



# **CORONERS COURT OF QUEENSLAND**

## **FINDINGS OF INQUEST**

**CITATION:** **Inquest into the death of Paul Thomas McGuire**

**TITLE OF COURT:** Coroner's Court

**JURISDICTION:** Mackay

**FILE NO(s):** COR 2014/1616

**DELIVERED ON:** 22<sup>nd</sup> May 2020

**DELIVERED AT:** Mackay

**HEARING DATE(s):** 18-22 February 2020; 17-18 March 2020

**FINDINGS OF:** Magistrate D O'Connell, Central Coroner

**CATCHWORDS:** CORONERS: Inquest – fatality in underground mining – asphyxiation *via* exposure to depleted-oxygen atmosphere – deceased misdirected to incorrect location by administrative failure to update sensor location data – recommendations concerning signage and access to “GOAF” areas containing irrespirable atmosphere

**REPRESENTATION:**

Counsel Assisting - Mr J M Aberdeen

Anglo Coal	- Mr P Roney QC, Ms G Dann, instr by Ashursts Lawyers
DNRME	- Mr Gim Del Villar QC, Ms D Holliday, Mr L Dollar, instr by Ms N Morrison (DNRME in-house legal)
CFMEU	- Mr C Rebetzke, instr by Mr C Newman (CFMEU in-house legal)
Ms M McGuire	- Mr M de Waard, instr by Mr A Busch (S B Wright & Wright and Condie)

## Findings

### **Paul Thomas McGuire**

- [1]. On 6 May 2014 Mr McGuire died in an underground mine. He had attempted to enter an area of the underground mine known as a GOAF which is an area which has been previously mined for coal but which had since been sealed off. It is an area with an unstable roof, and is kept in a state of excess methane so that it is depleted of oxygen to prevent spontaneous combustion. It also means the air inside is 'irrespirable', or of such little oxygen that a person cannot breathe.
- [2]. Why he was tasked to do a seemingly routine job which directed him to a sealed area of the mine, and how his job card had on it a job location which others had already indicated was in a 'No-go'<sup>1</sup> zone will be explored.

### Tasks to be performed

- [3]. My primary task under the *Coroners Act 2003* is to make findings as to who the deceased person is, how, when, where, and what, caused them to die<sup>2</sup>. In Mr McGuire's case there is no real contest as to who, when, where, how or what caused him to die. The real issues are directed to the 'how' Mr McGuire came to be tasked the job he was doing.
- [4]. Accordingly the List of Issues for this Inquest are:-
1. The information required by section 45(2) of the *Coroners Act 2003*, namely: who, how, when, where, and what, caused Mr McGuire's death,
  2. Whether any of the following factors caused or contributed to Mr McGuire's death:-
    - (a) training in tasks to be performed by Mr McGuire on the 06 May 2014;
    - (b) supervision of Mr McGuire while undertaking duties on the 06 May 2014;
    - (c) practice of the employer governing the sealing of mined (goaf) areas;
    - (d) the keeping of records pertaining to Mr McGuire's duties on 06 May 2014;
  3. Whether the actions of employees following the "high high methane" alarm at 1:07pm, until the location of Mr McGuire at 2:50pm, on 06 May 2014 were in accordance with best practice?
  4. Whether changes should be made to the systems of work applicable to the performance of Mr McGuire's duties, with a view to preventing further deaths in the mining industry?

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<sup>1</sup> This is just my term for the benefit of the layman.

<sup>2</sup> *Coroners Act 2003* s. 45(2)(a) – (e) inclusive

5. Whether the discretion to discontinue a prosecution in respect of a mining safety offence involving a death should remain with the Commissioner for Mine Safety and Health, or whether such discretion should fall under the jurisdiction of the WHS prosecutor?
- [5]. The second task in any inquest is for the coroner to make comments on anything connected with the death investigated at an inquest that relate to public health or safety, the administration of justice, or ways to prevent deaths from happening in similar circumstances in the future<sup>3</sup>.
- [6]. The third task is that if I reasonably suspect a person has committed an offence<sup>4</sup>, committed official misconduct<sup>5</sup>, or contravened a person's professional or trade, standard or obligation<sup>6</sup>, then I may refer that information to the appropriate disciplinary body for them to take any action they deem appropriate.
- [7]. In these findings I address these three tasks in their usual order, section 45 'Findings', section 46 'Coroners Comments', and then section 48 'Reporting Offences or Misconduct'. I have used headings, for convenience only, for each of these in my findings.

### **Factual Background & Evidence**

- [8]. The matter is deceptively straight forward. This was a coal mine worker given a job card to do a set task at a specified location in the mine. It was that the job card was not appropriately updated in the work system for the changing location of the gas sensors, that is, their location within the mine, which is the central causative issue. Other smaller issues generate out from that central issue. Unfortunately at the inquest much time was spent exploring periphery matters rather than this central issue<sup>7</sup>.
- [9]. Mr McGuire was an experienced mine electrician<sup>8</sup>. He was said by many<sup>9</sup> to be a competent employee, which I accept. On this day he was tasked with calibrating gas sensors in the vicinity of the 901 Longwall, both in the Main Gate and Tail Gate areas. This is a fairly routine task and gas sensors are re-calibrated at regular intervals<sup>10</sup> (approximately every 4-6 weeks) so that the

<sup>3</sup> Ibid s.46(1)

<sup>4</sup> Ibid s.48(2)

<sup>5</sup> Ibid s.48(3)

<sup>6</sup> Ibid s.48(4)

<sup>7</sup> In the future Interested Parties who stray, whether in material provided or questioning of witnesses, from the stated coronial issues simply to promote or explore their own client's agenda whether for commercial interests or workplace grievances may in future find their involvement in inquests more curtailed. Exploring matters outside the stated coronial issues causes undue prolonging of inquests and unnecessary costs to the diligent parties who remain focussed, and stay on, the set coronial issues.

