MASTER TAPE NO. 3111/1.
APPLICATION NO. 439/80.

CAMPBELLTOWN CORONERS COURT
QUEEN STREET
CAMPBELLTOWN

FRIDAY, 19TH DECEMBER, 1980.

BEFORE: J. HIATT, ESQUIRE, STIPENDIARY MAGISTRATE AND CORONER.

(INQUEST TOUCHING THE DEATH OF JAMES ALCHORN AND OTHERS)

APPEARANCES BY LEAVE OF THE CORONER.

APPEARANCES AS BEFORE

3111/1/1 VB
19th December, 1980

CORONER: My first observation is that inquests that arise as a consequence of deaths in mines have always posed problems because of the conflicts which arise between the functions and duties imposed upon tribunals and officials under the Coroners Act as it is now 1980 in the Coal Mines Regulation Act of 1912. However, the Coroners task is becoming even more difficult because of the recent trend for an inquiry to be conducted under other legislation prior to the holding of the inquest. In this case that has occurred and made this Court's task extremely difficult besides occasioning considerable delay. The holding of the inquest in those circumstances is also complicated by procedural difficulties some of which I intend to comment on in order to explain why this decision is being delivered some seventeen months after the event which caused the deaths. Under the Coal Mines Act of 1912 Section 36 where an accident occurs which causes loss of life etcetera in or about a mine, Inspector of the district is to notified; the place where death occurs is to be left as it was immediately after the incident until such time as the Inspector carries out his duties and investigations under the Act. In the interim only qualified persons are permitted into the mine to carry out rescue work. As a consequence qualified Police investigators were, in this case, not permitted into the mine to observe and investigate first hand in the normal course of their inquiries. They were not in possession of the important material which would be the basis of any proper investigation and inquiry to be made at the direction of the Coroner. Indeed, as it transpired they were deprived of very important information in regard to aspects of this matter in the early stages which, in my view, result in a loss of relevant evidence. The fact was that once the inspectors had commenced their inquiries the information gained was confidential to the Minister for Mineral Resources and later available only to the Court of Coalmines Regulation Counsel assisting. Police requests of the various inspectors involved for vital information was denied and my request to the Minister direct for it met with the same result on the basis that it was confidential to the Minister. The only information at the time the Police were in possession of were formal matters within the knowledge of the various workers in the mine which was gleened as a result of lengthy cross examination by the Police without any real knowledge of what the real issues might be as far as

finding

CORONER (CONT'D): the cause or circumstances of the explosion were. Much of that was based on rumour, observations of a scientific photographer and Police who were later allowed in the mine. However, that was at a time well after removal or dislocation of material evidence. The breakdown in liason and collaboration in regard to these vital matters gave me much cause for concern which I expressed to the Minister direct and the Commissioner of Police on 3rd August, 1979. It underlined, in my view, the conflict in the legislation applicable to Deaths in Mines and bearing in mind that one of the functions of a Coroner is to ascertain if a known person had committed an indictable offence. Such a position in my view made a complete mockery of the system. The proper authority,in my view, to investigate such causes in realtion to indictable offences or otherwise are the Police at the direction of the Coroner. However, it is as well to point out that the District Inspectors have all the powers under the Coalmines Regulation Act 1912 and as it transpired in evidence at this inquest they were in respect of certain areas investigating their own shortcomings in respect of this mine and provisions of the Coalmines Regulation Act 1912 makes evidence so obtained by them and also before an inquiry inadmissible against others before other Courts. Relevant evidence concerning certain issues which in my view were pertinent to my consideration in matters which may arise under Section 19 of the Coroners Act 1980 were not made available to the Police or to myself until such time as we learnt of it in the press. Finally, all the statements and Exhibits were handed over to the Police a short time before the 1st July, 1980, the first day of this inquest. It is not difficult to understand the mammoth task that confronted the Police. The Police Prosecutor and myself have sifted through some two thousand seven hundred pages of transcript and hundreds of documents commencing further inquiries and fresh matters to present them too to inquest within a reasonable time. When inquest recommenced on 11th August it was still necessary to make further requests for relevant material. It is significant that new material was placed before this Court. It is very significant that having regard to the evidence that emerged during this hearing that there is an absence of records of Intefview taken from various persons in regard to their actions and omissions in

CORONER (CONT'D): the light of that evidence. I have been very aware of the publicity given to both the evidence that was to be presented at this inquest before it was so given and that, of course, was a consequence of there being a prior inquiry. Of recent time I have been very much aware of the publicity given to delays which have affected the relatives and I am of the view that it is in the public interest that these facts be known. I might add that there was an inordinate delay in preparation of the transcripts and the reasons are well documented at the office of the Magistrate Courts Administration. The evidence reveals that an explosion occurred in a new development of K panel of the mine on 24th July, 1979 at approximately 11.00 p.m. The panel started as a two heading panel and after discussion during the early part of 1979 it became a three heading panel. According to the Manager of the mine Mr. A. Fisher, this was done to overcome problems as far as ventilation was concerned. Ventilation or lack of it being one of the prime issues concerning this inquest. The explosion, and I can conclude on the evidence, was an initial ignition of methane occurring at a time when a major ventilation changeover was taking place from brattice ventilation to a two fan system with vent tubes. Mr. A.Fisher at all time deposed that this would improve ventilation but it meant that each fan would require its own separate tubing and there would have to be ample air available and a proper splitting of it between the two fans. One fan in A heading was operational and the other was to be placed in B heading of the development. Two continuous miners would then be worked simultaneously in driving the headings. There would be a single intake, air roadway with two external returns. The object being to reduce gas in the intake heading breathing it in to the outside returns. In the four days prior to 24th July, 1979 the ventilation had been achieved by means of brattice there being no evidence of real problems in that regard. However, the evidence reveals that all involved were aware and concerned about 1) the length of B heading studding 2) the length of the brattice and its quality 3) the amount of traffic both vehicular and manual which would interfere with the brattice of B heading intersection 4) the need to be diligent in that regard and 5) the need to be on the alert for contamination by methane gas. It is clear that the changeover from brattice to two fan ventilation was imminent

CORONER (CONT'D): on 24th July, 1979 and everyone was working towards it, although there is no evidence of an actual timetable for it or which shift was to carry out the final operation. Certainly the evidence revealed that there was a lack of communication for the members of the afternoon shift in that regard and in particular Deputies O'Connell and Schuster. As it transpired it fell to the evening shift on which the deceased persons were employed to complete the changeover. I have examined the evidence in the light of those facts established as at the time of the change of shift at 7.00 p.m. What occurred up till the time of the explosion. That evidence before me in regard to rescue, identification, medical examination. I have considered carefully that material which is before me as to the reconstruction namely the facts determined; the circumstantial evidence; the expert evidence; the experimentation and tests. I have deliberated on that body of evidence concerning the role played by the Owners, Management, Officials, the electricians, crews and inspectorate. In doing so I have considered the evidence in relation to the established facts, weight to be given to it, addressing my mind to the law particularly as to whether there is prima facie evidence of indictable offence committed by any known person. Much has been said during this inquest about breaches of the regulations and provisions of the Coalmines Regulations Act 1912. In my view that, they have been referred to in some occasions with a casualness. There is in my mind no doubt that the evidence has disclosed such breaches. Yet no one seems to have taken any positive action in regard to them. The Coroners Act 1980 Section 22, Sub-section 3, prohibits me from referring in the record of my finding the fact or indicate or suggest that any offence has been committed by any person. However, it is noted that under the provision of Section 70, Sub-section D of the Coalmines Regulations Act 1912 there is provision where action for noncompliance with the Act can be taken at any time within six months after the conclusion of the inquest. I have given careful consideration to the evidence constituting in my view breaches of the Act in regard to whether, by any such unlawful act, it was shown to be dangerous or was the direct cause of the death of any of the deceased persons. I have considered the evidence as to whether any known person was in neglect of duty to ventilate the mine or if any of the acts or omissions which led to the

