trapped inside, and they immediately attempted to free him.

10. There was security mesh over the window and, in a feat of no doubt adrenalin fuelled strength, Mr Greenfield managed to pull the entire frame out from its fixings in the wall. The window behind the mesh was slightly ajar. Mr Greenfield and the neighbour slid the window open, and BJ jumped to safety.[19] BJ would most likely not have survived the fire but for the quick actions of Mr Greenfield and the neighbour.

11. BJ' s only concern was for Mitchell and he repeatedly said that Mitchell was still trapped inside.[20] Mr Greenfield tried to enter the home, including by throwing a chair at a kitchen window, but he was unable to gain entry.[21]

12. At about this time, police arrived. Immediately after the initial 000 call was placed a call come over the police radio at around 10:36[22] reporting a structure

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[14] Brief, Folder 1, p11.
[15] Brief, Folio 29 Audio recording of 000 call x21452_10.35.48.714_07-01-2023.mp3.
[16] T23,24.
[17] T23.
[18] T23.
[19] T24.
[20] T25.
[21] T24-25.
[22] T11; Brief Folio 8, Statement of Officer Liam Verity, para 3.

fire in progress. Officer Liam Verity and his colleagues were conducting an unrelated investigation nearby when they heard that call and they immediately went to 1 Thorold Court, arriving there at 10:40am.[23]

13. I had the benefit of viewing portions of Officer Verity's body worn video. It showed the entire home engulfed in smoke at 10:40am. It captured Officer Verity running to the house and within seconds using his police baton to smash the glass in a side door to gain entry. He said it was like opening an oven door. With disregard for his own personal safety Officer Verity entered. The heat was so intense he said it felt like his face, hands and neck were burning.[24] He saw flames coming from the couch in the living area.[25] Realising that he could not make it very far into the home due to the intense heat and smoke, Officer Verity retreated and tried to find another entry point.

14. Officer Verity made a second entry through a different door and crawled on his hands and knees to the lounge room. But again, with the heat even more intense this time[26] he was forced to retreat. Officer Verity re-entered through the original entry point and managed to get a little further inside but was forced to exit out a window due to the heat and smoke.[27]

15. Officer Verity did not give up and he found a fire extinguisher. He entered into the lounge area again and tried to extinguish the fire on the couch, but he said the extinguisher was not effective. Officer Verity entered yet again, this time with a garden hose, but he was again forced to withdraw.[28]

16. Officer Verity[29] and other attending police officers later required medical attention at the hospital and, although their efforts were not successful in

[23] Brief, Folio 8, Body Worn Video, Officer Liam Verity; Brief, Folio 8, Statement of Officer Liam Verity, para 6; T11.
[24] T12.
[25] T12.
[26] T13.
[27] T14.
[28] T14.
[29] Brief, Folio 8, Statement of Officer Liam Verity, para 22.

rescuing Mitchell, they clearly could not have done more in their efforts to save him and in doing so put their own safety at risk. Officer Verity's efforts were heroic, though he would be too modest to say so. He would say he was just doing his job. Well, he did so bravely. I commended his actions to the Commissioner of Police who has determined to award him the NTPF Valour Medal.

17. At around 10:46am – 6 minutes after Officer Verity and his police colleagues arrived – a fire engine from Northern Territory Fire and Rescue (**Fire and Rescue**) arrived, with several firefighters on board, including James Kenna.[30]

18. James Kenna described how he and a colleague were able to enter the home immediately upon arrival because they were wearing protective firefighting gear with breathing apparatus. They entered through the door that Officer Verity had smashed with the baton. The firemen searched for Mitchell and within minutes found him on a bed in a bedroom. He was non-responsive.[31] The fire had started in the roof cavity almost directly above where Mitchell had been sitting in the lounge room watching television. It seems that Mitchell had made his way from the loungeroom to his grandmother's bedroom seeking refuge.

19. Despite the efforts of the first responders, paramedics and doctors, Mitchell could not be revived. Mitchell was declared deceased at Alice Springs Hospital at 11:49am on 1 June 2023.[32]

The autopsy

20. Forensic Pathologist, Dr Marianne Tiemensma, conducted an autopsy on 5 June 2023. She found features of smoke inhalation and exposure, with grey and black soot covering the body, evidence of thermal inhalation injury, bright red discolouration of the blood and intestines, and an elevated carboxyhaemoglobin

[30] T31.
[31] T31-32.
[32] Brief, Folio 27, Department of Health, Occurrence of Death/Consent for Autopsy, dated 1 June 2023, p1.

concentration of 0.34%. There were no other significant injuries or underlying natural pathology that would have contributed to death.[33]

21. It is clear from the autopsy that Mitchell passed away from smoke inhalation.

Formal findings

22. With respect to the formal findings required to be made in accordance with sections 34(1)(a)(i) – to (iv) of the *Coroners Act 1993*, I make the following findings:

    a. The deceased was Mitchell Thomas, who was born on 3 December 2019;[34]

    b. The time and place of death was 11:49am, 1 June 2023 at Alice Springs Hospital;[35]

    c. The cause of death was smoke inhalation (with thermal inhalation injury and carbon monoxide poisoning).[36]

Issues for the Inquest

The cause of the fire

23. The inquest was by assisted by Leigh Swift, a Fire and Rescue investigator, and two independent expert witnesses. The first independent expert, Mr Marty Denham, is an electrical compliance consultant and forensic fire investigator with an electrical safety background. The second, Mr Simon Cox, is also a forensic fire investigator but with an expertise in metallurgy. Each of Mr Swift, Mr Denham and Mr Cox prepared reports and gave evidence. Mr Swift's report was prepared as a result of Fire and Rescue's statutory role to investigate

[33] Brief, Folder 1, Folio 4, Post-Mortem Examination Report for the Coroner.
[34] Brief, Folio 3, Affidavit of Identification.
[35] Brief, Folio 27, Department of Health, Occurrence of Death/Consent for Autopsy, dated 1 June 2023, p1.
[36] Brief, Folder 1, Folio 4, Post Mortem Examination Report to the Coroner, p 29

fires.[37] Mr Denham's and Mr Cox's reports focused on their respective areas of expertise and they were commissioned specifically for the inquest.

24. The inquest was also assisted by Mr Carey Joy who gave evidence based on his electrical qualification and his extensive experience in providing electrical works in Government social housing in the Northern Territory. Mr Joy was not formally retained as an expert witness but was summonsed to give evidence because his firm, Joytech, had carried out electrical maintenance work on the home in the months leading up to the fire. Initially there was some suspicion that that work may have had a connection to the fire.

25. Unfortunately for Mr Joy, he had invoiced for work at the home in a way which indicated that new electrical cabling had been run in the ceiling by Joytech in the months leading up to the fire.[38] An initial report by Mr Denham suggested that this cabling may have been linked to the cause of the fire,[39] although Mr Denham later retracted this as a possible cause.[40] Through vigorous and thorough examination, it became clear during the evidence that the relevant invoice contained an error by Mr Joy and no new cable was laid. Ultimately, there was no evidence of any connection between work conducted by Joytech and the fire.[41]

26. Despite being the subject of my obvious suspicion, Mr Joy provided considerable assistance to the inquest based on his experience providing electrical services to social housing in Central Australia. During the inquest I acknowledged and thanked Mr Joy for the assistance he provided in difficult circumstances, and I now formally repeat and confirm that acknowledgement and thanks.

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[37] *Fire and Emergency Act 1996*, s 6(ca).
[38] Brief, Additional Documents, Folio 2, Sub folder 2.30, Document 2.304 "Inv-13188".
[39] Brief, Additional Documents, Folio 4, QEC Report.
[40] Brief, Exhibit 16, Summary of Change to Opinion dated 13 October 2025, Marty Denham.
[41] T354 (witness Denham).