<sup>8</sup> I was led to many documents from his personnel file which detailed his qualifications and experience. I need only find, and it was widely accepted, that he was an experienced mine electrician, and I will not go to the individual documentation other than to say it was voluminous.

<sup>9</sup> The evidence of both management and co-employees was, universally, that he was a competent and diligent employee. He was not reckless, nor indifferent, to safety or following procedures.

<sup>10</sup> This will display some significance later.



sensors can accurately detect the gas levels in the underground mine which are constantly monitored.

- [10]. He commenced his shift and received a job card. It is important that I look at the prior job cards which relate to this area of the mine and the task of gas sensor calibration at Stations 3 and 5 (this particular job) as this becomes relevant later.

#### Job Card 00891033

- [11]. On 4 February 2014 an electrician, Mr Dean Archer, was tasked to do the similar job in 901 tailgate that Mr McGuire did in June 2014. His job card indicated that a particular sensor (station 5, channel 7) was at a particular location. What is evident on the job card is that the sensor at station 5, channel 7 was not at the 6-7 cut-through as indicated on the card, but was at the 1 cut-through (this is a distance of some 500-600 metres difference). This correction by Mr Archer was handwritten on the document when he completed it<sup>11</sup>, obviously something he discovered as he did the work for that job card. Why that information was not updated on the mine's source file which generated these job cards is unexplained<sup>12</sup>. Of interest was that it was authorised to be relocated from 6-7 cut-through to 1 cut-through on 6 January 2014 and the paperwork indicates this was done on 14 January 2014 by Mr Craig Coleman<sup>13</sup>. The consequential updating of the mine's source document for future job cards does not appear to have been updated for this relocation of gas sensor, otherwise how was it still generating a 6-7 cut-through description months later?

#### Job Card 00898735

- [12]. On 6 March 2014 the station 3 & 5 gas sensor calibration task was again performed in the 901 area. This was done by Mr Graham Hodges. The job card had not been updated from when Mr Archer did the task the month before<sup>14</sup>. When Mr Hodges did the task he did not note the incorrect location of the sensor said to be channel 7 at the 6-7 cut-through. Rather it is said to be calibrated. In evidence Mr Hodges indicated this was in the C Heading, rather than B Heading, so near the location indicated but outside the GOAF. I cannot reconcile how this can be when there does not appear to be any evidence of a sensor then at that location.
- [13]. On 10 March 2014 an authorisation to remove and decommission the station 5 channel 7 gas sensor was issued. Mr Scott Adams, who went to do the job,

<sup>11</sup> Exhibit D3.

<sup>12</sup> I will address this aspect later in my findings.

<sup>13</sup> See exhibit D4.

<sup>14</sup> The evidence was that there is a three-week period where job cards are created and capture information at that date, three weeks before the task is assigned. I merely mention this to highlight that if the job card was diligently updated at the end of Mr Archer's shift, or even a few days later, it still would have been updated before the 6 March 2014 job card was issued.

indicated on the job card 'Removal – Unable to access - Behind stopping'. Accordingly he 'disabled' it (as he wrote on the form). That form says that a Mr Simon McConnell updated the Citect Plan for the new locations (or perhaps it should be new information). It certainly appears from examining the later issued job cards that that did not occur in the source documents in the system from which Jobs were generated.

- [14]. The reality of this is that the mine's job card system was still issuing Jobs with the notation that a gas sensor was to be calibrated at 6-7 cut-through on B Heading. Not only is that two changes 'back' (1. The relocation to 1 cut-through, and 2. Its' entire removal altogether), but it remains as a location for work to be done.
- [15]. I have no hesitation in saying, and I find, that the mine's record keeping, particularly the updating or acting upon received information which required change, was grossly deficient. This aspect directly led to the situation where Mr McGuire was issued a work order or job card on 6 May 2014 with patently incorrect information (and information that if persons were diligent could have been avoided).

#### Job Card 00905975

- [16]. On 1 April 2014 this job card was done by Mr Dean Archer. The job card stated that the sensor was at the 6-7 cut-through B Heading 901 tailgate. Mr Archer wrote a very clear notation on the job card - "NO LONGER THERE". The evidence was that at the end of Mr Archer's shift his job card should have been checked by a supervisor and the information he gave updated in the system. Mr De Beer, the mine's Long Term Planner, gave evidence<sup>15</sup> that the Outbye Electrical Co-ordinator would update the system in such a circumstance or bring it to his attention. Mr Johns was then the Outbye Electrical Co-ordinator. There is evidence, and I find, that the job card was 'reviewed' (or checked<sup>16</sup>) at the end of the shift as evidenced by the 'strike-through' in pen or marker<sup>17</sup> obliquely made across the front page, but the system from which the jobs were generated was certainly not updated, as evidenced by the same 'error' being generated in the next routine job card for this work. When I say the card was reviewed at the end of the shift, the review appears to consist of merely looking at the front page, rather than the relevant information on about the fourth page of an attachment. Mr Roney SC for Anglo suggested that the supervisor merely needed to look at the first page (not the fourth of the attachment) but with respect that either means they are only doing part of their job or perhaps the worker was not instructed to properly check the document or the document is poorly laid out with critical "actioning" work instructions hidden in it. It does not really matter because I consider that this review or checking was deficient.

<sup>15</sup> See Transcript day 4, p 67, line 11 *et seq*; and day 4, p 69, lines 9-17.