CORONER (CONT'D): obvious lack of ventilation were the result of criminal negligence. That is a very high degree of carelessness going beyond near civil negligence. Whether such, or whether it showed such disregard to the life and safety of others as to amount to a crime against the State. It would be easy to say that one or more of the deceased persons was guilty of criminal negligence and leave it at that. However, it goes further than that for even if such person was guilty of contributing negligence but there was evidence of an act or omission by any person which was the effective cause of death, any contributing negligence of a deceased person does not afford it offence. I have borne that in, uppermost in my mind in considering the question of proper ventilation. The duty of the owners in that regard; the action of the Manager in regard to the unauthorized placement of the fan; the duties and responsibilities of the persons Schuster, O'Connell, Walsh and Christ in affecting work in the process of the changeover, the owners are, through its agents and servants, duty bound, in my view, to provide proper ventilation in a working place such as a mine. In this case the evidence revealed that the owners, its agents and servants were under an obligation to exercise a higher degree of care because there was knowledge over a long period of time that there had been ventilation problems. It was well known at the gassy mine that methane issued in high proportions and the ventilation was an important factor in diluting that heavy making of methane gas. I have viewed the evidence carefully in regard to the doctor and the criminal precarious liability in respect of corporations. I have analysed the evidence of acts and omissions of the officials of the mine bearing in mind their responsibilities under the Act and in particular under the general rule, the sixth and seventh Schedules and compliance with approvals and directions. I am very much aware of the fact that they have relied heavily on the exercise of a purported discretion contained in the preamble of the provisions mentioned. For example Section 54 "the following general rules shall be observed so far as is reasonably practicable." Or the sixth Schedule "the regulations herein set forth shall as far as reasonably practical be observed by the several officials whose names and descriptions etcetera". So in that regard in respect of evidence adduced where such a discretion has purported to

Finding

CORONER (CONT'D): have been exercised, I have examined the circumstances in each case closely to determine if it was a proper exercise of discretion. I have also borne in mind the fact that responsibility to enforce the Act and the regulations by officials of the mine move to the next senior official in charge in the absence of a more senior official. I have exercised in my deliberation in regard to the purported exercise of discretion by the District Inspectors where they were administering the act and regulations as I accept that it was the responsiblity of the officials in the mine to enforce day to day compliance of the Act where it is the duty of the District Inspector to administer the Act. However, in my view, if an Inspector is carrying out his duties properly under the Act it is the ultimate responsibility vested in him to enforce compliance where there are known breaches by closing down the working place or taking summary proceedings whichever is appropriate. Objection was taken during the inquest to the reception of evidence concerning level gas in longwall returns, machine mounted monitors in defeat and torrents of methane levels in the intake and it was suggested that such evidence was not relevant. In my view they were admissible firstly as being matters relevant to explaining and bearing on the matters which were the main issues and secondly they were admissible in the public interest. Time and again it was suggested that 1) that safety takes precedence over production 2) these men were competent and very conscientous of safety measure and 3) when gas was detected action was immediately taken to dispurse it immediately. Now in my view there is a body of evidence that revealed that really that whilst everybody working the mine would like to believe that to be true, the true position it just didn't happen on all occasions. There existed in the mine an atmosphere of complacency confirmed by the evidence of breaches and tolerance to proper standards of safety which in my view could not be supported as proper exercise of discretion. Those aspects of the evidence were also important as having a bearing on the actions of those working on the fan at the time of the explosion. Particularly as there was found on the evidence to be power on to the fan, shuttle car and continuous miner in B heading. There, it has been shown in evidence that regularly during that day and days previous men continued to work continuous miners after having been warned by the automatic sensor device on the machine that there was

CORONER (CONT'D): an element of danger. That is putting the warning device into the free(?) position. The question to be asked is whether that is par for the course in respect of the way men go about their business in this line, very complacent and oblivious to the constant breaches of the Act or constant dangerous situation exposing all the risk. The same can be said in respect of the policy for electricians pulling out plugs and tagging the end of their cables when working on electrical machine. There was conflict between witnesses as to what those safety measures were. In this instant case it appeared that a fan was being worked upon, non flameproof, whilst the power was still connected. If gas had been detected or not the facts reveal that gas was present in explosive level and the power was on the miner, shuttle car and fan in a gassy place. Were these deliberate breaches or were they just commonplace. The evidence concerning tolerance of excess gas of .25% in the intakes is, in my view, for the same reason was quite relevant as bearing upon whether those working in such a place were aware of such tolerances being allowed. How did that affect the attitude of those in the mine? If the District Inspector allow tolerances then of course it follows that the officials and others in the mine also tolerate diviations from the rules. That attitude rubbed off, in my view, as high as the Manager, Mr. Fisher, for instance is a fact that two fans were to be used in the development in parallel he discussed with Inspector Mould a change for that approved. Such change required written approval but yet he proceeded to place the fan in the mine otherwise and without the written approval. As he put it, he thought he had tacit approval. This matter and others that arose on the evidence being oral dealings between the Inspector and the Managers particularly as to ventilation and not subject to written report are matters of grave concern and when viewed in the light of what occurred amounted to neglect of duties on the part of each of them. They had been the subject of grave scrutiny in the light of the whole of the evidence on the question arising under Section 19 of the Coroners Act 1980. The second reason for allowing that evidence was on the question of public interest. Much publicity had been given to these matters. In particular on a television programme. The Court gave those people an opportunity to come forward and give evidence concerning the complaints

CORONER (CONT'D): made. Of those who gave evidence not one was able to establish any sustainable complaint. Indeed not only did they fail to do that 1) a deputy at the mine was shown to have completed records in the course of his duties just prior to the explosion indicating that ventilation was satisfactory. That gas when detected was being dealt with properly and generally there was no complaint made by him in those official records handed in evidence. In other respects these people who complained and others who, over a period of time, have expressed doubts as to the working condition could not find comfort from the following established fact 1) by statute rule 39 of Section 54 of the General Rule and I quote "the majority of the persons employed in or about a mine may from time to time appoint two of their number or any two persons who are practical miners and one of whom is the holder of at least a third class certificate of competency or of service under this Act to inspect the mine at their own cost and the person so appointed shall be allowed accompanied with the owner, agent or manager of the mine thinks fit by himself or one or more officers of the mine, to go at any time to every part of the mine and to inspect the shafts, levels, planes, working places, return airways, ventilating apparatus, old workings and machinery and also to examine the plan and section of the mine that is provided by Section 35 (the latter refers to the plan of the mine kept in the Manager's office) provided that such inspection shall not be conducted so as to impede or to obstruct the working of the mine. Every facility shall be afforded by the owner, agent and manager and all persons in the mine for the purpose of the inspection. Persons appointed shall forthwith make a true report of the result of the inspection in a book to be kept at the mine for that purpose or the persons appointed shall send for the manager within seven days of the inspection a true report of the result of the inspection and such report shall be kept on record at the mine. All those reports shall be signed by the persons making the inspection. The finding of any day of any inspection of any inflammable noxious gas or the existence of self heating coal, start(?) or other material whatsoever or of any other condition from which danger to safety, health or property may be apprehended shall be recorded in a book to be kept at the mine for the purpose by the persons making the inspection on that day before they leave the mine. And