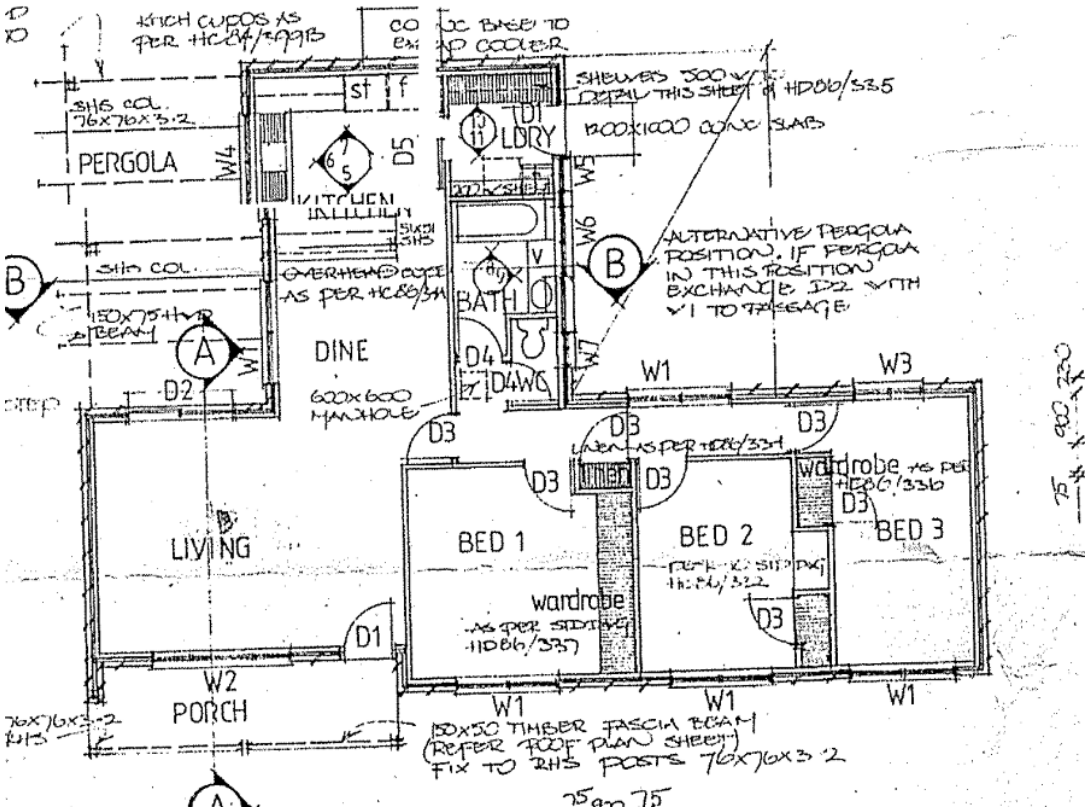
27. Further assistance on electrical matters was provided by Government witness Mr Michael St Clair, who has a background in electrical engineering.[42] Mr St Clair was originally an institutional witness for the Department of Logistics and Infrastructure (**DLI**), but at the time of the inquest he had moved to the Department of Housing, Local Government and Community Development (**Housing**) where his responsibilities include providing the strategic and program oversight for public housing assets.[43]

28. After hearing evidence from Messrs Swift, Denham and Cox, I was also assisted by the parties who, given the highly technical nature of the electrical evidence, attempted to agree a set of facts with respect to that evidence. Following that exercise, while not all details of the electrical matters were agreed, the more substantial aspects of the electrical matters were no longer in dispute.

29. As already noted, the home was constructed in 1988. It was a single-storey, three-bedroom, one-bathroom brick construction with a corrugated metal roof. After the fire the home was demolished. Figure 1 is the floor plan.[44]

[42] T6 (second block).
[43] T7 (second block).
[44] Coronial Brief Folder 2, 133.

Figure 1



30. Either at the time of or after construction of the house, an air-conditioning vent was installed in the "600 x 600 manhole" outside the bathroom and WC and marked on Figure 1 (**Air Vent**). The function of the Air Vent was to allow air brought into the home by the evaporative air cooling unit to escape from the interior of the home into the roof space.[45]

31. There was agreement between Mr Denham, Mr Cox and Mr Swift as to the likely approximate location of the commencement of the fire, being within a small area of approximately 100mm in diameter within the roof space adjacent to the Air Vent.[46]

32. Mr Swift was the first investigator to attend the home after the fire. Mr Swift took photographs of the home and the ceiling space in the immediate aftermath of the fire. Mr Swift's photographs showed he had moved some of

[45] T313.1
[46] T329.6

the electrical wiring during his investigation, to expose different areas of interest, including further electrical wiring.

33. In his report Mr Swift said it was probable damage had occurred to the electrical wiring running alongside the Air Vent which had arced on to the metal surface of the Air Vent frame leaving marks (evidence of arcing) on the frame. Mr Swift opined that this arcing produced enough heat to ignite nearby combustible materials which caused the fire.[47]

34. However, Mr Swift's opinion on this matter was not accepted by Mr Cox or Mr Denham. Mr Cox provided analysis of the arcing marks on the Air Vent that showed the arcing noted by Mr Swift was likely caused by welding at the time of the manufacture of the Air Vent and was therefore unrelated to the fire.[48] Mr Denham provided an initial report to the Inquest but after he had received the report of Mr Cox, provided a second report in which he amended his initial views as to the cause of the fire.[49]

35. Mr St Clair also disagreed with Mr Swift's opinion on this matter. In his oral evidence Mr St Clair said that this arcing was neither likely nor possible to be the source of the fire because there was nothing connected to the return Air Vent – that is, no earth connection – to make a circuit for an arc to occur.[50]

36. For their reports, Mr Denham, and, subsequently Mr Cox, were provided with items removed from the home to assist in their investigations. These items were:

    a. a smoke alarm;

    b. the Air Vent,

[47] Brief, Folder 2, Folio 25, p 15.
[48] T314.6
[49] Exhibit 16 to the Inquest produced at T283.2
[50] T12 (Michael St Clair).

c. electrical cables removed from the house after the fire that had been located adjacent to the Air Vent including sections of the mains supply cable, a twin core cable; and a single core cable.

37. A twin core cable and another cable were providing power and switching to the light in the toilet and to the light and fan in the bathroom respectively. Mr Swift found these cables wrapped around the mains supply cable.

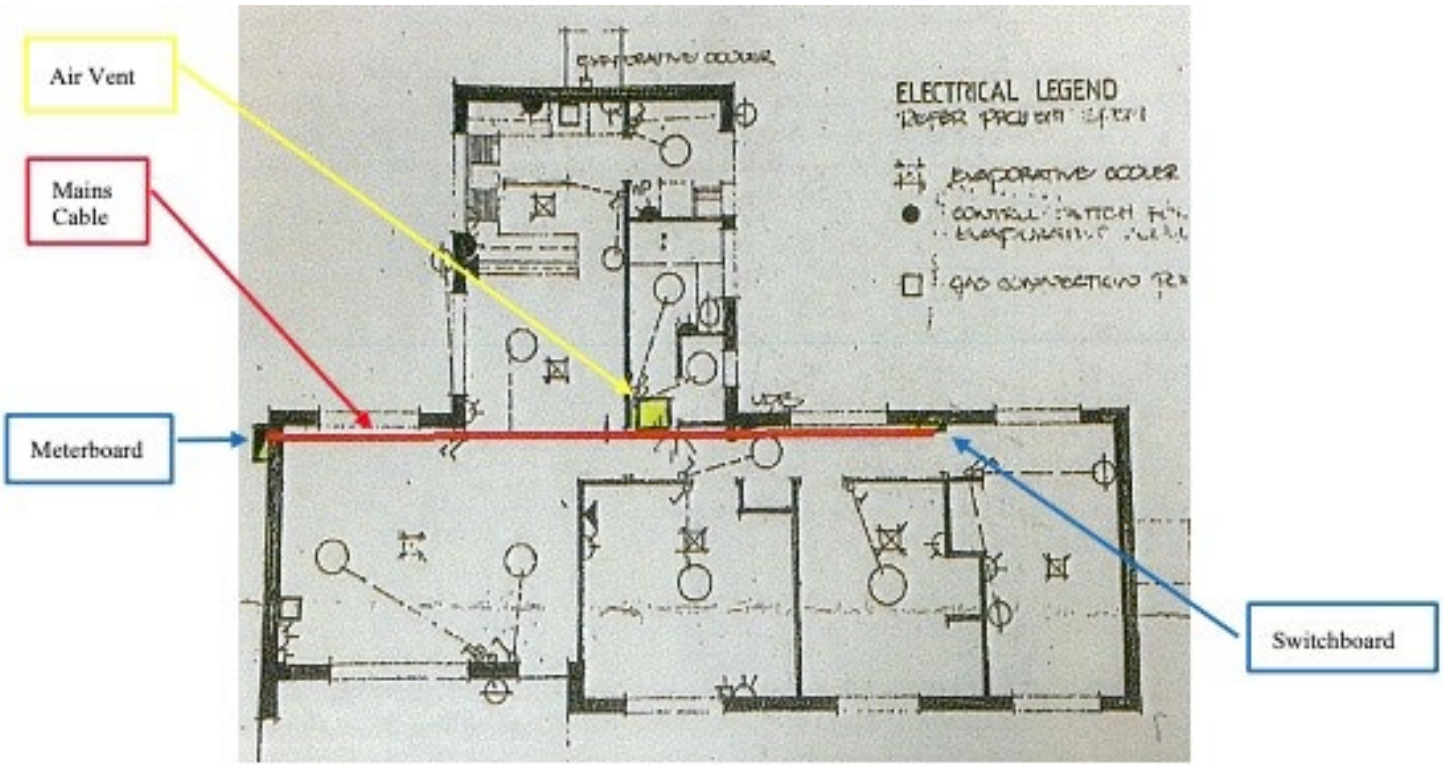
38. The mains supply cable is the cable carrying electricity from the meter box outside the home to an internal switchboard located in the passage leading to the bedrooms.