<sup>16</sup> I use these terms in the loosest sense only.

<sup>17</sup> On a colour copy the use of a blue pen across a black on white job card is obvious.



- [17]. What is abundantly clear is that the poor checking or failure of adequate checking of the completed job cards (Job Cards 00905975 and 00891033), with inaction to update the system, was at the heart of where the process broke down and directly led to Mr McGuire's death.
- [18]. Just one month after Mr Archer made his very clear notation that the gas sensor was 'NO LONGER THERE' Mr McGuire on 6 May 2014 collected job card 00913709 which said that station 5 channel 7 gas sensor was located at 6-7 cut-through B Heading 901 tailgate. The inaccurate information Mr Archer had noted had simply not been updated for the next routine calibration and testing. If it had been there, there was certainly time (more than the three weeks suggested for the update to 'filter' through the system as Mr De Beer advised in evidence) for the 6 May 2014 job card to have the correct information.
- [19]. On this particular day the longwall was not producing, that is, it was not cutting the coal seam so maintenance was planned for that day's shifts. Incidentally I merely observe that this calibration of the gas sensors was being done on the last available day, indeed at the very outer envelope of the window within which calibrations could take place. This means that the work had to be completed that day, so was the first task Mr McGuire was attending to. He had plenty of time that day to do the work but it had to be done that day. In a way, that is a time pressure.
- [20]. Mr McGuire attended the mine access gate at 11.15 am for his shift commencing at midday. Clearly he was not rushed. He had diligently turned up that day with ample time for any small matters he needed to attend to before commencement of his shift. He attended the Daily Update where a *PowerPoint* presentation of information is presented to crews before they entered the mine. At that update there was information that sealing up of the GOAF was then in progress, along with other information. There was no suggestion that at that presentation there was detailed information about the area that was sealed up nor the dangers that it may present.
- [21]. He arrived at the pit bottom at 12.18 pm along with others and at 12.23 pm made a call to the control room indicating that he was going to conduct calibrations at stations 3 and 5. This is good practice. Gas monitoring data indicated that he completed calibration of station 3 at 12.53 pm. Of interest the Log shows that he turned station 3 to 'Cal' or calibration mode whilst he calibrated the gas sensors. This was usual practise although I was advised that because the underground ventilation system was in 'IMAC Bypass Mode' it was unnecessary to turn the Station to 'Cal' mode because power underground would not be tripped by the sensors.
- [22]. After completing station 3 Mr McGuire then made a call to the control room informing the operator that he now intended to go into 901 tailgate to calibrate station 5. Perhaps at this time I should observe that the station 3 sensors were not located at the cut-through indicated on the job card (as Mr McGuire noted as he did the job). This is another example of poor record-keeping, or systems being inaccurate in the mine's paperwork.

[23]. The precise route he took to get to where he was found is unknown but as he went to station 5 he met and spoke with Mr Ken McCaffrey who spoke to him in B Heading at 27a cut-through. He and Mr McGuire had a short conversation and the matters Mr McGuire spoke of indicated he was being helpful and collegiate. Mr McCaffery did not look at where Mr McGuire walked after speaking to him, as he simply continued his work. The conversation is useful for placing Mr McGuire in B Heading and he did not seem troubled nor rushed.

[24]. The possible routes<sup>18</sup> Mr McGuire took to where he was located are:

A.

- i. Heading B,
- ii. turn right at 19a cut-through,
- iii. then past the first 'Danger No Road' tape,
- iv. then past the second 'Danger No Road' tape at the Man-stopping door, and
- v. then up to the sealed hatch; or

B.

- vi. Heading B,
- vii. then turn right at 25 cut-through,
- viii. then left onto A Heading;
- ix. then right onto 19a cut-through,
- x. then across (up and around (or through)) the 'dog-box'<sup>19</sup>, and
- xi. then up to the sealed hatch.

Each option has certain aspects I need to explore and consider in coming to a conclusion as a number of matters turn on this aspect.

[25]. It is necessary for me to describe the underground mine layout. At the inquest there was produced what I will term a 'road map' of the various passages or areas of the mine. I call it a roadmap, which is simply my term, because it represents what a city centre, or CBD, roadmap may look like when viewed from above. Unlike an established city centre, an underground mine roadmap progressively changes as new roads or passages are created, or no longer accessible as areas are sealed off as they have been mined out and are no longer in production. This means there is a constantly evolving road map of the underground mine. No doubt, and certain witnesses confirmed, it makes it difficult for people not readily familiar with the area in determining what are open areas, what are closed off areas, and where you are going (as there are no 'street names' erected as you find in a CBD). It was said that ERZ officers or

<sup>18</sup> Whilst I appreciate the Mines Inspectorate suggested in a very thorough way that there were four possible routes, and each is a variation on these two dominant route options. In essence these two routes capture the most likely route taken. And the parties at the inquest all agreed that as only two possible routes were suggested in addresses to me.

<sup>19</sup> This is a worker assigned term for an access way up a ladder and around to 19a cut-through at the Overcast (an industry specific term).



Deputies would be familiar with where they are going as they are down there almost daily, but other trades such as an electrician are not<sup>20</sup>.