CORONER (CONT'D): if any report made under this general rule states the existence or apprehended existence of any danger, the owner, agent or manager shall forthwith cause a true copy of the report to be sent to the Inspector of the District". A similar provision exists for the appointment of electrical check inspectors and set out in General Rule 39A. Now these provisions which are aimed at giving the majority of persons employed in the mine the opportunity of having a person representing them and acting as a watch dog on safety measure, conditions etceters in the mine with considerable powers in that regard. I have studied carefully all the reports that have been written by those check inspectors, both local and district and nowhere do I see evidence of major complaints in regards to these issues. Indeed, one would be most critical of them in two respects. Firstly in regard to the most relevant period of time, that is between January 1979 and 24th July, 1979 there was only one general inspection carried out. That was on 3rd May, 1979. The previous inspection had been carried out on 25th September, 1978. Now if the Court is asked to believe that the men working in this mine had real problems in regard to ventilation, presence of gas in intakes and other complaints that were rumoured strongly after explosion and their very own representative did not find them to be substantiated. In fact the present check inspector, Mr. Loy was appointed in January 1979 and he carried out a very thorough inspection on 3rd May, 1979. He apparently having no cause to carry out an inspection prior to that day or answer any complaint or investigate any problem in the mine. His thorough inspection of 3rd May, 1979, found nothing irregular. I found Mr. Loy appeared to be a very conscientious in regard to the performance of his duties and he impressed me as a reliable witness. The following are extracts from his report of 3rd May, 1979 in respect of K panel. "The area was well ventilated and stone dusted. I can see no immediate problems in this area. Air readings 22,000 c.f.m. going over the miner. 60,000 c.f.m. at the deep end. (those figures are important when related to those relied upon by Mr. Metcalf in making his decision about adequacy of air some two months later. One can see that those figures of Mr. Loy are consistent with the readings taken on behalf of the owners and by the District Inspector on the occasion of his visit just prior to the explosion.) Mr. Loy's report

Finding

CORONER (CONT'D): continues in various parts to indicate "in longwall 7 maingate development I found that the methane monitor was U.S. 15,000 c.f.m. going over the miner. No noxious or flammable was detected. K panel ventilation was good with about 25,000 c.f.m. going over machine". He was obviously doing his job properly in regard to that inspection because he got an immediate response bfrom the Under Manager to rectify the faulty methane monitor and adjustment of tubes where that was required to overcome C.H.4 where detected. I have taken extracts from previous reports just to complete the picture in respect of this aspect of the matter. 14/9/78 ventilation was fairly good and no gas was found. 6/3/78 ventilation good and no gas detected. 13/2/78 longwall 5, ventilation was good and no gas was found. J panel ventilation was good. 14/8/77 found at root(?) very well secured and ventilation very good. No gas found. All these matters can be found in Exhibit "61". These reports concern ventilation and gas are also confirmed from other sources. See ventilation Reports Exhibit "76"

CORONER (CONT'D): readings kept by Jerome Exhibit "50" Under Manager's reports Exhibit "49", Mr. Mould's readings Exhibit "117", G.R. REports, expecially those of Mr. Brewin Exhibit "97". The second matter from which the critics could not take comfort is that the majority of persons in the mine had not appointed an electrical checking inspector, General Rule 39A. In respect of this mine. The check inspector's reports over a period of time indicate a considerable number of problems concerning motors, yet those who now see fit to complain about conditions certainly did not see fit to pursue such an appointment to watch their interests. The evidence of Mr. Smith a machine driver at page 229, is that he has never seen a check inspector inspect a continuous miner or automatic methane monitoring device. I think it is in the public interest that this should be made known, having regard to the publicity which arose on those issues. There is another matter which is bound up with the publicity arising out of the same television programme. That is Mr. Alchin and Mr. Brewin gave evidence at this Inquest concerning poor ventilation and high gas readings in K panel during the early part of 1979, and of course Mr. Brewin referred to a period early in July 1979. Mr. Alchin indicated that he made complaints to the check inspector about these matters but of course since I've indicated as relevant that there was no general inspection carried out by the checking inspector between September 1978 and 3rd May, 1979 and that inspection on 3rd May, 1979 did not disclose any irregularity. Mr. Alchin was Secretary of the Lodge and he gave evidence that he had made many complaints to the check inspector and they would be covered in the reports. However when cross examined for details he was vague and couldn't remember them in detail, he was severely shaken under cross examination, he relied on Mr. Keith Brewin for support and/as I indicated previously Mr. Brewin was shown copies of general rule reports, Exhibit "97", prepared by him in respect of the days the second, third, tenth July 1979, in respect of K panel. These show ventilation was good and satisfactory action taken to remove gas. Quite contrary to that evidence given by them and spoken of publically by them in regard very adverse conditions.

Findings

CORONER (CONT'D): In respect of my function under the provisions of section 19, it is not my intention to set out all those considerations in detail as they are well documented in the evidence and Exhibits. The more important of those matters are referred to in the consideration of the evidence concerning the cause. Suffice it to say that my deliberations concentrated on acts and omissions concerning breach of duty to ventilate or to provide safe working place which may have effectively led to the fatal explosion. In acts and omissions which may have caused the ignition of explosive quanity of methane gas each within the concept of criminal negligence. In that respect I am of the opinion that the evidence does not establish a prima facie case against any known person for an indictable offence. Ventilation is an important factor in the diluting of heavy makings of methane gas. The evidence discloses that whilst the mine and in particular B heading of K panel was gassy, regular action was taken to clear it, however this required confirmation to the provisions of the Coal Mines Regulation Act, particularly control of gas emission and cessation of work at the face where the presence of high percentage of gas were detected. Whilst the general rule for reports, were limited in the information they supplied and were stereotyped in content. It was obvious in the days prior to the explosion that officials were detecting and controlling gas emissions and monitoring air supply. Indeed ventilation reports were kept regularly ~~and~~ Exhibit "76" and in particular studied by the manager, under manager, and others in the period leading up to the change over. Also air readings were taken by others in this period, and one of those involved was Mr. Mould the district inspector. The monthly ventilation record Exhibit "76" showed a constant air pattern during the months from the inception of the development, January to July, in the order of 19,000 cfm to 20,000 cfm, having regard to the pending change over, these figures were looked at carefully and discussed by officials and further Exhibits "50 and 117" show readings which averaged about 20,000 cfm . There is evidence from Mr. Harrington and confirmed by Mr. Metcalf that E panel had been sealed off, that work had been completed on 23rd July 1979 and an inspection was conducted by Mr. Metcalf on the 24th July and he asked for a further report at the end of the morning shift on it.

Findings

CORONER (CONT'D): The action of sealing off E panel, I conclude on the totality of the evidence did improve the air supply to K panel. There is evidence that air quantities after the explosion had improved, see cross examination of witnesses by Mr. Power, but in any case confirmed by Exhibit "82" ventilation tests. Those witnesses who complained of heat and bad ventilation in the Court's view were shaken under cross examination and the weight of evidence was against the propositions advanced by them. Exhibit "76" the monthly ventilation reports show that temperatures taken in K panel were constantly near normal levels, which were found and experienced in other districts of the mine. A systematic study of the general rule 4 reports, and the check inspectors reports confirm that ventilation was good with rarest exception. The evidence revealed that there was a requirement for a minimum of 48,000 cfm to run two fans and having regard to the evidence it appeared that as at 23rd July, 1979 there was approximately 55,000 cfm and Mr. A Fisher was always of the view, supported by Mr. Metcalf that it would improve on that figure because of the sealing of E panel. It is noted that the requirement was in respect of two fans in parallel and there is no evidence of whether at change over these figures would be attained or a proper split of the air would take place as far as each fan was concerned or did occur if indeed the second fan was operated. In view of the pending change over a report was made by Mr. Macalpine to Mr. Metcalf at the conclusion of his shift. Whilst he may have been confused on the figures he confirmed the ventilation to be good. Obviously Mr. Metcalf acted on the totality of the facts as known to him at that time in giving instructions to go on with the change over and I find on the evidence that the figures for air ventilation at that stage were adequate for that purpose. If any criticism could be found, it was that perhaps the persons to finally make the change should have been supplied with accurate air reading instruments and the change over completely supervised by an extra official for that purpose. It was revealed in evidence that the B heading stub was some 70 metres long and on brattice ventilation up to the point of change over.