39. The cables varied in size and each comprised either one, two or three bundles of copper conductors encased in PVC insulation and a further PVC layer encasing the single, double or triple bundles.

40. The approximate locations of the mains cable, Air Vent, meterboard and switchboard are shown on Figure 2 below, extracted from Mr Denham's first report.[51]

[51] Brief, Additional Documents, Folio 4, QEC Report, p 9.

Figure 2



41. At this point it is instructive to summarise the opinions of Mr Cox, since much of what he said was accepted by Mr Denham.

Cox Report

42. Arcing of an electrical cable is a known cause of fires. Arcing occurs when electricity jumps across a gap in a circuit, creating heat.[52] The heat can be sufficiently intense to cause the ignition of adjacent flammable material.[53]

43. Multiple instances of electrical arcing were identified in the copper conductors in the cables provided to Mr Cox. Numerous copper conductors had either been severed or gouged by the arcing.

44. Mr Cox used a stereo optical microscope to locate evidence of localized melting of copper conductors consistent with electrical arcing. Any areas of

[52] The technical definition of "arc" as set out in the NFPA 921 *Guide for Fire and Explosions Investigations 2017* is a " "high temperature luminous electric discharge across a gap or through a medium such as charred insulation": Brief, Additional Documents, Folio 12, 12.10, 3.3.8 (p 4).
[53] T307

melting identified were then prepared for metallographic examination to confirm (or otherwise) the occurrence of arcing and determine whether it was primary (causative) or secondary in nature. Where necessary, Mr Cox then employed scanning electron microscopy (SEM) and energy dispersive X-ray spectroscopy (EDS) to examine the severed or gouged portions of the conductors.

45. On the basis of this analysis, Mr Cox was able to express an opinion as to whether the arcing occurred in an oxygen-deprived atmosphere, such as would be prevalent after a fire had been burning, or whether the arcing began when there was an oxygen-rich atmosphere as would exist immediately prior to a fire commencing.

46. Mr Cox referred to "the principles of arc mapping". Mr Cox explained that arc mapping is a technique that can be used to determine where a fire has commenced.[54] Arc mapping involves attempting to locate the arcing point furthest from the power source, as this is the arc most likely to have first occurred.[55]

47. The task of analysing the effect of the arcing was made more complicated in this case, because there was no detailed plan available showing the precise location of the cables and how they were laid in the ceiling space. The cables were moved in and then removed from the ceiling space by Mr Swift without their original location being precisely recorded. I accept that the task of recording the location of cables after a fire and without disturbing them is difficult, given the likely presence of debris from the fire around the cables. However, so far as is humanly possible, it should be a routine step in the preservation of evidence after a fire suspected of being caused by an

[54] T308.2

[55] T309.2; The technical definition of "arc mapping is defined in the NFPA 921 *Guide for Fire and Explosions Investigations 2017*, as the "systematic evaluation of the electrical circuit configuration, spatial relationship of the circuity components, and identification of the area of origin and analysis of the fire's spread: Brief, Additional Documents, Folio 12, 12.10, 3.3.9(p 4).

electrical fault, for the location of cables to be precisely recorded before they are moved. In this case the lack of certainty about the location of the cables made it difficult to determine which cables were supplying power to the area of the origin of the fire when the fire began and/or whether cables obtained power due to other arcing events and/or had their power source interrupted by arcing or the operation of circuit protection devices during the fire.

48. Despite those uncertainties, Mr Cox did identify one primary point of arcing where the arcing had occurred in an oxygen rich atmosphere. Mr Cox found that all other instances were secondary arcing events, that occurred in an oxygen deprived atmosphere after the fire had commenced. Mr Denham ultimately agreed with Mr Cox as to the likely location of the cause of the fire and the likely arcing point.[56]

49. The location of primary arcing involved arcing between a single core conductor and what was thought to be the neutral wire of the mains cable. Mr Cox in his initial report stated that the single core conductor would very likely have been the switch wire leading to the fan and light in the bathroom,[57] although, on this point Mr Joy disagreed, and in his oral evidence Mr Cox stated that he could not be 100% sure which was the active supply.[58]

50. Mr Cox said the cause of the arcing involved an apparent compromising of or degradation of the insulation between those two conductors. Mr Cox said that insulation can be compromised or degraded by mechanical damage, chemical damage, environmental damage, or by the action of rodents.[59]

51. However, as to the cause of the degradation of the insulation that allowed the arcing to occur, the experts were unable to provide a definitive answer.

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[56] T320-321.
[57] Brief, Additional Documents, Folio 13, 13.20 Report of Simon Cox, p 15.
[58] T350.5.
[59] Brief, Exhibit 11, Expert Report of Simon Cox, p 14.

52. Mr Denham said that the copper conductors needed to be touching for the arcing to commence in a 240 volt supply[60] but there was no evidence of the likely cause of any mechanical damage to the cabling that would have allowed them touch and he said that PVC cables, such as installed in the home, would not have degraded chemically.[61]

53. Mr Cox found no evidence of rodent damage to the remaining insulation protecting the cables but found mouse droppings embedded in the insulation of the cable. Mr Denham was confident that the likely cause of the insulation degradation was rodent damage.[62] Mr Joy gave evidence that "80% to 90%" of electrical defects he encountered were caused by rodents.[63]

Conclusion on the cause of the fire

54. Having considered all the evidence my findings as to the cause of the fire are:

    a. The fire was caused by electrical arcing in the roof space of the home adjacent to the Air Vent.

    b. The electrical arcing began because of degradation of the insulation around two adjacent wires.

    c. It was not possible to determine whether the degradation of the insulation had been caused by mechanical damage, chemical damage, environmental damage or by the action of rodents, though rodent damage is widespread and common.[64]

55. I note that there was some to and fro during the inquest, particularly with the expert witnesses Mr Cox and Mr Denham, and Mr Joy, about which particular conductors were involved in the primary arcing event. Mr Cox's

[60] T317.9
[61] T361.1
[62] T354.3
[63] T274.5
[64] I note that Mr Denham expressed a view that the most likely explanation was the activity of rodents, but he could also could not rule out other possible causes.

view was that one of the conductors involved in the primary arcing event was the neutral conductor of the mains cable,[65] and Mr Denham shared this view.[66] However, as already noted, Mr Cox in his oral evidence said he was unable to be certain of which was the active conductor involved in the arcing event.[67] Mr Joy's preferred explanation was that the active core involved in the primary arcing event was either a) a single active core from the mains cable, or b) a single active core from a twin cable in that region.[68] Another possibility discussed was that the active core may have been the cable carrying power to the exhaust fan and light in the bathroom, as originally suggested by Mr Cox in his report.[69] However, that explanation seems unlikely because the evidence was that the switch for that was in the off position[70] during the fire,[71] meaning the conductor would not have been active at the time.[72] Ultimately, while it was not possible to determine which was the active supply with any certainty,[73] that did not impact my findings.