- [26]. It was suggested to me that Mr McGuire might have taken what I call "Route A" which would have taken him up to a man-stopping door which was subject to significant pressure which made it difficult to open. It was said he may have gone to this door and attempted to open it, but not go through it, because one witness said that when they walked past that area in the morning the "No Road" tape was across the door but after Mr McGuire was found deceased the "No Road" tape was caught in the corner of the door indicating it had been at least partially opened and the tape sucked in by the air pressure. That theory suggests that Mr McGuire would firstly have gone past "No Road" tape set up at the entry to that cut-through, and then walked the approximate 20 metres up to the man-stopping door where there was further "No Road" tape, ignored that, and then tried to open the man-stopping door. Whilst I appreciate that, in theory, I think the better conclusion is that he did not take "Route A", as I called it, but rather "Route B" where he went to the cut-through without ever approaching 19a cut-through where the "No Road" tape was up twice. Many persons said that Mr McGuire was a diligent employee. Accordingly, I find that he would not pass through two sets of "No Road" tape. On the evidence, I cannot resolve if the "No Road" tape was sucked into the door on that particular day, and it seems to me to be an unusual detail that the witness who allegedly saw the tape in the door recalled that when it was such an innocuous aspect of their day, as he said he walked past the cut-through along the heading. The man-stopping door is about 20 metres down that cut-through. In addition there was no lighting in the area except that provided from a worker's headlamp. In view of that, I think the more reasonable conclusion, and that which I feel a persuasion towards, is that Mr McGuire took "Route B" as I have described above in paragraph [24]. After speaking with Mr McCaffrey, who said *he* would have turned right at 25 cut-through, Mr McGuire went through the usual doors there, which is also what others said would be the path they would take.
- [27]. It was accepted by all parties that the likely route he followed to get to the door (excluding whether he first tried the man-stopping door at the 19a cut-through) is that he walked down Heading A to 19a cut-through and then went up through an area known as the "dog box" to access 19a cut-through before he walked up to the hatch seal where he died. What is of relevance is that at that area of the mine, in the dog box area, there was no tape indicating "No Road" nor any other barrier to prevent him from walking straight up to the hatch seal. The hatch seal itself is located in a darkened area and the seal was held shut by just one bolt. I will address this in more detail later.
- [28]. What I can say with certainty is that station 5 channel 7 was allegedly (at least according to the paperwork) then located in 901 tailgate and behind a sealed<sup>21</sup> hatch. It was in a GOAF which contains non-respirable air. Mr McGuire's body was located partly inside the hatch, and partly outside which is wholly

<sup>20</sup> Various witnesses including Mr Hodges and Lowe said this.

<sup>21</sup> Although not then *finally* sealed, it was left partly sealed to give 'purging options' I was told.

consistent with him stepping into that area. Reading anything more into this is trivial - he was simply overcome whilst in the routine act of stepping over and through the hatch opening.

- [29]. The sealing of a GOAF in this case was done by a metal door, set in a metal frame, and the door was secured by a bolt with a single nut. It was apparent that Mr McGuire used a spanner to undo the nut on the bolt to allow him to open the door. What is apparent on this inside door is that there were no warning signs or marking on the door to indicate the danger which lay beyond it, which danger was unable to be seen, heard or felt. It was simply air depleted of oxygen. I am left perplexed as to why such a dangerous location could not have simple warning signs attached on the face of the stopping man door and then on the sealed hatch warning of the dangers beyond. Many people would be aware of an electrical machinery cupboard where high voltage lies behind it and on the door it is clearly stated in signage "Danger High Voltage" and "Authorised Persons Only". Why does the same not apply here?
- [30]. It was not suggested at the inquest by any party that Mr McGuire deliberately entered the GOAF to end his own life, and I can readily find that he did not do so. Whilst that is always a theoretical possibility when first considering a death, it can be readily dismissed upon the evidence in this case.
- [31]. The first notification that something had gone wrong was when a "high high" level methane alarm activated in the control room at 1.07 p.m. for the number 2 West shaft monitor. Staff in the control room conferred and thought that it was possibly a faulty sensor. I am not critical of this assumption. Mr Adams was then sent to investigate and many minutes later reached the location. His portable gas detector alarmed and Mr Adams replaced the sensor and concluded that the sensors were in fact operating correctly and alarming due to elevated gas levels. Of course by now, when we know of Mr McGuire's cause of death, he had already passed away. So at around about 2 pm. management knew that there was a significant gas issue. Those in the control room then went below and began walking the returns against the airflow to identify the source of the high methane. They identified it as being near the 901 tailgate B Heading seal. Eventually Mr McGuire was located by Mr Zerner, and they removed him from the hatch area, commenced CPR and made an emergency call to the control room at 3.01 pm. An ambulance was called and Mr McGuire was brought to the surface first-aid room at 3.22pm. At 3.42 pm QAS paramedics confirmed that Mr McGuire had passed away.
- [32]. At 3.56 pm the site senior executive Mr Adam Garde notified the inspector of mines of the incident.

#### **Investigations into the incident:**

- [33]. The Department conducted investigations into the circumstances of the incident. Their initial report and final report were available at the inquest. Ultimately, their investigators concluded that there were certain breaches of



required procedures.

- [34]. It recommended that certain prosecutions be commenced, and I will deal with those later.
- [35]. There was prepared a report by the Industrial Health and Safety Representative (IHSR) of the CFMEU. The evidence was that this report was given to the Department on 8 May 2015 (although I note the report is actually dated 25 June 2015, and this anomaly was never explained to me). Accepting that it was received by the Department on 8 May 2015 it was received outside the then applicable twelve-month time limit for the Department to commence any prosecutions following Mr McGuire's death. I asked on a number of occasions for an explanation as to why that report was provided late, but I never received a clear or satisfactory answer. Any objective person cannot be critical of the Department not considering this information when it was not provided to them before the time limit for commencing any prosecution expired<sup>22</sup>.

