TRANSCRIPT OF PROCEEDINGS

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CORONERS COURT

VERRA, Coroner

COR-00002012/04(9)

IN THE MATTER OF AN INQUEST INTO THE
CAUSE AND CIRCUMSTANCES SURROUNDING
THE DEATH OF SAMUEL PUGH

CHARTERS TOWERS

..DATE 10/06/2005

FINDINGS

BENCH: The Coronial system was subjected to considerable change by virtue of the Coroners Act of 2003 and I think it appropriate as a preamble to findings and comments to read some relevant sections of the new legislation into the record. Section 45(2) of the Act provides:

> "A Coroner who is investigating a death or suspected death must, if possible, find-
>
> (a) who the deceased person is; and
>
> (b) how the person died; and
>
> (c) when the person died; and
>
> (d) where the person died; and
>
> (e) what caused the person to die."

Section 45 subsection (5):

> "The Coroner must not include in the findings any statement that a person is, or may be-
>
> (a) guilty of an offence; or
>
> (b) civilly liable for something."

Section 46(1) under the heading "Coroner's Comments":

> "A Coroner may, whenever appropriate, comment on anything connected with the death investigated at an inquest that relates to-
>
> (a) public health or safety; or
>
> (b) the administration of justice; or
>
> (c) ways to prevent deaths from happening in similar circumstances in the future."

Section 46 subsection (3):

> "The Coroner must not include in the comments any statement that a person is, or may be-
>
> (a) guilty of an offence; or
>
> (b) civilly liable for something."

Section 48, which I will not read into the record, makes provision for the reporting of offences or misconduct.

My findings then are as follows: The circumstances under which Mr Pugh came by his death are as follows: Mr Pugh was an employee of mining contractor, Faminco Mining Services, and the accident which resulted in his death occurred while he was working underground approximately 370 metres below the surface at the Highway Reward Mine some 33 kilometres south of Charters Towers.

Mr Pugh had been bogging ore from the 970 Lower Reward Deeps Footwall Stope on the 970 footwall ore drive since the commencement of day shift on the 17th of August 2004. Mr Pugh had ceased bogging when Dennis Smith, the shift supervisor, drove into the footwall access in a Nissan Patrol utility and parked the vehicle approximately six metres back from the brow with the bullbar of the utility facing the stope. Mr Pugh followed Mr Smith to this location on foot. Mr Smith and Mr Pugh jointly inspected the stope and agreed that no further bogging should take place and that the charge crew would proceed with preparation and firing of the next blast rings.

Mr Smith and Mr Pugh returned to the front of the utility and were both leaning on the bullbar having a conversation on matters unrelated to the stope inspection. Mr Smith's evidence as to what occurred next was:

> "We were just making our way out, he was going to the left and I was going to the driver's side when down it came. Just a couple of rocks came shooting out of the drive. I saw the rock come out and Sam got hit and pushed on his bum."

See paragraphs 26 and 27 of Mr Smith's statement of 17 August 2004.

After being struck by the rock Mr Pugh was positioned with his back leaning on the bullbar of the utility as depicted on slide 15 of Exhibit 8. Mr Smith dragged Mr Pugh to a safer area adjacent to the rear of the utility and ran out to the access area and told Gerald Cooper, who was driving a truck in that area, to call emergency, whilst quickly explaining to him what had happened and that help was needed. Mr Smith returned to Mr Pugh but could not hear Mr Pugh breathing nor could he detect any pulse. Mr Smith's evidence was that the round trip probably took about three to four minutes and that he spoke to Mr Cooper for approximately 30 seconds.

The recorder's log sheet, which is contained at appendix 5 in volume 2 of Exhibit 1, records that Mr Cooper's emergency call was received at 7.32 a.m. This would fix the time of Mr Pugh's death, as best can be determined on the evidence, at approximately 7.32 a.m.

