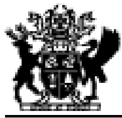

Queensland Government Department of Natural Resources and Mines

Phillip Anthony FOWLER

Findings and Recommendations

[Schedule A] [Schedule B] [Schedule C] [Schedule D] [Schedule E]

The *Mines Regulation Act 1964* -

Findings and recommendations of reviewers and mining warden following an inquiry into fatal injuries received by Phillip Anthony Fowler at Cannington mine on 14 december 1997

Warden's court of Queensland 22-26 february 1999

Before: Mr F W Windridge esquire Warden

Reviewers:

- Mr J P Brady
- Mr A E McMaster
- Mr S Sodervik
- Mr W B Elrick

To assist:

Mr J Tate, instructed by crown law office, with him MS D Silvester

Appearances:

- MR R Lynch, instructed by Sciacca's Lawyers, for next of kin, Ms Ruth Fowler
- MR R Traves, instructed by Allen Allen & Hemsley, for BHP Cannington mine and the mine manager, Mr Lennox
- MR G Mullins, instructed by Clayton Utz, for Peabody Resources
- MR S Yates, district workers' representative

Witnesses examined: refer transcript and schedule "a"

Exhibits tendered: refer transcript and schedule "b"

Findings: refer transcript and schedule "c"

Recommendations: refer transcript and schedule "d"

Report of mining warden: refer transcript and schedule "e"

Schedule "A" Witnesses examined:

Day One

- Scott Nicholas MEAD (telephone evidence)
- Mark Thomas HESTER (telephone evidence)
- Christopher Paul SKELDING
- Sergio Eduardo CESPEDES
- Alexander Scott PETRIE

Dat Two

- Ian Robert DICK
- Troy Ashley ROCK
- Brian Raymond CHRISTIE
- Darrell Ralph ANDERSON
- William David DAVIES
- Alan Laurence WELLS
- William Noel MILNE
- David Phillip REED
- Marnie Jayne PASCOE

Day Three

- David Phillip REED (recalled)
- Sara McCULLOCH
- Dr Richard Phillip STONE (telephone evidence)
- Dr Andrew Joseph O'NEILL (telephone evidence)
- Dr Jeremy Steven HAYLLAR
- Professor Anthony Joseph ANSFORD
- Beverley Anne WORDSWORTH
- Dr Robert Byron COLLINS

Day Four

- Michele James BAGROWSKI
- Gavin George BORRESEN
- Michael Earle AULD
- Brian Alexander KERR
- Michael Edward DAVIES
- Dr Robert Frances O'SHEA (telephone evidence)
- Anthony William LENNOX

Schedule "B" List of Exhibits

No of Exhibit	**Date Day No**	**Nature of Exhibit**	**Tendered by**
1(a)	22/2/99 D1	Statement of Scott Nicholas Mead dated 15/12/97	Ms D Silvester
1(b)	"	Statement of Scott Nicholas Mead dated 15/7/98	"
2	"	Statement of Scott Mead dated 14/12/97	Mr R Traves
3	"	Police Report to Coroner	Mr J Tate

4	"	44 Colour Photographs	"
5	"	Analyst Certificate dated 16/4/98	"
6	"	Pathology Report dated 21/1/98	"
7	"	Preliminary Report - C P Skelding - dated 14/12/97	"
8	"	Volume 1 - Report of C P Skelding	"
9	"	Volume 2 - Report of C P Skelding	"
10	"	Welding Equipment	"
11	"	Plan 1 : 574 Level - Crib Room - Incident Site Survey Plan 2 : 574 Level - Crib Room - Incident Site Survey - (showing approximate body position)	"
12	"	90 Colour Photographs (excluding photos 82,83,84 & 85) including a description list	"
13	"	WTIA - Health & Safety in Welding	"
14	"	Electrical Safety in the Workplace (SAA HB94 - 1997)	"
15	"	Effects of current passing through the human body AS 3859 - 1991	"

16	22/2/99 D1	Aide De Memoir - OHM'S LAW	Mr J Tate
		(a) Manual Metal-Arc Welding Electrode Holders (AS 2826 - 1985)	

17	"	(b) Approval and test specification - Residual current devices (current-operated earth-leakage devices) (AS 3190 - 1994) (c) Electric arc welding power sources Part 1: Transformer type (AS 1966.1 - 1985) (d) Safety in welding and allied processes Part 2: Electrical (AS 1674.2 - 1990) (e) Approval and test specification - Portable machines for electric arc welding and allied processes (AS/NZS 3195 - 1995)	"
18	22/2/99 D1	Two (2) Reports of Alexander Scott Petrie	"
19	23/2/99 D2	Statement of Darrell Ralph Anderson	Ms D Silvester
20	"	Statement of William David Davies	"
21	"	Statement of William Noel Milne	"
22	"	Statement of David Philip Reed	"
23	"	Document - Safe Working in Hot Conditions	Mr R Traves
24	"	Colour Photograph - BHP of Milne & Reed	"
25(a) (b) (c)	"	Three (3) Colour Photographs - BHP to demonstrate Position of items	"
26	"	Colour Photograph - View from inside	Mr R Lynch
27(d) (e) (f)	"	Three (3) Colour Photographs - Views inside of Crib Room	"
28	"	Polaroid Photograph - Crib Room	"
29	24/2/99 D3	Statement of Brian Raymond Christie	Ms D Silvester