### **DNRME Prosecutions**

- [36]. DNRME commenced prosecutions against the mine operator and the Site Senior Executive (SSE), Mr Adam Garde. The prosecutions were handled by the Commissioner for Mine Health and Safety. The evidence was that the Commissioner sought legal advice from a reputable law firm as well as Senior Counsel's advice on the prospects of a successful prosecution. Following counsel's advice prosecutions were commenced for four charges. These were laid on 5 May 2015, the last day within the one-year window<sup>23</sup> for commencing a prosecution.
- [37]. The prosecution then proceeded through its various stages and the most relevant (as to Inquest Issue 5) was a letter dated 13 September 2016 from the solicitors on behalf of the mine operator and Mr Garde which is said to highlight deficiencies or uncertainties with those prosecutions such that the Department should accept a plea of guilty from the mine operator to one of the charges, but that the other three charges be discontinued, effectively 'dropped', if I use the layman's terminology for better understanding by non-lawyers. The Commissioner, who gave evidence, said that whilst the matters raised in that letter were relevant to their consideration (it is really just the matters listed under point '3' of that letter which raised three issues), they reviewed the strength of their evidence, sought further advice on the likelihood of success, and ultimately themselves determined that they would accept a plea of guilty by the mine operator to just one charge, and offer no evidence on the other three charges.

<sup>22</sup> No doubt in future if the IHSR report is to be considered it will need to be provided some time, perhaps at least three months, before the time limit expires so that the Department has adequate time to consider and investigate any issues raised. Those practitioners who have been in the 'cut and thrust' of actual legal practice realise that receiving a report, considering it, and then taking appropriate action does take time.

<sup>23</sup> Section 257, *Coal Mining Safety and Health Act 1999*.



[38]. I must say I am a little perplexed if it is said that the letter of 13 September 2016 is said to be persuasive. Apart from a summary of alleged factual events, it merely raises three matters of interest<sup>24</sup> to the continuation of the prosecution:-

- a. the certainty of outcome to the prosecution,
- b. the question of a possible adverse cost order, and
- c. the appropriate use of court and prosecution resources.

An adverse cost order and the use of court and prosecutorial resources is always a consideration but not the major consideration in any prosecution. It is the evidence or strength of the case that is of most importance. Really it is whether the elements of the offence can be proved to the degree necessary in that court. I think it is worthwhile that I set out the entirety of that part of the three-page letter directed to the alleged uncertainty of outcome of the prosecution, what someone may term 'prospects of success'. The letter stated:

*Disposition in the manner suggested would bring:*

- a. *Certainty of outcome to the prosecution. That is, securing a conviction without the risk of the prosecution being unsuccessful at trial. As you are aware, these trials are complex, and by their very nature, the prosecution carries with it the disadvantage of not being privy to the entire gamut of the defence material. There would, it is submitted, be very significant risk to the prosecution not being able to establish the offence against either defendant at trial at all, with respect to Mr Garde; and in particular, with respect to the aggravated offence, against the company.*
- b. *Removal of the risk of a very sizable adverse cost order in the event of acquittal of either or both defendants. In this regard, we note, as an example of an adverse cost order in a preceding involving nine hearing days, the decision of Bell v Unimin Australia Pty Ltd (No.4) [2013] QMC 3. There, Magistrate Lee ordered costs in the amount of \$199,577. The assessment of this amount was, in some significant aspects, on the basis of quite a conservative approach. We would envisage that recoverable costs in this matter, from a defence perspective, could be considerably more.*
- c. *A resolution which reflects an appropriate use of court and prosecutorial resources. Obviously, the amount and costs of preparation of this trial will be taxing. While we fully acknowledge that costs are only one consideration, and that a more prominent consideration for a prosecutorial agency will be the need to uphold the law, and foster the principles of both general and specific deterrence,*

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<sup>24</sup> And they are matters common to possibly every prosecution, by that I say they were hardly case specific or novel.

*in our respectful submission, those objectives are best served here by securing a conviction against the corporation, rather than pursuing an individual who has very good prospects of successfully defending the charges, and risk not securing a conviction against either defendant.*

- [39]. In my personal experience, and I raised this at the inquest, if the defendant wishes to suggest that there are deficiencies in the prosecution case you usually expect that they would specify the elements of the offence required to be proved, and then highlight the specific or identified deficiencies that the prosecution then has. I could not see any of this in that letter<sup>25</sup>, and indeed it talked about generic prosecution issues of which many are already aware. There were no specifics to highlight deficiencies in the case to be presented. I was advised there were no other letters, conferences, nor meetings *etc*, which placed any further material forward for the defence.
- [40]. In view of this an objective reader may be perplexed with the decision to discontinue three of the charges, and how this single paragraph would dissuade an experienced prosecutor. Some may even take the view that if the defence cannot point to any particular deficiency in the evidence then perhaps there is no deficiency at all. I am not critical of the Commissioner's ultimate decision to discontinue three charges as I am not privy to all<sup>26</sup> of the material and advice she had at her disposal and which she considered. I appreciate she engaged experienced solicitors and Senior Counsel, so she took the correct steps. It may be, on one view, that it is simply she then had far less legal prosecutorial experience than she has in mining experience, and I mean no disrespect to the Commissioner<sup>27</sup> but she readily accepted that fact. Her evidence was that her *forte* is her extensive experience in the mining industry to which she brings great insight and independence<sup>28</sup>.
- [41]. I only cover these matters because it highlights to me that there are benefits in having a specialist prosecutor deal with the court aspects of the prosecution, with input from the Mines Commissioner as to mining practices (as one can readily understand how a legally trained prosecutor may not understand the mining processes). I note that during the inquest I was informed that this Inquest Issue was addressed by legislation being passed by the Queensland Parliament. Accordingly the Inquest Issue was legislatively addressed.
- [42]. Before I leave this issue there is a point which I feel should be canvassed as it was raised in the public domain. At the inquest there was terminology used<sup>29</sup> which was attributed to a certain CFMEU delegate or organiser that the discontinuance of the three charges and the agreement to a plea of guilty by

<sup>25</sup> Indeed as no such specific shortcomings in the prosecution case is highlighted or identified it may leave the prosecution slightly buoyed with their prosecutions' likely success.