Mr Smith commenced performing CPR on Mr Pugh for about two minutes when Gerald Cooper, John Pickering and Kenneth Acton arrived and assisted in endeavouring to revive Mr Pugh and treat his wound. Ambulance officers arrived at the scene at 8.23 a.m. and continued the attempts to revive Mr Pugh. Their endeavours were also unsuccessful.

The rock, which upon consideration of all the evidence is the rock which most probably struck Mr Pugh, can be seen in its complete form in various photographs at appendix 3 volume 1 Exhibit 1. By the time the rock had been brought to the surface on the 20th of August 2004 the rock had absorbed water and broken into numerous pieces due to the clay-like nature of the rock. The rock which struck Mr Pugh is of a rock type described as serecitic schist and the rock in its complete form weighed some 219 kilograms. The location from which the rock dislodged and its probable path of travel is examined by Inspector Dryden at paragraph 5.4 appendix 1 volume 1 Exhibit 1 under the heading "Source of Rock". That evidence supports Inspector Dryden's conclusion that in terms of probability it is probable that the rock came from near the back of the stope between rings 8 and 10 and deflected from high up on the rill. (See also slide 44 of Exhibit 8.)

Dr Williams' autopsy report, Exhibit 4, describes the injuries suffered by Mr Pugh under the heading, "Recent Injuries", in the following terms:

> "Recent Injuries: There is a laceration measuring 19 by 13 centimetres at the medial aspect of the right thigh. This laceration has exposed much crushed muscle and the femoral artery is seen in the depths of the wound, this artery being free of obvious transection. There appears to have been bleeding from smaller veins in this area. This laceration extends around the back of the right thigh in one area. There also appears to be minor crush injury to the anterior aspect of the left thigh."

And he continues:

"The back of the body is normal apart from the right buttock which appears severely bruised and mildly abraded."

As will be seen in my formal finding as to what specifically caused Mr Pugh to die, the primary cause of death was cardiac failure suffered as a result of loss of blood. Mr Pugh also suffered from significant natural disease including hypertensive heart disease and also ischaemic heart disease. His ability to withstand blood loss was compromised by his ischaemic heart disease.

There are a number of other factors which contributed in varying degrees to the occurrence of the accident. Firstly, the issue of clarity of communication between the principal and the contractor. The evidence of Michael Harper, the foreman of Thalanga Copper Mines Pty Ltd, was that he had issued a clear directive during his meeting with Joshua Baxter on 15 August 2004 that the brow of the 970 footwall stope was to be cracked. Mr Baxter's position at Highway Reward is contracts manager and relieving projects manager. At

paragraph 8 of his statement of 19 August 2004 Mr Baxter states:

> "I have an involvement in the daily meeting. My direct involvement with the day to day activities is based on communication with the foreman. The mine foreman between themselves and the shift bosses organise the day to day activities."

What followed was described by Hamish McLeod, the site senior executive at Highway Reward Mine as:

> "A communication breakdown by FMS management that failed to ensure the shift supervisors and bogger operators were aware that the stope was only to be bogged until the brow was just open."

That is an accurate description of what occurred or, more accurately, what did not occur for reasons which have not clearly emerged on the evidence as it was presented. To compound the issue Peter Schmalkuchen, a foreman in the employ of Faminco Mining Services Pty Ltd, at paragraph 40 of his statement of 18 August 2004 states:

> "We bogged the 970 SF/W stope on Sunday. The night-shift operator was Dale Ferguson. Dennis Smith bogged the stope on Monday day shift, then we dipped and charged it. We fired it at about 2 p.m. The client (Mick Harper) said to bog the stope until the brow is open and then charge it."

Mr Harper denied that he issued any instruction to open the brow.