30	"	Memorandum - D Reed dated 7/10/97	Mr R Traves
31	24/2/99 D3	Memorandum - D Reed dated 22/10/97	Mr R Traves
32(a)(b) (c)	"	(a) The blood alcohol curve and units of measurement (b) Severe hyperthermia: Heat stroke; neuroleptic malignant syndrome; and malignant hyperthermia (c) Environmental factors and disease - W R Keatinge	Mr J Tate
33	"	Statement of Sara McCullouch dated 15/12/97	"
34	"	Confidential Health Assessment - Dr R Stone	"
35	"	Observations by Nurse at Cannington and signed by Dr Stone	"
36	"	Form A - Pre-Employment Health Assessment	"
37	"	Health Summary - Dr Andrew O'Neill	"
38	"	Statutory Declaration of Dr A J Ansford	"
39	"	Pre-Placement Medical Examination Form	"
40	"	Kodacome Slides of Microscopic Slides of Mr Fowler's Coronary Arteries	"
41	"	Report of Dr Robert Byron Collins dated 12/10/98	Mr J Tate
42	25/2/99 D4	Accident/Incident/Hazard Report - Cannington Project (00087)	Mr Mullins
43	"	Statement of Adrian G L Pratt dated 17/12/97	Ms D Silvester
44	"	Report of Dr Robert F O'Shea	Mr R Lynch

45	"	Statement of Anthony William Lennox	Mr J Tate
46	"	Partnering Agreement between BHP Minerals Pty Ltd & Peabody Resources Ltd (Ref: No. CAN UG 009)	Mr R Traves
47	"	"Fit for Work, Fit for Life" - BHP Cannington Project	"
48	"	Electric Shock (Minimisation/Elimination)	"
49	"	Designation of Responsibility for Health and Safety	"
50	"	Control of Contractors (CAN-SM-012)	"
51	"	Contractors/Construction - BHP Cannington Project	"
52	"	Pocket Safety Book	"
53	25/2/99 D4	PRL Employee Site Induction Manual	Mr R Traves
54	"	(CAN-SM-017) Welding Procedure & Sheet Regarding Clamps	"
55	"	Overhead Projections - Ventilation and Safety Comparisons	"
56	"	Further Actions Report dated 11/1/98	"

RULING

The proceedings before us have been two-fold.

In my capacity as warden, assisted by four reviewers, I have conducted an inquiry under the provisions of the *Mines Regulations Act 1964.*

In my capacity as coroner, sitting alone, I have conducted an inquest under the *Coroners' Act 1958*.

The purpose of an inquiry under the *Mines Regulation Act 1964* is to establish the nature and cause of the accident (s.42(1)), and to make recommendations with a view to the prevention of a similar accident (s.42(3)(a)).

The purpose of an inquest conducted under Part 10 of the *Coroners' Act 1958* is to establish so far as practicable -

The fact that a person has died;

The identity of the deceased person;

When, where and how the death occurred;

The person's, (if any) to be charged with murder, manslaughter, the offence of dangerous driving of a motor vehicle causing death as set forth in the *Criminal Code, s.328A*, or any offence set forth in the *Criminal Code, s.311*.

At some stage during directions hearings in brisbane, the issue of jurisdiction was "flagged". This was due to the fact that the cause of death may be not determined or may be found to be "natural causes".

This would therefore affect the jurisdiction of the warden and reviewers to conduct an inquiry pursuant to the *Mines Regulation Act 1964*, and any such inquiry would therefore have to terminate.

The pertinent words in Section 42 of the *Mines Regulation Act 1964* are "In every case of accident causing death or serious bodily injury".

There is some dispute about the cause of death. This dispute revolves around the evidence of forensic pathologists and other medical experts, and the evidence of electrical engineers and other electrical experts.

However, it is not the function of the reviewers to find or make a finding about the cause of death. They need to be satisfied only that there has been a death or serious bodily injury from an accident.

What is an accident? The definition in the Australian Concise Oxford Dictionary is -

"1. An event that is without apparent cause, or is unexpected. 2. An unfortunate event especially one causing physical harm or damage, brought about unintentionally. 3. Occurrence of things by chance."

Other definitions of a similar vein are available (see Strouds Judicial Dictionary - 5th Edition, and Jowitts Dictionary of English Law).

We have the matter of Eaton v Caledonian United and New Zealand G.M. Coy Ltd (7.4.1897) when considering a death in a mine - "Any event out of the ordinary course happening in a mine which itself causes or is likely to cause injury is an "accident" within the meaning of s.18 of that Act".

Notwithstanding that there is some dispute as to the cause of death, we consider the finding of a mine worker in an unconscious or dead state with an electrode against his neck constitutes a "serious bodily injury" which would invoke the jurisdiction of the warden's court to hold an inquiry under the provisions of Section 42.