<sup>26</sup> Legal professional privilege was not waived.

<sup>27</sup> And I readily concede the Commissioner's own mining experience enormously dwarfs my limited experience.

<sup>28</sup> And I should add for completeness that any suggestion that she was conflicted in this prosecution because she once worked for a period at a division of mining in South Africa which ultimately became part of Anglo's global company network is noted, but it is far from being persuasive.

<sup>29</sup> See Transcript day 4, p 6, lines 5, 17, 20.



Anglo on one charge was some 'dirty deal'<sup>30</sup>. I simply say that I saw no evidence before me that there was a 'dirty deal'. Any suggestion that there was is, in my view, unfounded and unfair to all those involved in the prosecution.

- [43]. It may be that the comment made by the union official was made due to their personal displeasure that the prosecution of three of the charges were discontinued. Perhaps it was made to assuage their union members rather than to provide any balanced commentary on the prosecutorial process. It appears to me to be a comment made without any solid foundation<sup>31</sup>. I mention this aspect merely because professional reputations take many years to forge and should not be tarnished by any remarks or opinions which are made without the benefit of all of the facts.
- [44]. When I consider the evidence before me, together with the reports provided and oral evidence of witnesses, it became apparent to me that Mr McGuire was a good and diligent employee. Accordingly, as I have said I cannot accept that he would have taken the route whereby he crossed any "No Road" tape. Mr McGuire took the route where he went along Heading "A" and then turned up through the dog box and cut through 19a up to the particular hatch seal. In doing so, there was an absence of "No Road" tape in the immediate area of the hatch seal. He has likely gone to the hatch seal before he has gone to station 5 to turn the calibration monitor box into "CAL mode". Quite likely, in my view, Mr McGuire has simply been going first to the station 5 channel 7 monitor to ascertain where it is because that was on his way on the route he was taking. That is the simplest and most reasonable explanation, and the one I am most persuaded to and so find on the facts presented before me. When he came to the hatch seal, the outer door was not sealed, and the inner door only sealed by one nut, rather than the 20 nuts evenly spaced around its entire perimeter or on four sides, which one expects if it is a *final* seal. I appreciate the evidence given before me that this seal was only partially sealed (if that be the term) so as to give the ventilation officer purging options.
- [45]. I appreciate that the ventilation officers require purging options and that it can take some weeks for the GOAF gasses to reach a point of stability and non-volatility such that the hatch seals can be finally closed, and that period may

<sup>30</sup> That was the term used.

<sup>31</sup> It was made after the prosecutions were discontinued and well before relevant Inquest documentation was available to the interested parties. I actually invited counsel for the CFMEU to seek instructions as to whether the individual who used that term still held that view after further details of the prosecution process had been laid out during the inquest process and hearing of evidence (and see the apparent broad concession on this precise point by Counsel for the CFMEU at TT D6-28 line 34 et seq). Rather than concede any ground the instructions relayed to me were, effectively, that they were not withdrawn. Accordingly I simply record my observations on this aspect of the terminology used on the Record as professional persons' reputations may be affected by the comment remaining. **Nothing was put to the Commissioner by counsel for the CFMEU which could possibly support a claim of "dirty deals" with respect to any prosecutorial decision by the Commissioner.** The coronial function has long been accepted as having a role in assisting to dispel unfounded rumour or suspicion (see eg *R (Amin) v Secretary of State for the Home Dept* [2004] 1 AC 653, at [31] *per* Lord Bingham of Cornhill), and in my opinion it was appropriate, in this case, to give attention to this aspect of the public interest. The CFMEU official is certainly entitled to his opinion although my observations on the prosecutorial decisions are expressed above. Readers may draw their own conclusions. Persons in a position where their comments or views may be broadcast need to utilise that position responsibly.



be a number of weeks, but it presents a clear danger that persons may inadvertently access the hatch seals because they are not fully sealed.

- [46]. Indeed, evidence was given from Mr Hodges, also an electrician, that a few years prior he had even placed his spanner on a hatch seal to a GOAF ready to undo the bolts but just felt that it wasn't right and so stopped. Mr Hodges was doing exactly what Mr McGuire had done and I appreciate that an electrician may be confused because these hatch seals were not marked in any way at that time. I appreciate that since Mr McGuire's death the hatch seal design has been changed to provide a padlock and key system, as well as warning signs placed on them, all of which are good and sensible steps, and simply done.
  
- [47]. Of interest, the area where this hatch seal was, was at the end of a cut-through which was unlit except for the light from Mr McGuire's headlamp. Accordingly, that would make it even more difficult to discern the nature of the seal presented in front of you as to whether it was simply a man-stopping door or a hatch seal that one is not to enter. People need to realise that the area is dark and not properly lit and viewed from just a headlamp. I think it quite significant that there was only one bolt used to retain the door closed which would likely have indicated to Mr McGuire that the door was not fully sealed. In addition, it would have been very easy to erect "No Road" tape in front of the door or some other barrier to prevent persons walking up the door, such as temporary fencing across that cut-through.
  