Secondly, whilst the evidence of Dr Williams was that prompt administration of first aid would in all likelihood not have saved Mr Pugh's life, prompt administration of first aid in other circumstances where life-threatening injuries are sustained may well result in saving the person's life. For some unexplained reason there was no first-aid kit in Mr Smith's vehicle. The issue of Mines having adequate supplies of first aid and trauma kits is addressed in section 39 of the Mining and Quarrying Safety and Health Regulation of 2001 and in my view need not be the subject of any further specific recommendation.

Thirdly, a safety and health management system audit had been carried out at the Highway Reward Mine. The document dated 13 May 2004 at paragraph 8.8 identifies safety issues related to personnel being put at risk from unexpected rock falls within blasted and unsupported excavations. (See appendix 6 volume 2 Exhibit 1.) The report had not been made available to the mine workers.

Fourthly, whilst in this case more prompt communication of the emergency would in all likelihood not have saved Mr Pugh's life, radio communication from the immediate site of the accident was not possible as radio communication cable had either been removed from or not extended into the accident site. The advantages of being able to make immediate radio communication are two-fold. An emergency response can be activated more promptly. Secondly, any persons in the vicinity such as Mr Smith in this instance do not have to

leave the accident site to initiate an emergency response and can thus give assistance to the injured person more promptly.

Fifthly, Mr McLeod states at page 13 of his report:

> "The over-drilling and charging of a number of the holes in rings 10 and 11 could have possibly contributed to poorer ground conditions internally within the stope that resulted in the rock fall. However, given the weak ground conditions that were known to exist in the area of the 970 FW stope and the presence of serecitic rock type the rock fall could have occurred regardless of this issue." (See appendix 7 volume 2 Exhibit 1.)

Rock falls can and do occur regardless of whether or not the charging and firing process results in the anticipated outcome. I note that some action has been taken in relation to Faminco's stope charging plan sheets. (See appendix 1 item 11 volume 1 Exhibit 1.) I am of the view that any broader recommendation on this issue is not necessary.

Upon consideration then of all the evidence I find:

(a) The deceased person is Samuel Pugh;

(b) Mr Pugh died as a result of injuries sustained when struck by a falling rock;

(c) Mr Pugh died at approximately 7.32 a.m. on the 17th of August 2004;

(d) Mr Pugh died in the 970 Lower Reward Deeps Footwall Stope at the Highway Reward Mine. The mine is situated 33 kilometres south of Charters Towers;

(e) The cause of death was:

1. (a) Cardiac failure due to or as a consequence of
(b) blood loss.

2. Other significant conditions contributing to the death were hypertensive heart disease and ischaemic heart disease.

Pursuant to section 46 of the Coroners Act of 2003 I make the following recommendations which almost mirror Exhibit 16. They are as follows:

(1) The mines inspectorate facilitate a workshop with the Queensland Metalliferous Mining Industry with the goal of establishing an industry Guidance Note for safe operation near open voids, particularly stopes.

(2) In relation to the Mining, Quarry and Safety and Health Act of 1999 the Mines Inspectorate review, with industry consultation, the issues surrounding

fitness for work and the general health surveillance of workers.

(3) Effective communication is the cornerstone of emergency response in underground mines. Where practicable, immediately accessible 2-way communication should be available to workers at all times.

(4) Communication/directives between the principal and the contractor should be accurate and clearly defined, particularly in respect to matters that may have safety and health implications.

(5) The results, findings and recommendations of safety audits and inspections should be made available to all workers and actioned by management in a timely manner.

The evidence does not, in my view, warrant the reporting of any offences or misconduct pursuant to section 48 of the Act. I commend Inspector Dryden and other investigating and supporting officers on a thorough investigation. I also thank counsel assisting and other legal representatives.

Finally, this Court offers its sympathy to next of kin.

Before I formally close, are there any other issues?

MR TAIT: I don't believe so, your Honour, no.

MR MURPHY: Nothing from me, your Honour.

MS WILLIAMS: Nothing, your Honour.

BENCH: That being the case, I now formally close this inquest.

RECORDER:

M T COLLINS