Findings

CORONER (CONT'D): There is evidence that it was sufficient providing it was kept tight and secure. Most witnesses agreed in that respect, although Mr. Vassack in particular was critical of it in hind sight. I have come to the conclusion that all those working in the panel during the afternoon shift and the evening shift could easily understand the ventilation scheme that was to be implemented, despite the fact that some may not have been fully aware of the plan. It is clear in the evidence that it had been well planned and thought out by experienced people in Messrs. Fisher and Metcalf were most impressive witnesses in that regard and the evidence revealed that all the under managers have been involved in the conferences and discussion on its implementation or had material made available to them concerning it. The plan had been fully discussed at length and approved by the Mines Department inspectors and it transpired during the course of these proceedings that both senior inspector Kinninmonth and Inspector Mould, in the Court's view were experts in that field. That it was later carried out by inspector Mould after the explosion with little difficulty, Exhibit "82" was significant and of course at the present time the same system is operating, that is at the time of the hearing of this matter, without complaint. These matters confirm the effectiveness of it as an efficient means of ventilation. Criticism is justified that whilst those officials above mention were well acquainted with the plan others involved in its implementation do not have full details of it communicated to them. In fact in the actual working place the evidence revealed a breakdown of proper communication in respect of the implementation of it which I will refer to later. I return at this point of time to the matters of gas emission, use of mounted methane monitors in defeat and placement of fan in position without written approval. So that in the public interest these matters might be fully disclosed. To this point of time, 24th July, 1979 the situation leading up to the changeover was such that adherence to the law by all was critical. Proper communication between those involved was imperative. Problems of gas emission at Appin Colliery was of long standing concern to the owners, management, officials, workers and Mines

CORONER (CONT'D): Department inspectorate. I requested of the Minister information in respect of these problems, and in fact the files were produced and departmental files were tendered and some became Exhibits and in this case which had the effect of publication. The contentious matter being high concentration of gas being emitted from the intakes above the percentage prescribed leading to too higher concentration at the working place, and whether such high concentrations were tolerated or disregarded. The problem was highlighted by the use of the continuous miner with automatic methane monitors attached. For various reasons there were continuous stoppages, delays and on the evidence breaches of the Act in regard to the use of these machines whilst the sensoring devices were held in defeat. Clearly that occurred on 24th July, 1979 and had been a long standing feature of Appin Colliery.

Findings

CORONER:(CONT'D): Clearly, on the evidence it is such that the automatic monitor regularly tripped out either by high gas ignition or some malfunction of the sensor by loss of calibration or other defect. No witness gave clear evidence as to whether in fact it was ascertained which was the cause of the tripping out on the majority of occasions. There is evidence that a continuous miner was operated whilst in defeat, for a considerable period of time on 24th July, 1979 in A heading. See the evidence of Mr. Smith, the driver, at page 224, knowledge of it by Mr. Walsh the Under-Manager, at pages 63,66 and 71. That it was reported to the Electrician, Mr. Kearce, see page 258, but he did not attend to it. The fact that the machine should have been withdrawn from use under those circumstances is confirmed by the direction, Exhibit 80, which was issued on 16th January, 1979. But obviously the proper rule was not communicated by the officials to the machine men, the deputies, the under-managers, and the electricians, is clearly indicated in the evidence. These personnel gave varying accounts of what they thought the rule was, but on the balance I am able to find that it was accepted by them, that it could be placed in defeat and the machine operated until rectified, or for twenty four hours after calling the deputy or Electrician, and in any event, testing for gas every half an hour. Mr. Smith indicated that he called the deputy, and that was his only responsibility, page 226. And the evidence discloses, he didn't test for gas as required, and at no time after, did the Electrician Mr. Kearce come to check the methanometer, page 227. Mr. Kearce the Electrician said he was too busy to look at it, and left it to the following Electrician next shift, and that was the accepted thing, page 260. A continuous miner would continue to operate through the shift until the next shift came on. Mr. Kearce indicated that it was a most urgent job, yet he didn't look at it, and in fact the type of work being performed by him is described later by a Witness as labouring work. In fact it was shown in the evidence that on this day those checks, every half hour, despite the machine being in defeat, were not being carried out. Only when it commenced and Mr. Garner, page 448 confirms that checks each half hour were not being carried out. Only when it commenced, and Mr. Garner, page 448 confirms that checks each half hour were not always done. In this case, on 24th July, 1979 the Electrician Mr. Kearce did not tell the Assistant Electrical Engineer Mr. Francis about the problem. It was only picked up by Mr. Francis later on reading the report, page 390, and

CORONER (CONT'D): Mr. Francis confirms, page 391 that prior to the explosion the miners were used in defeat to cut coal. Mr. Buick, a machine man deposed that you test about every hour when the machine is placed in defeat and operated to cut coal. When it was put to him under those circumstances, he should have tested every half hour, he replied "it's a good question". He couldn't answer it and when pressed he said "It really depends on the conditions you're working under, you know,"page 555. Now I have referred to these specific matters because it leads to the fact that it was Mr. Buick (?) who was the driver of a miner in B heading stub, an intersection on that same date, 24th July, 1979. The evidence is clear that it was at a time when gas had been found in B heading. There is evidence that on the same day a continuous miner had been operated in defeat. It was the same day that Electrician Kearce was too busy to attend to attend to more urgent business, and the same day that Buick drove the miner into the intersection to move the fan, which operation was not supervised by a superior official, was in the vicinity of a place where Witness after witness is given evidence of gas being found and the evidence confirms it. The place was on brattice ventilation, a lengthy stud, brattice which on the evidence was faulty, and being constantly disturbed by the movement of men, material and machinery. This very same miner had reversed electrical wiring on the warning sensor methanometer. Barroback type (?) 23 methanometering system. Exhibit 98M report of Mr. K.J. Fisher. Examination of item 4, connection of the sensory head to the control unit in the colour of colour sequence. Indicated that the moniroring system read backwards when put in a gassy atmosphere, i.e. application of a methane test gas to the sensory head caused the meter movement to indicate a negative gas concentration. That is my interpretation that it was consistently or constantly in defeat. (Mr. Corcoran (?) Chief Electric Inspector had not seen this item, so was not able to assist any further, but Mr. K. Fisher's findings soon concludes it in the Court's view.) It has been submitted that the miner was in a fmaleproof condition at the time of the explosion. That is not relavent, and in affect I should ignore it. How can I do so in the light of what I have just referred to, when the evidence is that Buick left it in the B heading with the power on, the on position. He did not pull out the plug, page 558.

Findings

3111/1/4 BW
19th December, 1980.

CORONER (CONT'D): Now the evidence is that he was not supervised by a Deputy, and that the Deputy did not check the brattice or the area in B heading, or take any gas readings after 4.00p.m.