Smoke Alarms

56. One smoke alarm was sounding when the police arrived at the home.[74] This was recovered from the home and when the battery in was tested by Mr Cox, two years after the fire, it provided 8.8 volts, and his expectation was that the alarm would have been operational at the time of the fire.[75]

57. A second smoke alarm was present in the home prior to the fire, located in the loungeroom.[76] As the loungeroom ceiling was largely destroyed by the

[65] T350.
[66] T352.
[67] T350-351.
[68] Response to draft agreed facts on behalf of Carey Joy; T 348-349.
[69] Response to draft agreed facts on behalf of Carey Joy.
[70] T 323; Brief, Additional Documents, Folio 225. Image 498.
[71] There was some discussion around whether the switch could have been wired backwards, but ultimately family members confirmed during the hearing that the switch was wired in the usual manner.
[72] T334-335.
[73] T350.
[74] T17.4
[75] T318.7
[76] Brief, Folio 9, 9.10, Affidavit of Michelle Walker, para 132, and exhibit MW-12.

fire, it is likely that the second smoke alarm was also destroyed by fire[77] and it could not be located or tested.

58. In January 2023 a Housing Officer completed an "Inspection Report" in which, under the heading "safety", and against the check boxes "*smoke alarm 1 intact and checked*", and "*smoke alarm 2 intact and checked*", the box "*no*" was checked against both check boxes, with a handwritten annotation stating "*new ones needed*".[78] However, the requirement to replace these smoke alarms was not included in a subsequent email to the repairs and maintenance team,[79] and there was no evidence presented that they were replaced.[80] This is a most unsatisfactory position.[81]

59. Although one smoke alarm remained operational, I am not prepared to infer from that anything positive in respect of the second smoke alarm. In respect of the loungeroom smoke alarm, relying on what was said by the Housing Officer in that Inspection Report, which is the only evidence on this issue, I cannot exclude that the loungeroom smoke alarm was not functioning when the fire broke out. In those circumstances, family members are left with the terrible uncertainty as to whether events might have turned out differently if the loungeroom alarm was operational.[82] No doubt, this weighs very heavily on Government which, as owner, is responsible for providing safe and habitable premises and is responsible for maintenance and repairs.

The electrical safety audits of public housing

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[77] Photograph 2302999_124, in Brief, Folio 25; Brief, Additional Documents, Folio 9, 9.10, Affidavit of Michelle Walker, para 136.
[78] Brief, Additional Documents, Folio 9, 9.10, Affidavit of Michelle Walker, para 130-134 (see specifically Annexure MW11, p338): The inspection report lists the answer "no" in the boxes in the report against the items "Smoke alarm 1 intact and checked" and "Smoke alarm 2 intact and checked" and includes in handwritten text "new ones needed".
[79] Brief, Additional Documents, Folio 9, 9.10, Affidavit of Michelle Walker, paras 131-133.
[80] Brief, Additional Documents, Folio 9, 9.10, Affidavit of Michelle Walker, para 134.
[81] I note that on page 1 of the Annexure at MW11 the Housing Officer checked "yes" to the question "smoke alarm tested and cleaned during inspection", however it appears that the Housing Inspector is merely confirming there that the test was done, with the result reported later in the document under the heading "safety".
[82] Brief, Additional Documents, Folio 9, 9.10, Affidavit of Michelle Walker, paras 136-137

Initial investigation and an 'early theory'

60. As already mentioned, the initial coronial investigation indicated that non-compliant electrical wiring in the roof space of the home was the likely cause of the fire. This 'early theory' was supported by Mr Swift's Fire Investigation Report and a report by NT WorkSafe.[83] Ultimately, however, the reports and expert evidence of Mr Cox and Mr Denham obtained for the inquest did not support this theory and were preferred.[84]

61. According to the early theory:

    a. cables in the roof had not been fixed in place as prescribed by the relevant regulations at the time of construction,
    b. the cables may have been inadvertently damaged as a result of people entering the roof space, causing compression, degradation, and movement, and
    c. this degradation was the cause of the arcing.[85]

62. That early theory gave rise to fears that similar cabling problems might be widespread across social housing, giving rise to the risk of further house fires. To determine whether this risk was replicated in other houses, an audit of a selected portion of public housing was conducted. That audit was a very worthwhile exercise and what it revealed was considered in this inquest.

Public housing

63. The home at 1 Thorold Court fell into a category of public housing stock owned by the Northern Territory Government, referred to as "social housing". Social housing involves the management and provision of public housing to eligible Territorians with an asset base of just over 4,800 urban

[83] Brief, Additional Documents, Folio 8, 8.20 Signed Affidavit of Michael St Clair dated 15 September 2025, paras 14 – 17.
[84] See, eg, Brief, Additional Documents, Folio 4, QEC Report, p 38 (9.11);
[85] Brief, Additional Documents, Folio 8, 8.20 Signed Affidavit of Michael St Clair dated 15 September 2025, paras 14 – 17.

and 5,400 remote homes.[86] The Government allocates public housing to those in need and provides tenancy management services or funds community organisations to provide these services.[87]

64. The Government owns about 5,000 homes that were built around the same time or earlier than the home at 1 Thorold Court.[88]

Scope of the audit

65. The early theory that non-compliant wiring in the ceiling space was the cause of the fire was communicated to the Government by the police investigator, who also advised that these concerns would be raised with the Coroner. The police investigator suggested that an electrical audit be conducted of homes built around the same time as 1 Thorold Court.[89] A process thereby began where an audit was scoped by the Government, with the Coroner's office requesting updates along the way.[90] I have no doubt that but for this inquest, an audit of the type and scale ultimately undertaken, which uncovered many compliance and repair issues, would not have been done.

66. Tranche 1 of the audit inspected 594 properties constructed between 1980 and 1989 in the Alice Springs and Tennant Creek area.[91] Tranche 2 inspected an additional 100 homes including homes outside of the 1980-1989 date range. Specifically, it included homes built from 1960 to the time of the audit, located in the Alice Springs and Tennant Creek area, in order to

[86] Brief, Additional Documents, Folio 9, 9.10 Institutional Response of Michelle Walker, Department of Housing, Local Government and Community Development, para 55.
[87] Brief, Additional Documents, Folio 9, 9.10 Institutional Response of Michelle Walker, Department of Housing, Local Government and Community Development, para 55.
[88] Brief, Additional Documents, Folio 9, 9.10 Institutional Response of Michelle Walker, Department of Housing, Local Government and Community Development, para 191.
[89] Brief, Additional Documents, Folio 8, 8.20, Affidavit of Michael St Clair, para 14-17.
[90] Brief, Additional Documents, Folio 8, 8.20, Affidavit of Michael St Clair, para 17-20.
[91] Brief, Additional Documents, Folio 21, Supplementary Affidavit of Michael St Clair, p 28; Note that the total number of properties listed in Tranche 1 was 639, but the total number of properties accessible for the audit was 594.

"provide a representative snapshot and cross section of the broader property portfolio".[92]

67. The audits essentially followed the requirements set out in certain clauses of an Australian Standard for periodic inspections of electrical installations known as AS/NZS 3019:2022 (**AS 3019**).[93] That standard describes its purpose as follows: [94]

> This document aims to provide the means to determine, as reasonably practical, whether the installation and all its constituent equipment, is in a safe condition for continued use, and that the electrical installation complies with all safety requirements for the prevention of fire and the protection of persons and livestock from electric shock…

68. Specifically, the audit involved testing in accordance with clauses 3, 4 and 5 of AS 3019.[95] An electrical contractor attended each property selected for audit and conducted the various inspections and testing of the electrical systems as required.