- [48]. What is clear on the evidence was that after Mr McGuire opened the seal he attempted to step through but was immediately overcome by the GOAF gases which are lacking in sufficient oxygen, and he fell to the ground. With no respirable air, he would have quickly succumbed. That air, which was high in methane, has then drifted from that hatch seal and by various air pressures the first sensor or gas detector it reaches is at West Station 2 which sounds the alarm in the control room of a "high high methane" reading. The evidence was, and I accept, it took about two minutes or a little longer for the air to travel to that gas detector and then register. By that time Mr McGuire would have already passed away and so any response was not going to save him.
  
- [49]. In view of my findings above, I can safely reject any alternate suggestion which was put to me that perhaps Mr McGuire was confused as to the location of the four-way sensor or the Station 5 control box and that he thought he was in a different location than he was when he opened the hatch seal. That suggestion I do not accept. Rather I feel a strong persuasion, indeed, I am convinced beyond any doubt, that Mr McGuire was simply following that information printed on his job card which told him that the sensor was on Heading 6-7 on cut-through 19a, and that is where he was headed when he attempted to step through the hatch seal. In making that finding, it does mean that I do not accept that the information on the first page of the job card gave the coalmine worker directions as to where they were to head, rather it was a four page attachment to the job card which sets out where the station was. That was the critical information, and that is the information which was not updated despite earlier information from other coalmine workers that the information was inaccurate.

- [50]. In making my finding that the job cards were not updated, I then go back to the source of *why* they were not updated. To me it was clear that there was a failure in the system at the mine by certain persons that the job cards at the ends of shifts were not checked, and the mine's source system for issuing job cards was not then updated. In particular, I refer to Job Card 00905975 conducted on 1 April 2014 by Mr Dean Archer which I have set out earlier. Mr Archer clearly indicated that the relevant gas sensor Mr McGuire was headed to, as I have found, was "NO LONGER THERE". It was suggested to me that there was no evidence as to who was responsible for the updating of that information. With the greatest of respect, this was information I attempted to tease out of certain witnesses and in fact in an exchange<sup>32</sup> I had with Mr De Beer he indicated that it was the outbye electrical coordinator who updated that system. The outbye electrical coordinator at that time was Mr Anthony Johns. That information given by Mr De Beer was not challenged in any way by the representatives of Anglo, so in the absence of contrary evidence I cannot see any barrier to accepting what Mr De Beer said and it is that it was the outbye electrical coordinator who should have checked Mr Archer's completed job card, noted the information required to be changed, and then updated the system. There was then sufficient time for the new job card to be issued, in an updated form, for Mr McGuire. No doubt there will be employment records to easily establish who the relevant outbye electrical coordinator was on the day that Mr Archer completed his shift and handed in his completed job card with the relevant information to be updated, but Mr De Beer's evidence was clear to me.

### **List of Inquest Issues Answers**

#### **Coroners Act s. 45(2): 'Findings'**

- [51]. Dealing with the list of issues for this inquest the answers are as follows:-
- [52]. Issue 1. My primary task is the information required by section 45(2) of the *Coroners Act 2003*, namely:
- a. Who the deceased person is – Paul Thomas McGuire<sup>33</sup>,
  - b. How the person died – Mr McGuire died when he opened an inner hatch seal door which was then secured by only one bolt, and was overcome by the GOAF gases behind that door which contained severely oxygen-depleted air,
  - c. When the person died – 6 May 2014<sup>34</sup>,
  - d. Where the person died – Grasstree Underground Mine, Middlemount, Queensland<sup>35</sup>, and
  - e. what caused the person to die – Asphyxia, caused by the inhalation of severely oxygen-depleted air<sup>36</sup>

<sup>32</sup> Transcript TT4-69 at 1-28

<sup>33</sup> See Exhibit A1 QPS Form 1

<sup>34</sup> See Exhibit A1 QPS Form 1

<sup>35</sup> See Exhibit A1 QPS Form 1

<sup>36</sup> See Exhibit A2, Form 3 Autopsy Certificate



- [53]. It does not appear that the training and tasks to be performed by Mr McGuire were deficient, or that he required immediate supervision while undertaking the duties when he was in a returned-air area, although one witness<sup>37</sup> said they wished to be accompanied by a ventilation officer or deputy – what was deficient was the practice of his employer in failing to adequately prevent ingress by a person through a hatch seal, and in failing to warn that a particular metal door was a hatch seal and that dangerous GOAF gases were behind it. They were factors which caused or contributed to Mr McGuire's death. Most significantly, the failure to keep adequate, accurate and up-to-date records pertaining to the duties Mr McGuire was to perform on 6 May 2014 was the most significant contributing factor.
- [54]. The actions of the employees following the “high high methane” alarm were adequate. I cannot say they were in accordance with best practice as it appears certain regulatory breaches or technical breaches may have occurred, but these persons did the best they could to establish the source of the high methane, but due to the fact that the control room is located some distance from where the hatch seal was, and the labyrinth of areas underground, it took time.
- [55]. It is appropriate that changes should be made to the system of work applicable to the performance of Mr McGuire's duty to prevent further deaths in the mining industry. Those changes include appropriate guidelines as to what should be considered to be an appropriate hatch seal (whether interim, or final), and that persons or tradesmen who are not daily underground and familiar with areas of dangerous gases can request to be accompanied by a deputy or ventilation officer to be taken to locations where they are to do work when working in the return air area because that is where the dangerous gases in a mine are to be found.