SHORT ADJOURNMENT

UPON RESUMPTION

BENCH: I had just referred to the fact that the check hadn't been made or gas readings taken after 4.00p.m. and the fact that the machine been left with the power in the On position. It is in the Court's view clearly indicative of the breach of safety, a breach of regulations, to disregard the safety of others. There are so many involved in this sort of careless approach, it is difficult to sheet blame home (?) in a definite way. However, when one is required to examine a given set of facts, particularly in regard to circumstantial evidence, can choose between whether one might expect a person to comply with safety standards or otherwise the weight of evidence is against a conscientious and careful approach. This is not only applicable to the use of continuous miners being used in defeat, but it is also shown on the evidence to exist in other areas. There was a lack of discipline in the Court's view in regard to compliance with some safety standards. As far as the onus on Managers was concerned, it was disclosed that the direction was given in regard to defective methone monitors on 16th January, 1979, Exhibit 80. It was brought to a head, it did bring to a head at Appin Colliery, their problems, particularly bearing in mind that Appin was not able to comply with the directive. Now it appeared initially that the Company by letter, Exhibit 81, endeavoured to use a device to overcome the problems by asking the Mines Department for a definition of normal coal winning operation. In the interim continued to use the machine whilst it was in defeat, in breach of the direction, Exhibit 80, with a reliance on some form of local rule which has never been clearly stated, indeed seeing Inspector Kinninmonth had trouble defining it, and Mr. Alan Fisher, Manager, didn't know of it. And I can find that the evidence reveals one, that the direction Exhibit 80 was

CORONER (CONT'D): not communicated to those working in the mine, and 2, the so called local rule was not understood by those persons, including the Manager, that he, the Manager was of the view that they were not so operated, although the weight of evidence was against him. This aspect of the evidence left much to be desired, and it transpired that Senior Inspector Kinninmonth had knowledge of the fact that oral discussions had taken place between the Chief Inspector of Mines and the Manager, about the use of the continuous miners. He therefore was not going to enforce the direction, but allow compliance in accordance with some local rule (which no one could properly understand) which applied to mounted methaneometers issued in 1969. In any case such direction was uncertain and vague, and the evidence revealed that no one had an understanding of it. It is regrettable that the letter ffom the Company, dated 9th February, 1979, asking for clarification, was not answered by the Department, until 26th October, 1979, and the explosion had intervened. It is alarming that the Court should hear of vague discussions between the Manager, Inspector Kinninmonth, Mould, and the Chief Inspector of Coal Mines about this matter, and no official reports committed to writing, and no reply given to the mine until well after the explosion. The Court draws the inference that those oral discussions led to oral approval for the use of the continuous miner in defeat, together with some other conditions. These directions were not properly communicated. It is important when it is remembered that the proposal was to use two continuous miners in the new development of K panel, and the implications arising through the mis-use of those machines with the people involved were not fully aware of the correct directions. Is this another example of some tasset approval being given without written approval. This is what Mr. Fisher was given to understand in respect of the fan in B heading. It is clear that the plan was discussed fully with Inspector Mould, there was no written approval for modification, but Mr. Mould had approved of it as he saw it as a solution to the methane intake problem. I conclude that no approval was given to use the second fan in the manner mentioned, and it was intended that a written approval be made for a variation of the original development. The men (?) put in effect the proposal without written permission. Mr. Fisher gave the authorisation, and Mr. Metcalf was under the impression that it had been approved. Preparations commenced with a cheque by

3111/1/4 BW
19th December, 1980.

CORONER (CONT'D): Mr. Puppet and the lane of the reticulation cables on 24th July, 1979. The written approval was not received by the Inspectorate until after the explosion. Much was said about torrenses of gas emmission by the District Inspector. There was a history of it, and in these proceedings evidence through Exhibit 84, a letter written on 4th April, 1977 by Inspector Kininmonth, to the Manager of Appin Colliery, pointing out at that time that conditions gave cause for concern. That letter was written after an inspection where higher percentages of gas emmission were found and those permitted. On that occasion the finding of .5 percent methane was found in the intakes.

CORONER (CONT'D) The matter was discussed with the Inspector, the Chief Inspector, and the then Senior Inspector, and discussions continued over the intervening years from time to time. The following evidence of Mr. Allan Fisher, Mine Manager, throws some light on how he understood some tolerance arose, that is after discussions with those senior officials and later cross examination revealed in relation to gas omissions (?) the Chief Inspector of Coal Mines was answerable to the Under Secretary. At page 864, "Question: And have those discussions continued over the intervening years from time to time? Answer: Yes. Question: And have they had an influence in having you change your development system to a central intake and two returns on the side? Answer: Yes, certainly. The position was that as at that stage we had hoped to achieve something by way of drainage from the solid to allow us to continue with the two heading system as I said previously, we were very reluctant to drive that third heading initially, but the fact the thing had been dragging on for two years with our relying heavily on the, as far as reasonably practical part of the legislation to justify our continued non-compliance, which wasn't continuous, non-compliance, but certainly was at times continuous for periods. Certainly that had its effect, plus the fact of course, that you just have a problem and if you have your intake air contaminated with half a percent instead of something less than a quarter of a percent, you have that much more difficulty diluting the gas that's made in a working place." Now that evidence of Mr. Fisher clearly indicates that for a considerable time until April, 1977 up until January, 1979 when the driveage was commenced they had acted on a purported tolerance in regard to gas omission, and the figure clearly relied upon by him in that evidence was point five percent. That is, there is evidence there of continued non-compliance with general rule one (e) in that the management was not told to comply with point two fivepercent and that the management of the Mine relied upon the tolerance and they were lead to believe that the higher level was accepted. This day Fisher has given evidence that pages 866 and 7 that the belief was held after discussions with the Chief Inspector, approximately 4th May, 1977, the Deputy Chief Inspector, 14th July, 1977

CORONER (CONT'D) and again the Chief Inspector on 9th March, 1978, that during discussions generally Mr. Fisher was of the view that the point five percent figure was accepted as being the figure that was going to be in the new Act and was certainly discussed at various times through the period. Now that is not the evidence of the present District Inspector's view of it, that is how the Manager of the Mine interpreted it and he made no secret of it and it rose at a point of time before for the present District Inspector was appointed to the position. After appointment I turned to the following from Mr. Fisher. Again on this question to allow point five per cent instead of point two five per cent, Mr. Fisher in answer to Mr. Alchin, page 896: "Question: And you are not sure who you discussed the point five percent with? Answer: I am sure to the extent that it would have been Messrs. Pyrmont, Mulg and Muir. Question: Could you recall what the Inspector's attitude was? Answer: When Mr. Olsen, at what stage? Question: When you discussed that point five per cent? Answer: Well my recollection of the situation was not that we were being granted discretion because of the proposed amendments to the regulation, my impression was that we were being granted discretion because it was felt that we were as far as reasonably practical of complying that we were doing everything within our power to have the level. Mr. Muir in H-panel in my presence made the remark that H-panel at that stage was the best ventilated panel that he had ever visited. Question: You say that you were granted discretion? Were you granted discretion on a verbal basis or did you have some reason for assuming that you had been granted discretion? Answer: It was on a verbal basis. Question? Who granted it? Answer: I think ultimately Mr. Muir. He was the senior officer who visited the Mine at any stage when we were in a condition of non-complying with the letter of the law. Question: Well could you tell me what way he granted that discretion Sir? Answer: Well in discussion. It is clear initially that Mr. Kinninmonth and District Inspector for Appin, highlighted these problems of excessive gas omission, that he instigated by way of report action. What occurred thereafter, including those who were present at inspections, the figures are recorded and are well documented. In Exhibit 121, Departmental File 77/1/770 and also see the evidence of Mr. Kinninmonth Pages 1381, 1384. To that document can be added the evidence