69. Originally, the audit of Tranche 1 properties proposed a visual electrical safety inspection of all selected homes, and a more intrusive inspection (in accordance with clause 5 of AS 3019) on just 20% of the homes[96] because the more intrusive inspections required power to the homes to be disrupted for 3 – 4 hours.[97] However, the more intrusive testing of this 20% of homes in Tranche 1 identified a significant number of faults which would not have been found by visual inspection alone.[98] The types of faults identified by the more intrusive testing included cable insulation failures, earthing failures and

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[92] Brief, Additional Documents, Folio 21, Supplementary Affidavit of Michael St Clair, p 46.
[93] Brief, Additional Documents, Folio 21, Supplementary Affidavit of Michael St Clair, dated 23 February 2026, p 5-7; See also Brief, Additional Documents, Folio 15 AS NZS 3019 2022 Periodic Assessment.
[94] Brief, Additional Documents, Australian/New Zealand Standard, Electrical Installations – Periodic Assessment, p 4.
[95] Brief, Additional Documents, Folio 8, 8.20, Affidavit of Michael St Clair dated 15 September 2025, paras 41-44.
[96] Brief, Additional Documents, Folio 8, 8.20, Affidavit of Michael St Clair dated 15 September 2025, paras 30-31.
[97] T13-14 (second block).
[98] Brief, Additional Documents, Folio 8, 8.20 Affidavit of Michael St Clair, 15 September 2025, para 32.

circuit protection device failures.[99] In response to those results, it was decided that the more intrusive testing would be conducted on all homes in Tranche 1 – not just 20%.[100]

70. The Government engaged an independent engineering firm, Aurecon Australia (**Aurecon**), to analyse the findings of Tranche 1 and Tranche 2 of the audit and prepare reports[101] identifying any risks associated with potential electrical issues at the inspected properties.[102]

71. There were two final reports authored by Aurecon provided to the inquest; a report concerning Tranche 1,[103] and a report concerning Tranche 2.[104]

Tranche 1 audit results

72. The project methodology included categorisation of the issues identified by type of fault/issue as set out in Figure 3 below.

[99] Brief, Additional Documents, Folio 8, 8.20 Affidavit of Michael St Clair, 15 September 2025, para 32.
[100] Brief, Additional Documents, Folio 8, 8.20 Affidavit of Michael St Clair, 15 September 2025, para 32.
[101] Brief, Additional Documents, Folio 9, 9.10 Institutional Response of Michelle Walker, Department of Housing, Local Government and Community Development, para 184.
[102] Brief, Additional Documents, Folio 21, Supplementary Affidavit of Michael St Clair, dated 23 February 2026, p 27.
[103] Brief, Additional Documents, Folio 21, Supplementary Affidavit of Michael St Clair, dated 23 February 2026, Annexure 14 (p23). The document at Annexure 14 superceded a previous version of the same report, with minor corrections which is at Annexure 13.
[104] Brief, Additional Documents, Folio 21, Supplementary Affidavit of Michael St Clair, dated 23 February 2026, Annexure 15, (p41).

Figure 3

Table 3-3: Common fault types identified across Tranche 1 properties – All Regions

Fault Type	Number of Properties Affected	Percentage of Properties Affected
Major Electrical Faults	203	34%
Minor Electrical Faults	487	82%
Electrical non-compliances [1]	107	18%
Final Subcircuits Without RCDs[2]	36	6%
Smoke Detector Failures[3]	66	11%
Missing Smoke Detector Installations[4]	35	5%
No faults indicated	86	15%
Vermin Issue[5]	17	3%

73. "Major Electrical Faults" in this table were defined in the report as "significant electrical faults that pose an immediate safety risk". "Minor Electrical Faults" were defined as "less critical electrical faults that may affect functionality or long-term system reliability where there is no immediate risk to safety.[105] "Electrical Non-Compliance" was defined as non-compliance with the current Australian standard, namely, AS/NZS 3000:2018, which is also known as the 'Wiring Rules'.[106] The other categories are self-explanatory. For reasons which I will further explain, the figures in this table, and the Aurecon reports generally, need to be treated with some caution.

74. If you add up the percentages results in Figure 3, there is a much larger value than 100%. That is because a) some houses had multiple issues and b) some specific faults appear in more than one category. For example, "Smoke Detector Failures" comprised their own category but were also counted as a "Major Electrical Fault".

[105] Brief, Additional Documents, Folio 21, Supplementary Affidavit of Michael St Clair, dated 23 February 2026, p 27 (Exhibit 14).
[106] Noting the current standard is AS/NZS 3000:2018, but that there have been amendments to that document, and there is a new draft version underway: T360 (witness Denham).

75. The results for Tranche 1 were further broken down in various ways, including by major fault type as set out in Figure 4:

Figure 4

Common Major Fault Type	Number of Affected Sites	Percentage of Major Faults	Percentage of Properties Affected
Earthing related faults	57	28%	10%
Insulation resistance and cable faults	85	42%	14%
RCD & MCB faults	53	26%	9%
Switchboard faults	11	5%	19%
Appliance and accessory faults	44	22%	7%

76. Mr St Clair, who was the key Government staff member behind the scoping and execution of the audit, gave detailed evidence about the audit process and the results. Mr St Clair explained, for example, that 'earthing related faults' captured any issues with the earthing system of a property, primarily between the connection of the switchboard and the main earth stake for the home. He gave examples of the earth stake not being connected, or cables being damaged, or the contractor not being able to locate the earth (for example, if hidden by vegetation). Each of these issues were identified as a potential safety risk requiring remediation.[107]

77. Mr St Clair also explained how electrical installations are required to comply with a version of the Wiring Rules;[108] being the applicable version when the wiring was installed (unless the installation is subsequently modified or upgraded etc). However, the Aurecon reports flagged some items as "major faults" even though the work was technically compliant with the Wiring Rules at installation, because the approach in the report was to test items against the current Wiring Rules. Mr St Clair gave the example of the acceptable resistance level between the earth stake and switchboard, which

[107] T19 (second block).
[108] The "Wiring Rules" is the common name used to the standards for electrical wiring / installations set out in the document titled "AS/NZS 3000: 2018" (and subsequent and previous versions), authored by the Joint Standards Australia/Standards New Zealand Committee EL-001. Located at Brief, Additional Documents, Folio 10, 10.20.

had changed over time. Even if the resistance level was compliant with the Wiring Rules at the time of installation, if it did not comply with the current Wiring Rules it was flagged as a fault.[109]

78. Essentially, for all categories, Mr St Clair described a conservative approach; if the contractor was not able to verify compliance for any reason, it was reported as a fault. [110] The approach was, therefore, appropriately risk averse.[111]

79. The effect is that care is required in representing what the figures in the Aurecon reports actually mean. For example, given the explanation of Mr St Clair, it is clear that there may be items reported as Major Faults which, when further investigated, may not meet that definition.

80. While acknowledging that the raw numbers need to be treated with some caution, it is still clear that there were significant electrical safety issues uncovered in Tranche 1. In addition to the type of earthing and cabling fault issues set out in Figure 3, which can pose risks of electrocution or fire, there were other significant risks to occupants identified, for example, smoke alarms either not working or not installed, and residual current devices not installed.