If that approach is rejected, we turn to Section 43(2) of the *Mines Regulation Act 1964*.

This section states interalia that the minister on his own initiative or when requested to do so, may order an inquiry to be held. I am aware that an internal memorandum referring to the deaths of Mr Fowler and a Mr Johnston has been "noted" by the minister, and endorsed under his signature in his own handwriting -

"I must stress that we do all we can to expedite these hearings".

While the purist may say those words are not a "direction", they are so close to a direction the difference is immaterial, and the intention and the desire of the minister is clear.

We therefore consider we are able to proceed under the authority of Section 43 of the Act, and Section 43 uses Section 42 of the Act for procedure.

In relation to the inquest, I desire to examine the evidence given over the past four days, and I adjourn the inquest to a date to be fixed.

Schedule "C" Findings:

We find -

Name of deceased: Phillip Anthony Fowler

Date of death: 14 december 1997

Place of death: Cannington mine

Nature of accident:

At about 10.45 am on Sunday, 14 december 1997, Mr Phillip Anthony Fowler was found in an unconscious state by Mr Scott Mead and Mr Brian Christie at the crib room of the 574 metre level (mLv) at the BHP Cannington mine.

An initial assessment of the situation by Christie and Mead indicated that Mr Fowler was lying on his back with a welding handpiece in his right hand that was resting on his chest.

The handpiece contained a welding electrode that was resting on the right side of his neck and the welding cables across and beneath his body.

The power was isolated at the main switch by Christie and the welding handpiece, electrode and cables removed from Mr Fowler. When the handpiece was removed an electrode burn was clearly visible on the right side of Mr Fowler's neck.

Attempts at resuscitation were commenced and continued until registered nurse Sara McCulloch and others arrived from the surface and Mr Fowler was transported to the medical centre. Resuscitation attempts continued during transport and on the surface.

After arrival of the Royal Flying Doctor, Dr Richard Stone, and after further resuscitation attempts, life was pronounced extinct at 12.32 pm.

Cause of accident:

From the evidence presented to the inquiry, we are satisfied that -

Mr Fowler, a boilermaker, was completing the fabrication and installation of the door and door frames of the crib room at the 574 mLv. This work entailed the use of a Transarc Junior Welder type TAD Z19, serial number AB5201 and Satincraft 13 electrodes.

The electrode holder was found to be defective.

He was not wearing protective gloves.

The atmosphere in the work area was hot and humid and most probably, above the standard that required special precautions to be taken as per Part 2.3.2 of the metalliferous mining regulations.

Parts of the crib room floor, in particular the section where Mr Fowler was alleged to be working and eventually found, have been described as wet.

There was no evidence that special precautions had been taken.

Mr Fowler was working alone.

Other observations

Due to the belief that Mr Fowler was a competent craftsman with many years experience, there was a lapse in active supervision on this occasion. This lapse in supervision was critical given the nature and the location of the work.

There was a failure to observe the requirement of Section 39.1 of the *Mines Regulation Act*. While we appreciated the efforts made to rescue Mr Fowler and remove him to the surface, subsequent activities may have resulted in the loss of vital evidence which would have assisted the Inquiry.

The delay in notification of next of kin is noted, and we trust that measures are put in place to prevent a recurrence.

Schedule "D" Recommendations:

The recommendations of the reviewers are as follows:

We acknowledge the development and implementation of the Cannington welding procedures, including the installation of voltage reducing devices (VRD's) on all alternating current welding equipment on site and would recommend the adoption of similar procedures and personal protection devices for welding equipment at all mines.

Effective standard work instructions for working in heat must be developed, implemented and enforced.

Contractors and sub-contractors employed on mine sites must have effective safety management systems in place that clearly define the role and responsibility of supervisors and their inter-relationship with the mine owners, agents or managers.

Schedule "E" Report of the Warden:

I concur with the findings of the reviewers as to the nature and cause of the accident and, before closing, I have a few comments: exhibit number 10, that is the box containing the equipment is to be returned to the custody of the senior inspector of mines at Mt Isa to be held for a period of 12 months. Any party desiring access or possession of the property can make application to either the court or the senior inspector. One proviso there is that the welding handpiece and the cable attached to it will be retained by the court and similar provisions exist to gain access.

We thank the inspectors at Mt Isa for their reports and also Mr Lennox, the mine manager, for his report. We thank Mr Tate and Ms Silvester for their assistance and those at the bar table who have appeared and participated in the proceedings. A number of witnesses travelled considerable distances in order to give evidence and we thank them for their attendance.

This inquiry was able to proceed because additional resources have recently been made available to the court. I thank the deputy director-general for his assistance in that regard. And, last of all, but not the least, to my staff Mr Dahlke and Miss Susan Weller who, apart from their duties in Mt Isa this week, have put in a huge effort over the last month in the preparation for this inquiry.

The inquiry is closed.

26 february 1999

Last Updated 20 October 2007

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Great state. Great opportunity.