Findings

CORONER
(CONT'D) of Mr. A. Fisher which indicates the Department did tolerate higher gas omission, then that is set down in the Act in respect of Appin Colliery. Mr. Mould took over as District Inspector, who specifically had this file referred to him by Mr. Kinninmonth and indeed on his inspections he highlighted the same problems and anticipated them for K-panel. At this Inquest, Mr. Mould is reported as saying as follows: "Question: And Mr. Kinninmonth while expressing great concern about the gas said 'Make sure it's safe but the Act doesn't have to be strictly complied with'? Answer: Yes." At a later stage, "Question: Certainly there was a practice there to permit gas levels which didn't strictly conform with the Act? Answer: On the odd occasion provided it was safe." Mr. Mould indicated in evidence that any breaches that he found were drawn to the attention of the Manager or the Under Manager, and explanations were given, page 1522, and that he never had to issue a Section 28 Notice to stop work in Appin Mine, because whenever he had found a fault and brought it to the notice, action had been taken to rectify it, page 1525. As to the continuance of the discretion concerning omission of gas in the intake airways, he said, this is Mr. Mould at page 1529 "I have always understood my requirements as being to continue with the practice, if you like, of what was done before I became an Inspector and that is to regard the point five percent as being the absolute limit rather than point two five, in view of the revision of the Act which is being done." And later in answer to a question by Mr. Kinninmonth, "Question: But you have reported from time to time during your inspection visits that the gas level has been above point two five? Answer: Yes. And you did not consider that this was in breach of your duty provided the gas did not reach beyond point five? Answer: Well I considered that if I reported over point five and no comment was forthcoming there was some agreement with what I had already done." Mr. Mould indicated that he was of the opinion that it was Departmental Policy to allow up to point five percent, he could not point to any written direction, but clearly he relied upon what was past practice and obviously what was allowed when he was present with more senior officers. Now there was objection to this evidence being received on the basis that

SLATYER (COMP'D) it was not relevant, such objection being overruled. Clearly on the first count it was in the public interest that it be known, quite a deal of suspicion was attached to the District Inspector as to why he allowed such tolerances and whether as he has indicated it was departmental policy. It has now been brought out in the open. In my view the body of evidence supports that whilst it may not have been the written policy of the department, it certainly was policy by implication. And why such would not come to the notice of the Minister it is not for this Tribunal to find, however, it is clear that senior officers were well aware of it. On the second count, it is important because again it illustrates tolerance in respect of matters concerning safety and the attitude has flowed onto others as a result thereof. For instance, just as non-compliance with the direction as to use of machine mounted monitors in defeat was accepted by the Inspectors, gas omissions were permitted above regulation which in turn can explain why in many instances verbal approvals were common place providing the written application was forwarded at a later stage. Written reports of inspections were not always made, verbal instructions to overcome problems were issued and only rarely followed up by written letters and reports. All these matters view culminate in an attitude of complacency in general, that Mr. Mould has given evidence, page 1532, that instructions have now been given not to use any discretionary powers in regard to point two five percent, and as a result he has enforced general rule one (e) to the extent of closing the panel down, highlights a fact that there was a tolerance in the past. On the third count it was important as showing that the Department was endeavouring to do something about overcoming these gas omissions by encouraging the management of the mine to be involved in control, there is a logical course of events that lead to an exemption dated 16th July, 1979 and I appreciate that the exemption does not refer to A-panel but certainly it, Exhibit 78, draws attention to the fact that Mr. Mould was raising again problems as a result of an inspection and that as a result of his letter to the management dated 14th May, 1979 in evidence the Management made the application for exemption 8th June, 1979, also in

[illegible] (JCLP'S) evidence. In fairness to the Minister it also shows that on 16th July, 1979 the Minister drew attention to the management, his concern for

Findings

CORONER (CONT'D): the quantities of methane being liberated in the colliery. There is no evidence before the Court that there was any breach of general rule 1(E) between 16th July, 1979 and 24th July, 1979, or that any person had any knowledge of such a breach if one did exist. Messrs. A. Fisher and Metcalf had both given evidence which support that proposition as far as K panel is concerned. I refer to some matters that arose during the shift leading up to the changeover period, and particularly those relating to the use of mounted methane monitors, ventilation and gas emission. I intend now to touch on and comment on matters that occurred prior to the evening shift, emphasizing what I found to be inadequate communication, in my view that, the question of proper ventilation or no proper ventilation for the changeover hinged on communication of the exact state of affairs for the oncoming shift. Because even if deputy Rawcliffe was astute enough to remove the brattice number 3 cut through, there were other factors that had to be taken into account, and so important that he had been properly advised of them. Were Mr. Oldcorn and Mr. Rawcliffe advised or adequately advised as to the true position at the change of the shift. It could be argued that it would not matter because Mr. Rawcliffe with his experience and knowledge, would have been able to effect it. However, in my view, there were matters and incidents that occurred during the afternoon shift that had a major bearing on the whole question of proper ventilation, particularly the likelihood of a further contamination of B heading. Keeping in mind that it is indisputable that it had been comtaminated with methane over a period of at least forty eight hours to the extent of cross sticks for a considerable period. The general rule report showed how other contaminations were dealt with, witnesses Vassic and O'Connell gave evidence of it, and also see Exhibit '56'. Mr. Dyson deposed at page 168 there was a notice on the board in the crib room when the shift just completed, which showed there was inflammable gas at the face of K panel 4. Deputy Schuster referred to the face that the GR4 board

CORONER (CONT'D): in the crib room showed gas problem in B heading, page 135. Mr. Ekhardt was told not to go into B heading during the shift, 1.00 to 8.00 p.m. because cross sticks had been erected. See also witness Stadler at page 216. There was other evidence concerning the presence from witnesses Wall, pages 238,239, Regan, O'Connell, pages 461 and 517, Vassic 517, and Hughson at page 541. That something unusual must have happened should be accepted for a number of reasons. Firstly, if he had been told exactly what the position was at the change of shift, A. he would have known that the stopping had to come out. B. he would have not have been misguided or concerned by the leakages that existed if he had knowledge of them. 2. When seen by Mr. Burn at about 9.15 p.m. in the panel, everything appeared to be normal, and Mr. Rawcliffe was in a good mood. Page 1481. 3. The under-manager Mr. Oldcorn acted in a routine manner, no matters of urgency apparently arising. 4. No messages to the control room of urgency. 5. The men were at crib and Mr. Statts appeared to be carrying out normal maintenance work during crib. 6. There is evidence that Mr. Rawcliffe had checked the gas during the shift. However, the work that was carried out during the afternoon shift in my view, did lead, as I say, to these number of imperfections, this is my term, which gave rise to a state of affairs which in my view had an important bearing on the ultimate contamination of B heading. I am completely satisfied the evidence before this Court, that the initial explosion was caused by the ignition of methane gas. The body of evidence supports it, and particularly the experimentation and the search of Mr. Ellis, Exhibit '83'. Whilst the weight of evidence is such that the most likely path of the flame which caused the ignition was the vent tube. I do not exclude the fact that the flame part could have been a layering of $CH_4$ on the roof of B heading. My reasons for finding so is that whilst the majority of witnesses had proceeded on the basis of a flame path through the vent, inside the vent was not tested as it could easily have been, to show whether that did in fact occur. Indeed it was only after cross examination

CORONER (CONT'D): by Mr. King of Professor Keys near the very end of the hearing that the point was raised. Pages 1327-8. It was then that an endeavour was made to test the inside of the vent tube as opposed to the external parts, however, whilst such testing gave a negative result, it is qualified in the Courts view by reasons of fact there was no real evidence as to whether the vent tested was in fact from B heading. It was said to have come from B heading and that was the extent of the evidence in that regard. There was evidence during the hearing that the flame path could have been along a layering of gas at the roof. Ellis, page 848, but he indicates that this could occur, although he formed the opinion because of the damage involved that it was probably via the vent tube, as it was the obvious one, (path) available. I am satisfied on the totality of the evidence that the initial explosion was methane gas at the face of B heading. These imperfections or conditions which prevailed at the change of shift included, A. the fact that the B heading was some seventy metres long, on brattice, ventilation which was shown to have faults, if not attended to, caused a build up of methane gas because of the short circuiting of B heading stub. It was unusual for it to be so long, deputy Schuster, page 151, it was leaking, see evidence of O'Connell, and it was of poor quality, see evidence of Mr. Vassic, and Mr. Ashelford on reflection, the method of ventidation of B heading was not adequate. B. there is no evidence that at the time of changeover being commenced that anyone had accurate instruments to measure the air, in particular the fact that the air was being split sufficiently to properly run ~~to~~ two exhaust fans. This was left to the judgment of those present without the aid of instruments bearing in mind the last tests were taken at considerable time prior and without the benefit of knowledge of existing leaks. Mr. Metcalf relied on a message from another officer who was not present at the change of shift and who had no knowledge of the existing conditions. C. the overcast at A3 intersection had not been completed, holes were in it