Tranche 2 audit results

81. Tranche 2 of the audit was also in Alice Springs and Tennant Creek, but it was not limited to homes built in the period 1980-89. The methodology adopted was essentially the same as for Tranche 1, but the reporting enabled

[109] T20-21 (second block).
[110] T19 (second block).
[111] T17 (second block).

an analysis to be conducted by age of the property. Figure 5 is reproduced from the Aurecon report for Tranche 2:[112]

Figure 5

Year of Construction	Sample Size	Percentage with Major Faults Excluding Earth Bonding (Post 2000)
Pre 1970	23	41%
1970-1979	24	58%
1980-1989	576	35%
1990-1999	12	33%
2000-2009	14	1%
Post 2010	20	1%

82. Similar explanations which applied to Tranche 1 also applied to Tranche 2 and so items which have been reported here as "major faults" may, on further investigation, not have been substantiated as such. In addition, Mr St Clair explained in his evidence that for the post-2010 category, the contractors who had conducted the audit were instructed to list as a major fault, any failure of connection between certain pipes and earths. However, this was essentially an error because the relevant piping in all of the new houses had been changed to a non-conductive type so the contractors should not have been asked to report that as a fault. Mr St Clair explained that the rate of major faults for the post 2010 homes was in reality close to zero when adjusted for this. Figure 5 is the version of results in the Aurecon report which is adjusted for this "false positive."[113]

83. That aside, as with Tranche 1, it is clear from the Tranche 2 report that there were a significant number of major faults detected in the older properties. The categories for Tranche 2 were as follows (noting again an overstatement of earthing issues for the reasons previously explained):

[112] The Aurecon report for Tranche 2 explains that the analysis in this table includes that data from the Tranche 1 survey so as to provide the 1980s data points: Brief, Additional Documents, Folio 21, Supplementary Affidavit of Michael St Clair, p 50.
[113] T24 (second block).

Figure 6

Common Major Fault Type	Number of Affected Sites	Percentage of Major Faults	Percentage of Properties Affected
Earthing related faults	18	58%	20%
Insulation resistance and cable faults	1	3%	1%
RCD & MCB faults	15	48%	16%
Switchboard faults	2	6%	2%
Appliance and accessory faults	9	29%	10%

84. With respect to the incidence of major faults, the Aurecon report for Tranche 2 stated: [114]

> The incidence rate for major faults is generally greater for all age ranges than would typically be expected for residential buildings. However, there is a clear pattern with the number of major faults reported increasing with the age of the property as would normally be expected. *The nature of the faults recorded are not typically related to care taken by occupants, indicating these are predominantly influenced by age related deterioration.*

85. I note the submissions of Counsel for Housing that the Aurecon reports were not prepared for publication, and that in essence, aspects of the reports overstate the actual risks.[115] Nevertheless, it is concerning that there appear to be a significant level of major faults present, particularly in older homes.

86. Given the issues identified in the Aurecon Tranche 1 and Tranche 2 findings, important questions for this inquest were: a) what was the Government doing to fix the faults already identified and b) what steps were being taken to improve safety and reduce the risk of electrical faults occurring in the future.

[114] Brief, Additional Documents, Folio 21, Supplementary Affidavit of Michael St Clair, p 51.
[115] Submissions on Behalf of the Department of Housing Local Government and Community Development, dated 23 April 2026, para 15.

87. Housing is the Government Department currently responsible for public housing, including for repairs and maintenance. Social housing owned by Government and subject to a social housing tenancy agreement between the CEO of Housing and a social housing tenant (the type applicable to 1 Thorold Court) falls within the ambit of a residential tenancy agreement under the *Residential Tenancies Act 1999* (NT) (**RTA**).[116] As the Landlord, the CEO of Housing is required under the RTA to, among other things:

> provide a premises and ancillary property that is habitable, that meets all health and safety requirements under an Act that applies to residential premises or the ancillary property, and that is in a reasonable state of repair. [117]

88. Mr Andrew Walder, the Acting Deputy CEO for Housing, provided a statement and gave evidence as the institutional respondent. In his oral evidence Mr Walder explained how the CEO acts as both a landlord and as a social service provider, through things like tenancy support services.[118] He also explained how the Government uses outside qualified trades people to do all of the repairs and maintenance work on its housing stock.[119]

89. With respect to the electrical safety audits, Mr Walder's evidence was that all of the faults identified in the Tranche 1 and Tranche 2 audits had been rectified.[120]

90. Mr Walder said that the fire at 1 Thorold Court and the audit results also formed the basis for Housing to take a number of additional actions.

91. Mr Walder explained that "safety feature" training was now being provided to Housing Officers. The training equips Housing Officers who conduct inspections of social housing to identify any faults in safety features, for

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[116] Brief, Additional Documents, Folio 9, 9.10 Affidavit of Michelle Walker, paras 34 – 38; RTA, ss 47, 48, 57(1)(a) and (2).
[117] Brief, Additional Documents, Folio 9, 9.10 Affidavit of Michelle Walker, para 39.
[118] T73 (second block).
[119] T73 (second block).
[120] T97-98 (second block).

example, missing or damaged smoke alarms, problems with residual current devices, or faults with earth stakes. Housing Officers conduct visual tests and physical testing of the smoke alarms.[121] A tenanted residence is inspected at least once a year.[122] Mr Walder said that since this training was commenced he is confident that Housing Officers are checking safety features.[123]

92. These inspections are supported by a new device referred to in evidence as the "Mobile Inspection Tool".[124] Essentially this is an online software tool on a tablet, which requires and enables data to be entered before a housing inspection can be completed. For example, if there are no photos of the smoke alarm or the earth stake the software will not permit the inspection to be completed.[125] The process ultimately results in the generation of an inspection report and a maintenance report.[126] The report is automatically 'filed' in the departmental systems, and an email to housing maintenance is generated.[127] Mr Walder clarified that a Housing Officer cannot finalise an inspection until a work order (for repairs and maintenance) for defects discovered in safety features, is logged.[128]

93. The new system, with the Mobile Inspection Tool, can be understood as aimed at preventing the type of failure in process that occurred in respect of the 1 Thorold Court smoke alarms.[129] This is of course a welcome development, albeit too late to assist with understanding the events of 1 June 2023.

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[121] T98 (second block).
[122] T76 (second black).
[123] T76(second block).
[124] Brief, Additional Documents, Folio 19, Supplementary Affidavit of Andrew Walder, paras 87 – 93.
[125] T92 (second block).
[126] T92 (second block).
[127] T95 (second block).
[128] T97 (second block).
[129] T84 (second block); Brief, Additional Documents, Folio 9, 9.10, Affidavit of Michelle Walker, para 137.

94. I was told that education is delivered to tenants at the commencement of a tenancy.[130] Mr Walder said that in practice this means the Housing Officer, as part of the first inspection, will point out the safety features, including the smoke alarm specifically, including how it works, how to check it, and the need to report any faults. Inconsistent with this evidence, Counsel for the family produced an affidavit from a family member who took on a new tenancy in 2023 (after the fire) and she said she was not provided with education about any safety features, including the smoke alarm.[131] Mr Walder undertook to investigate this.[132]

95. Mr Walder said that whenever a qualified electrician attends a property, they are now required to check the key safety features of the property.[133]

96. A further audit which was been termed "Phase two" is now planned. Mr Walder explained that this would involve examining all public housing in the Alice Springs, Tennant Creek, Katherine and Borroloola regions. Mr Walder's evidence was that this would include the kind of rigorous testing under AS 3019 as was done for Tranches 1 and 2 discussed above.[134]

97. I was told that there is to be a re-implementation of a Register of Accidents and Incidents, including fires, damage or injury contributed to by electrical issues.[135] Establishment of a such a database was one of the recommendations in the *Inquest into the death of Monica Presley* in 2006, which examined the death of a child from an electrical fault in public housing.[136] Although this recommendation was accepted by the Government and tabled in Parliament,[137] it became apparent during this inquest that this

[130] T86 (second block).
[131] T86 (second block)
[132] T86 (second block).
[133] T98 (second block).
[134] T99 (second block).
[135] Brief, Additional Documents, Folio 9, 9.10, Affidavit of Michelle Walker, para 181.
[136] [2007] NTMC 037
[137] Brief, Exhibit 17, *Report to the Legislative Assembly In the matter of the Coroner's Findings and Recommendations into the Death of Monica Marie Presely*, dated 12 November 2007.

important recommendation had been long forgotten about. There was no such Register of Incidents that could be located by the Government or Housing. It is deeply disturbing that lessons learned from that tragedy have been forgotten and it is hard not to feel cynical about commitments to recommendations moving forward. However, I am determined to remain hopeful and I accept the assurances provided by Mr Walder in good faith.