#### **Coroners Act s. 46: ‘Coroners Comments’ (Recommendations)**

- [56]. This incident does provide the opportunity to recommend improvements aimed at reducing the risk in relation to GOAFs.
- [57]. I do accept that this mine has made changes to hatch seals as to how they are manufactured and marked to prevent inadvertent access by a person. There was a suggestion that there should be some mandated standard issued by the Department in relation to this. It was clear to me that there should not be a mandated standard, rather the Department at best can only suggest a guideline (or guidance note) as to what may be applicable. The obligation is upon the individual mine operator to assess each individual circumstance to determine what is an appropriate design, and other relevant considerations for their hatch seals. Whilst I recommend that the Department establish a guideline of what may be considered, that guideline will not be all-encompassing because there are so many different considerations at different mines, and I note that, as I

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<sup>37</sup> Mr Graham Hodges was the only witness who said this.



said, the obligation rests with the mine operator. They cannot abrogate their duty to the Department because it is *their* responsibility under the law to take the appropriate steps to protect coalmine workers. Accordingly, whilst I will recommend that the Department develop a guidance note which can be included in the regulations, the mine should prepare a risk assessment of what is being done to prevent any further ingress to the GOAF during sealing up operations. Any consequential regulation refinements<sup>38</sup> should also occur.

- [58]. I am not convinced that it be mandatory that a person must be accompanied by a ventilation officer or deputy when working in a return air area of the mine; rather it simply be that a coalmine worker, if they choose, can request to be accompanied by a deputy or ventilation officer when working in the return air area.
- [59]. In addition, there should be widely promoted (which I believe may have already been done) as to what are appropriate, or acceptable, minimum design requirements<sup>39</sup> for a hatch seal which should include those things identified in the changes made by Grasstree Mine. These included that it is padlocked and the key kept by the ventilation officers, it is to be clearly marked as to the dangerous gases in the GOAF that lie beyond the hatch seal, and that no entry by persons is permitted, and that steps are taken to prevent physical access up to the hatch seal, whether by temporary fencing or “No Road” tape or both.
- [60]. With respect to the prosecution aspect being conducted by a specialist industrial prosecutor, I note that the government has acted in this regard and it has been implemented, and accordingly no recommendation is required.

#### **Coroners Act s. 48: ‘Reporting Offences or Misconduct’**

- [61]. The *Coroners Act* section 48<sup>40</sup> imposes an obligation to report offences or misconduct.
- [62]. It was submitted to me by certain interested parties that employees in identified positions of authority were derelict in their duty and that failure directly led to Mr Maguire’s death. It was strongly suggested for Anglo that no person should be referred.
- [63]. In considering the evidence, and in view of my findings set out above, I reasonably suspect that a person<sup>41</sup> holding a certain position, Mr Anthony

<sup>38</sup> Regulation 326.

<sup>39</sup> As a Guidance Note, rather than a set or prescribed method due to particular mine factor variances between mines.

<sup>40</sup> The threshold for a coroner is simply if that coroner ‘*reasonably suspects*’ a person has committed an offence it is then referred to the relevant authority for that authority to conduct their own investigation and then they decide whether to prosecute or not.

<sup>41</sup> Senior Counsel for Anglo indicated that whilst they represented Anglo at the inquest they only represented Mr Johns as an individual in his claim for privilege from giving evidence (and not for submissions: Transcript day 1, p 1-2, line 29). That is a somewhat curious position to me so I have had to adopt a very conservative approach. Fortunately *Neumann v Coroner Hutton & Anor* [2020] QSC 17 is a good guide for how to observe the principles of natural justice when a person may be adversely

Johns (at the time an Outbye Electrical Co-ordinator), may<sup>42</sup> have committed an offence. Accordingly I will refer his actions (or inactions) for that aspect of the matter to the Chief Executive of DNRME for further investigation and possible action as determined by that Department.

**Magistrate O'Connell**

Central Coroner

Mackay

22 May 2020

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mentioned in Findings of an inquest. In this matter Mr Johns was clearly aware of the inquest because he was subpoenaed and attended as a witness. Any person called as a witness must reasonably expect to be subject to examination in the witness box otherwise their statement alone would be used. It is naïve or disingenuous to think otherwise. Mr Johns refused to give evidence on the basis that his evidence may incriminate him. He was given a direction by me to give evidence and accordingly his evidence attracted immunity. It could not be said that he was unaware of the inquest as he actually attended and gave evidence. He clearly knew his evidence may implicate him in an alleged offence by his claiming privilege from giving evidence (no doubt after receiving legal advice, and Counsel spoke for him in seeking the claim of immunity). That he chose not to be separately represented is his choice (leaving aside the peculiarity of precisely who Anglo's counsel were representing). As I said I have adopted a conservative approach and so provided Mr Johns with the draft findings and invited him to make submissions to me as to why he should not be adversely named. This is to ensure that the principles set out in *Annetts v McCann* (1990) 170 CLR 596 were followed. He made a detailed submission. That submission contained many transcript and exhibit references from the inquest so clearly he had access to all inquest material. It was a lengthy submission and I have considered it. His chosen firm of solicitors incidentally were also the solicitors for Anglo. That law firm was involved for Anglo throughout the coronial investigation and the inquest (indeed apparently appearing for Mr Johns in some limited capacity at the inquest and Senior Counsel for Anglo appeared to be specifically making a submission against Mr Johns being referred under s.48, see TT6-44 line 1 on to TT6-48, and especially at TT6-48 lines 3-38 which are more than mere cursory comments) so it could hardly be said he was at some type of 'disadvantage' as that law firm instructed by him were involved throughout the entire coronial investigation over many years.

<sup>42</sup> In accordance with the *Coroners Act* s.45(5) no inference can be drawn of civil or criminal liability merely from my Findings. Any reporting of my Findings needs to be mindful of that fact.