CORONER (CONT'D): and had been filled with brattice. Witness Guest deposed that the building of the overcast was not supervised, there was delay in it, caused by an argument over the use of a flat top. There was a gap on it. "I filled the gaps with brattice instead of mortar on the overcast. The job was not checked whilst he was present there until some time prior to 6.30 p.m." Page 242. The matter of concern to the Court was the fact that this dispute caused the defect. The dispute between Mr. Christ and Deputy Schuster and it leads me to a view that perhaps this overcast was not done in the best manner acceptable. Witness Mr. Davis deposed that the use of the flat top by Deputy Schuster caused an altercation between Christ and Schuster, page 109, it disrupted work on the overcast Christ was going to knock off and walk out of the pit. Page 110. And he was going to do all sorts of things because it disrupted his job, it was an important part of the nights work. Page 110. I have a very uncomfortable feeling that indeed they did finish the job early despite their combined evidence that they worked on it just prior to 6.30 p.m. That evidence is in conflict with Deputy Schuster who deposed that he was told at late crib or just before that, the overcast was finished, and the evidence showed that late crib was about 5.30. Davis ~~has~~ is given some support for his version there, and this is the second incident in which Davis is the odd man out. The others on each occasion, the others being the account of the erection of the stopping in the Courts view closing ranks. For various reasons, not the least being the inconsistencies of evidence and subsequent events. I accept the evidence of Davis as giving the true version of each of those events. In my view the others should have been subjected to a Record of Interview by the Police as to these incidents and confronted with the facts which are inconsistent to their versions. The overcast was not completed, there were considerable gaps in it and resulted in leakage. Indeed, there was a considerable amount of disturbance to brattice in B heading intersection. There was quite a deal of traffic going through it and the flap was up for quite a time during work on the vents, Dyson, page 173. The

CORONER (CONT'D): shuttle car was driven through it, and it was lifted. Guest at page 185, and witness Horvath didn't see anyone checking it after the vent tubing was finished, page 191. Mr. O'Connell deposed that the brattice was split at the corner of number 4 cut through and hanging over the top of the 10 CM miner, page 461. He checked and fixed it at 4.00 p.m. and did not check it after that time, page 479. Mr. O'Connell admitted he did not go back and check the gas after 4.00 p.m. and if Mr. Rawcliffe had not checked there could have been an accumulation of gas in that three and a half hour period. In that regard, there is evidence that the make of gas would have been in B heading at least 1.5 cubic metres per second, see Exhibit '83' and clearly if the heading was not being ventilated an explosive amount of methane would accumulate in a very short period of time with one estimation being at less than half an hour. The total evidence in regard to this brattice at B4 intersection leads the Court to conclusion that at the intersection because of the faults and considerable disturbance there would be considerable short circuiting of air depriving B heading stub of proper ventilation and consequent contamination by methane gas. E. there was considerable inconsistency in the evidence concerning the construction of the brattice stopping out-bye number 3 cut through in B heading. However, two matters that emerged are certain. 1. It was erected in a different position to that which was planned, and appeared to be temporary according to witness Mr. Metcalf, who said it was supposed to be a plaster board stopping and erected new number 2 cut through. 2. The brattice when erected, was on the wrong side of the supports holding it. If the oncoming shift was not aware of the new location, would they really discover it is the question I ask. And another matter arising was there was, was there was considerable leakage from it that could lead to a mistake in belief as to it's non existence. When this stopping was erected, the stopping which still existed had to be pulled down and it is clear that at the shift changeover that had not been done. The erection of the stopping and the overcast in

CORONER (CONT'D): my view left a lot to be desired, Mr. Mould who obviously is qualified as an expert in the field of ventilation has given evidence that both these jobs should have been properly supervised,

Finding

CORONER (CONT'D): particularly where you've got the situation where there is an overlap in shifts, pages 1541 and 1545. It was apparent from the evidence that Deputy O'Connell was supposed to be in charge, yet he did not know where Deputy Schuster was up to, and Deputy Schuster did not want to accept any responsibility for it. Yet the total evidence before the Court is that Deputy Schuster was the person in charge, and he has shown a complete lack of understanding in the change over procedures. He has not closely supervised them, and even if I accepted his evidence, it would have been well within his power to have corrected a situation by pulling down a stopping, which would have taken some three minutes to overcome a dangerous situation. I have my doubts that Deputy Schuster ~~was~~ went back to check the job done on the brattice and B heading. There was conflict in his evidence and that of Prince, Dyson and Mr. Davis. Davis, when questioned as to the supervision said "no, not the actual supervision, we were just told to do it, and just obviously you know what to do, so you just go and you do it" page 113. They put the brattice on the wrong side of the props, page 113. No person came back to check it after its erection. We were called out by the shake of a light, up at the little cut-through. Davis said he was there and Schuster had called out "right, if you are finished, come out". Deputy Schuster said that prior to crib, Under-Manager Walsh had told him to put up the brattice in B heading, outbye number 3 cut-through, after the overcase was completed. He took two men to do the job. He said that he returned to them later and they were in the final stages of putting it up, page 129. He carried out an inspection and made observations. But Witness Mr. Dyson, page 175, said that Deputy Schuster came before they had finished, and said that he would see them at the crib room. When asked if Schuster waved them from a distance, he said "no I can't recall now". In the Court's view this device of a faulty memory became fairly common in these proceedings. In my view it was evident that they had closed ranks to back deputy Schuster. If accepted, it showed that Schuster was aware of the defects, substantial leakage and the fact that the stopping improperly fixed in the props. Therefore, I come to the conclusion, bearing in mind his period of a service as a Deputy, that he did not completely understand the plan, the changeover and the effects of it. If he had have,

CORONER (CONT'D): he could have pulled down the brattice in number 3 cut-through. It would have only taken three minutes to do it, and it was vital to the plan. Mr. Metcalf didn't spell it out chapter and verse, but he was of the view that he didn't think anyone would put one up and not take the other down. In any case he had given Under-Manager Walsh clear instructions to take the stopping at number 3 cut-through down, and of course if was Walsh who had given Deputy Schuster his instruction. I consider much of what Deputy Schuster has said in evidence at this Court, if his view looking at it in retrospect, indeed, I have considered his evidence carefully in the light of the question of culpable negligence, in failure to provide proper ventilation. This must be so because of the duties that a Deputy has under the Act and Regulations. Particularly the general rules in the Sixth Schedule. Responsibilities that go with the position can't be fobbed off by saying someone else was in charge and the evidences against that proposition. Under-Manager Walsh must also come under review in this regard. It is a most important matter when it comes to communication to the oncoming shift. It's easy for them to say "yes we told them" because those people are now deceased and can't answer. Deputy O'Connell must also be under review on the same question of adequate ventilation, because the combined affect of him not checking the inadequacies of the brattice of B intersection, after 4.00p.m. and not checking for gas after that time, and his complete lack of knowledge of what Deputy Schuster was doing together with his limited knowledge of the plan, leaves much to be desired, concerning responsibilities of the Deputy. There appears to be a lack of knowledge by each of these key personnel as to what the instructions were for the change over. Under-Manager Walsh first received instructions three or four days before, page 89. He had been told by the Under Manager, and there was never any plan as far as he knew. He didn't know what stage matters would reach that day. It is clear from Walsh's evidence at page 101, that there was a lack of communication to the Deputies as to the duties to be undertaken. He had knowledge that there was gas in B heading stub, but he didn't tell O'Connell. It would be wise to cut the power off, bearing in mind the use of the machine to move the fan to B heading, and there is evidence that the plug was not pulled by the machine man after the machine was used. "No, I did not pull