98. Another initiative being undertaken, is a type of 10 year cyclical maintenance program, through what is known as the "Joint Committee on Remote Housing Partnership". This includes measures aimed at pest control (the installation of bait stations in the roof), electrical maintenance, hydraulic maintenance, and mechanical repairs, and I was told that work has already commenced.[138] Concerning pest control, the Aurecon reports were anecdotal on this point, but reported frequent rodent activity in homes,[139] which can be a cause of electrical incidents.[140] Mr Denham[141] and Mr St Clair[142] supported the implementation of a bait station program. If the current baiting program is for remote housing only, as the name suggests, it would appear that a Territory wide program is needed.

99. Mr Walder gave examples of other types of cyclical maintenance which Housing was undertaking, including cyclical maintenance on evaporative air conditioners and on solar hot water systems.[143] Mr Walder also explained the challenge of delivering cyclical maintenance in the Northern Territory due to vast geography, sparse populations, and a lack of skilled trades people, which all add to complexity and cost of delivering cyclical maintenance programs.[144] However, the desirability of and necessity for cyclical

[138] Brief, Additional Documents, Folio 19, Supplementary Affidavit of Andrew Walder, paras 87 – 93.
[138] Brief, Additional Documents, Folio 19, Supplementary Affidavit of Andrew Walder, para 45.
[139] Brief, Additional Documents, Folio 21, Supplementary Affidavit of Michael St. Clair, Annexure 14, p 36.
[140] T354 (witness Denham).
[141] T370 (witness Denham).
[142] T23 (second block).
[143] Brief, Additional Documents, Folio 19, Supplementary Affidavit of Andrew Walder, para 35.
[144] Brief, Additional Documents, Folio 19, Supplementary Affidavit of Andrew Walder, paras 36-43.

maintenance has been acknowledged and identified by Housing and DLI over many years and it has been raised in several inquests. It is Government's responsibility to meet the challenges and to maintain its housing in a timely way to an acceptable and safe standard.

100. The various initiatives described by Mr Walder are to be commended.

101. However, in my view, the most critical improvement that can be made is regular periodic inspections of the type set out in AS 3019. It is clear on the evidence I received that some form of periodic electrical safety inspections conducted with reference to clauses 3, 4 and 5 of AS 3019 will be important going forward in order to ensure that the housing stock under the responsibility of the Government is and remains safe for tenants. Of note, it is the more intrusive testing – specifically from clause 5 of AS 3019 - that is necessary to uncover some of the major electrical faults.

102. While AS 3019 provides that "the maximum intervals between periodic assessments may be set by legislation," in the Northern Territory there is no such legislative requirement in place.

103. Under the *Residential Tenancies Act 1997* in Victoria, however, an "electrical safety check" must be conducted by a licensed or registered electrician *every two years* in accordance with clause 4 of AS 3019[145] (but not clause 5 which requires the prolonged disconnection of supply to the home). It seems that the safety checks by Housing Officers for public housing, which are said by Housing to occur at least once every 12 months, will cover some of the sorts of checks that would be included in the mandatory Victorian scheme. Critically, however, Housing Officers do not have the skills or the tools available to licensed or registered electricians. In particular, clause 4 of AS 3019 includes limited testing which would not be able to be undertaken by

[145] See s 26(1) of the *Residential Tenancies Act 1997* (Vic) (**RTA Vic**), Regs 5 and10 of the *Residential Tenancies Regulations 2021* (Vic) and the prescribed forms set out in Schedule 1 to those regulations which create this requirement. There are also related provisions for record keeping of these safety checks set out in s 68B of RTA Vic and in Reg 30 of these regulations.

housing officers – such as earth continuity testing, polarity and leakage current testing. [146] It was not clear from the evidence whether the additional testing to be done by electricians on callouts would be of a similar nature to the type of testing set out in clause 4 of AS 3019. It is therefore not clear whether the combination of additional testing that Housing said is now occurring will provide an equivalent level of safety check to the mandatory checks required in Victoria.

104. AS 3019 provides that: [147]

> [t]he frequency of periodic assessment of an installation shall be based on the type of installation and equipment, its use and operation, the frequency and level of maintenance and the external influences on which it is subjected.
>
> For domestic dwellings, longer periods (eg 10 years) may be appropriate. When occupancy of a domestic dwelling has changed, an assessment of the electrical installation is recommended.

105. Consistent with the example in AS 3019, Mr Denham's evidence was that checks of the clause 5 type would be "reasonable" every 10 years. [148] Given the cost of those types of inspections and the evidence as to risks increasing with the age of housing, Mr Walder said that "the Department considers that it is likely appropriate that such verifications commence once a dwelling reaches a particular age."[149]

106. Albeit on the relatively small sample so far: 58% of homes built in the 1970s; and around a third of homes built in the 1990s, 1980s, and pre 1970s; were found to have major electrical faults. [150] It is only the more recent homes – those built post 2000 - where the major faults dropped to 1% (when adjusted

[146] Brief, Additional Documents, Folio 15, 15.10 AS NZS 3019:2022, page 16 (4.2.2.5).
[147] Brief, Additional Documents, Folio 15, p 11 (clause 2.9).
[148] Transcript 362, 374.
[149] Brief, Additional Documents, Folio 19, Supplementary Affidavit of Andrew Walder, para 75.
[150] Brief, Additional Documents, Folio 21 Supplementary Affidavit of Michael St Clair, p 52 (Table 3-3).

for "false positives"). Those findings mean that, until proven otherwise, properties in the public housing stock built before 2000 ought to be subject to clause 5 of AS 3019 type inspections as soon as possible, and on a 10 year interval thereafter.

Housing Records

107. Housing conceded that it was difficult to locate tenancy, and repairs and maintenance records for 1 Thorold Court.[151] It was evident that various electrical works which had been completed at 1 Thorold Court were not contained in the repairs and maintenance records for the home produced for the inquest. Ms Lacy SC, for Mr Joy, took me to some of those items in her closing submissions.[152] This is not to suggest that information was withheld, rather it was evident that the records were *incomplete*. That is a most unsatisfactory state of affairs. For one, it means that the Government could not be confident that the home at 1 Thorold Court was at all times compliant with the statutory requirements for electrical installations. It may be that the replacement of paper based records with electronic records will result in better record keeping in the future, as Housing suggested in its evidence.[153] But the reasons provided by Housing for the difficulties in locating records included matters such as the transfer of responsibilities between Departments, changes in staff and ownership of records.[154] That suggests that the Government needs to put in place more robust systems, whereby critical data is not lost when IT systems and/or departmental responsibilities change.

Investigation of electrical fires – a joint responsibility of Fire and Rescue and the Electrical Safety Regulator

[151] Brief, Folio 9, 9,10 Affidavit of Michele Walker, para 156.
[152] T156 – 157. The items included the installation of an air conditioner, and moving of a light and fan.
[153] Brief, Additional Documents, Folio 9, 9.10, Affidavit of Michelle Walker, para 163.
[154] Brief, Additional Documents, Folio 9, 9.10, Affidavit of Michelle Walker, paras 156-162.

108. Fire and Rescue have a statutory responsibility to investigate the cause of fires in the Northern Territory.[155] They have a team of fire investigators, one of whom is Mr Swift, who provided the initial Fire Investigation Report for this inquest and gave evidence. Mr Swift is a trained and qualified fire investigator with many years of experience. His evidence was of great assistance, particularly as he physically investigated the home on the day of the fire and was able to explain in detail the damage which had occurred and likely area of origin of the fire.

109. In the Northern Territory, the Electrical Safety Regulator (**ESR**) role is carried out by NT WorkSafe which is also the Work Health Authority.[156] The ESR monitors and regulates electrical safety standards in the Northern Territory, in addition to being the authority responsible for issuing electrical licences.[157]

110. Daniel McElholum, Director Regulatory Reform at NT WorkSafe gave evidence in the inquest. His role includes developing legislation and policies specific to the powers and functions of the ESR. He also manages the electrical safety team which has six positions, two of which were vacant as of 26 February 2026.

111. Despite the legislation at the time providing the ESR with specific powers to investigate suspected electrical accidents[158] and the current legislation providing power to investigate any possible contravention of the Act,[159] the ESR's role in the investigation of this fire was quite limited. The ESR examined electrical wiring and items retrieved from the premises and a produced a report focused principally on the nature of the wiring/electrical circuits, and observations relating to the cabling, including that the cables in

[155] *Fire and Emergency Act 1996*, s 6(ca)
[156] Brief, Additional Documents Folio18, sub-folio 18.20, WorkSafe Responses to Questions from Counsel Assisting, Role of Regulator, Fire Investigation.
[157] Brief, Additional Documents Folio 18, sub-folio 18.20, WorkSafe Responses to Questions from Counsel Assisting, Role of Regulator, Fire Investigation.
[158] Clause 77(1)(c) of *the Electrical Reform Act 2000*, applicable at the time of the fire, provided for a power to "investigate a suspected electrical accident".
[159] *Electrical Safety Act 2022*, s 130(1)(b).

the roof space were not fixed in place.[160] Mr McElholum gave evidence to the effect that the electrical safety team did not have the necessary skills to investigate the cause of fires.

112. Presently, there is a potential gap in the investigation of electrical fires in the Northern Territory. While Mr Swift's report was significant, his expertise was different to that of Mr Cox and Mr Denham and without their specialised knowledge, the cause of the fire could not have been properly understood. It is apparent that this type of specialised expertise does not exist within NT WorkSafe or Fire and Rescue.

113. With both Fire and Rescue and the ESR having statutory powers with respect to the investigation of electrical fires, one solution is for ESR and/or Fire and Rescue to commission a relevant expert or experts to conduct an examination and provide a report and opinion, when additional expertise is required to identify the cause of a fire. While such an approach would come with a cost, it would be consistent with the statutory roles and responsibilities of those agencies. The Coroner will only ever be involved in fires resulting in a death. It is just as important that lessons be learned from fires that do not result in a death, as this is the majority of fires. This is precisely where prevention and safety improvements should start, not following a death and discretionary inquest.

114. Mr McElholum said that NT WorkSafe is exploring with Fire and Rescue how their respective expertise and resources can be used in a more efficient and complementary manner. I understand that the agencies are developing a Memorandum of Understanding (**MoU**) to facilitate better co-ordination with respect to the investigation of electrical fires. A mechanism for ensuring an electrical fire is thoroughly investigated and for engaging and briefing external experts when necessary should be incorporated into the MoU .

[160] Brief, Folder 2, p 88, 91-93 (Folio 31), NT WorkSafe – Interaction Report

115. I learned that in Victoria there is a statutory requirement for suspected electrical fires to be reported to the ESR. [161] Counsel for DLI made it clear in submissions that under the current legislative regime in the Northern Territory there is no mandatory requirement for the ESR to be informed by Fire and Rescue of a suspected electrical fire.[162] Mr McElholum considered that it would be a good idea to have a statutory requirement for the ESR to be notified by Fire and Rescue whenever there is a fire with a suspected electrical cause that Fire and Rescue becomes aware of.[163]

116. Following a mandatory report to the ESR, the Victorian legislative regime then requires the ESR to give directions concerning the preservation of the site.[164] However, in the Northen Territory the current legislation permits a fire investigator, who may have no electrical experience, to remove or keep possession of materials which the fire investigator believes may tend to prove the origin of the fire.[165] In addition to this concern, I received supplementary written submissions from the Counsel for DLI which proposed that there be a legislative amendment requiring the preservation of the site of an electrical fire where property damage or injury occurs when investigations are continuing, as in this case when the matter was before the Coroner. Although slightly different in focus, Ms Lacy SC for Joytech also made submissions critical of the decision to demolish the home. The submissions were to the effect that the Northern Territory legislation ought to be amended so as to reflect the Victorian requirements.

117. These matters were not investigated or considered in any level of detail. Further, the items of evidence seized in this case were not in fact seized by the fire investigator Mr Swift, but rather by the police using their powers under section 147N of the *Police Administration Act 1978.* Any change to

[161] DLI Supplementary Written Submissions at para 34.
[162] But noted in those submissions that the occupier has such an obligation, which may not be an effective mechanism to ensure such reporting.
[163] T50 (second block).
[164] DLI Supplementary Written Submissions at para 34.
[165] DLI Supplementary Written Submissions at para 29.

arrangements with respect to preservation of evidence, which may impact on police powers, would no doubt also require careful consideration by police as well as the ESR and Fire and Rescue. Nevertheless, there may be lessons to be learned from the Victorian arrangements.

Late evidence

118. After the hearing of evidence in this inquest was completed, the Coroner's Office receive a proposed statutory declaration from Mr Carey Joy, via his Counsel. The proposed statutory declaration provided additional potential evidence around issues that had been raised in the inquest. I considered whether to admit this late evidence and received submissions from two of the parties objecting to its admission. As already acknowledged, Mr Joy contributed in a positive way to this inquest, despite having to face some difficult questions himself. The additional proposed evidence is also in my view a genuine attempt by Mr Joy to highlight what he understands to be unresolved safety issues in public housing. After careful review of that proposed evidence, and the submissions made against admitting that evidence, I was satisfied that at least some of the matters raised by Mr Joy would require a re-opening of the inquest in order for the evidence to be tested and to provide an opportunity for the other parties to respond. I agreed with the submission of Mr McCarthy for Housing that the costs and delay occasioned by such a course would outweigh any benefits in receiving the evidence and declined to admit the proposed statutory declaration.

119. However, the process undertaken means that DLI and Housing have the proposed declaration and are fully appraised of Mr Joy's concerns and suggestions for improvement. The matters raised included: improving smoke alarm testing by the use of widely available aerosol smoke detector sprays; installing and/or upgrading to interconnected smoke alarms (when any detects smoke all are activated); increasing staffing in the Alice Springs

housing office; the electrical safety of an identified dwelling and the removal of an electrical lockout tag he had placed at the dwelling; and failures to inform contractors of safety issues known to DLI/Housing. I note that the Government is perfectly capable of investigating and considering all of these matters outside of any inquest process. I would therefore expect that any issues of safety raised would be taken seriously and explored by the Government.

I make the following recommendations

Recommendation 1

Housing is to complete Phase 2 of the audit as described in the evidence and promptly complete remediation of any issues identified in the audit process.

Recommendation 2

Housing is to embed in policy, guidelines and training:

a) the training of Housing Officers to conduct checks of safety features using the Mobile Housing Tool, including smoke alarms, and earth stakes, and visual inspections; and

b) that electricians on call outs are to undertake routine safety checks which must be recorded and captured in Housing records.

Recommendation 3

Housing is to implement a program of periodic inspections of all of its public housing in accordance with AS/NZS 3019 (clauses 3, 4 and 5). The first clause 5 inspections are to be occur before a property reaches 20 years of age, and then every 10 years thereafter (or more regularly if the results indicate more regular testing is necessary to ensure electrical safety).

Recommendation 4

Housing is to implement a Territory wide, cyclical, baiting program in all its public housing.

Recommendation 5

Housing is to establish at a senior level responsibility for, and a mechanism for:

a) ongoing tracking of recommendations from coronial inquests, their implementation, and the retention of documents as to implementation; and

b) the establishment and maintenance of a Register of Accidents and Incidents.

Recommendation 6

The **Electrical Safety Regulator** is to do all that is necessary to progress legislative reform to ensure that suspected electrical fires are reported to it for investigation, similar to the Victorian regime established in the Victorian *Electrical Safety Act 1998*, and is to consider and progress any further changes necessary to ensure the legislation is consistent with and promotes best practice.

Recommendation 7

The **Electrical Safety Regulator** and **Fire and Rescue** are to work together to develop a memorandum of understanding to ensure there is clear communication between the agencies and to ensure that all electrical fires are thoroughly and vigorously investigated by persons with sufficient expertise to carry out the investigation (including provisions for briefing external experts when external expertise is required).