CORONER (CONT'D): the plug out, because I didn't think the changeover would have got as far as what it did", page 102. Deputy Schuster was not aware of the plans for K panel at the time, and not aware of what was planned for the changeover, page 148. And Deputy O'Connell did not have instructions for the changeover as he was mainly concerned with the operation of A heading. As I indicated these were key personnel on the shift who were supposed to have adequately communicated instructions to the oncoming shift about A changeover. On the evidence they did not know anything about it in detail, nor were each of them aware of what the other had done, or observed prior to the change in shift. In regard to this aspect of the evidence, in my view those who were involved should have been each subjected to a Police record of interview, having regard to the responsibilities of their office, and their responsibility to provide adequate ventilation. The nature of the evidence supplied to the Mines Inspector is such that it would be admissible only against the person making it, in proceedings for an offence under paragraph B of Sub-Section 2 of Section 27 of the Coal Mines Regulation Act, 1912. The evidence of these proceedings is based on such statements. Obviously any admissions in such circumstances were based on material leading from such statements would be objected to in the light of the fact that the person had not been properly cautioned, and the evidence given at the Court of Coal Mines regulation would be similarly objectionable. Now these matters, together with the delays and procedural difficulties of the prior enquiry, has detracted from the quality of the evidence now available concerning this matter, of failure to provide proper ventilation. There is no doubt in my mind that at the change of shift, the acts and admissions of these people, led to a potentially dangerous situation in B heading. I intend to further comment on it and some of the evidence concerning the purported communication and the state of affairs to the oncoming shift. There are inconsistencies in the evidence, both oral and circumstantial, given by Messrs. Davis, Schuster, Walsh, O'Connell, Prince, Dyson and Cross. I have come to the conclusion that some of them have closed ranks to protect each other. It is easy to say you told someone else who is deceased, something, when that person is unable to answer, but a considerable volume of that evidence does not stand up when scrutinized in the light of the circumstances as to the completion of the work and the times, together with a documented evidence now before the Court by

CORONER (CONT'D): way of exhibits. Mr. Davis is the odd man out, as I indicated previously, but it is relevant that he was present in the three troublesome areas. Others knew of his presence, but when it came to a direct answer as to whether he was there or not, there was a difficulty in recall of memory. On the other hand Mr. Davis had had a very good recall in regard to each matter, down to the last detail. For example Mr. Schuster can't recollect whether he sent Davis on the job, page 159. Mr. Dyson said only he and Prince was there, but in answer to a question from myself he was not sure if Davis was there, page 171. He doesn't come straight out and say "no he wasn't there". Deputy Schuster showed the same reservation. Now when one examines Mr. Davis's evidence, he certainly had a detailed knowledge of what was done on each of those jobs, namely the vent tubes, the over cast and the B heading stopping. Mr. Davis was one of the Witnesses the Police were able to interview to throw some additional light on these problems after the enquiry. Mr. Davis said that Mr. Schuster waved from a distance with a lamp to call them out. A fairly significant event. Schuster said he didn't, however, Dyson gave a contrary version to Schuster, and then when pressed as to the circumstances, resorted to the loss of memory. The version is more consistent with Deputy Schuster's expressed desire not to miss the transport to the pit top. Deputy Schuster was most unconvincing, particularly in cross examination by Mr. Murray, page 145. If he was to be believed, he had the answer to the problem itself. He could have concluded the changeover by making the last step. His reasons for not doing so are far from satisfactory, and hard to accept in the light of his experience, as I understand the evidence twenty years in mines in Appin and in Europe. It is unlikely that Deputy Schuster was ever instructed to remove the brattice at number 3 cut-through. The evidence is strongly in favour of the fact that Schuster, O'Connell and Walsh were not really fully conversation with the details of the changeover, In Schuster's mind completion of the work assigned to him completed the changeover. The fact that in his evidence he proffered an air of puzzlement and uncertainty about reverse of airflow supports the finding that he didn't know or understand it or otherwise he would have removed the brattice at number 3 cut-through. That being the case he was not in a position to

CORONER (CONT'D): properly inform Mr. Rawcliffe. He didn't inform O'Connell, because O'Connell has admitted he didn't know where Deputy Schuster was up to. Under-Manager Walsh couldn't have known, because if the position was such as Schuster had indicated, it would have been an important matter to bring to the notice of Under-Manager Oldcorn. Obviously Mr. Oldcorn, by his demeanour on that night, had not seen anything in the reports to him of the magnitude ways in evidence by Deputy Schuster at these proceedings, to cause alarm or change of routine. Deputy Schuster admits he was not aware of what was planned for the changeover. Page 148. And at pages 157,158, show he was not certain at the time whether the cut-through number 3 stopping had to come down. He varied his evidence as to the fact that at crib, about 5.30, he was told the overcast was finished, but later varied that to 6.30. Page 160. Because quite obviously other evidence was contrary to his evidence. His evidence is in contradiction and conflict with others on the completion of the brattice stopping in B heading. He pondered the trouble concerning the stopping and then added "didn't think the fan would be run without another stopping", page 161. However, there is no evidence, he told Deputy Rawcliffe, this important information, a great deal of Deputy Schuster's evidence and that of Dyson is given in retrospect, pages 148 and 170, and of course he had prior knowledge of the presence of flammable gas in B heading, through the general rules or reports. See page 135. Deputy Schuster at the time showed a greater concern to be on the transport to be, to the top, so as to be not left behind. There is considerable evidence for me to find that Deputy Schuster believed that the ventilation changeover was completed, as far as he was concerned. That in retrospect he realised his precarious position, which has led to a considerable number of inconsistencies in his evidence. This was most evident as between himself and Walsh, in that they both endeavoured to shift the blame from themselves to others. A communication of the position in the panel to Oldcorn and Rawcliffe has been considered carefully. Some of the material relevant to that has already been traversed by me, particularly in regard to the roles played by Messrs. Schuster, Walsh and O'Connell. What are referred to in my viewpoints are their obvious incompetencies, that they after the event have seen this and have now in hindsight provided the version of what occurred.

Findings

CORONER (CONT'D) No matter which way you look at it on their versions and from the view of each of them, one material factor comes through clearly, that is the ventilation of B-heading Dubb was in a potentially dangerous situation. They have given their versions of communication, however, there are areas where the lie is given to those versions. Firstly, Exhibit 56. Reports made by the deputy of inspections made in compliance with the Coal Mines Regulation Act, particularly periodic inspections made under general rule 4. In respect of the condition of ventilation for M-panel, shift 1.00 p.m. on 24th July, 1979, each inspection shows ventilation satisfactory. Now whilst I appreciate that the report was signed by Deputy O'Connell, he of course was not in possession of information known to Deputy Schuster, according to O'Connell, because according to Under Manager Walsh, that was supposed to have been communicated directly to him by Schuster. However, in these proceedings, O'Connell has given evidence which is corroborated by other witnesses that the ventilation was far from satisfactory. As the Deputy in Charge he has reported satisfactory, and that was despite clear evidence that he himself did not carry out a proper inspection in that regard. At the very least one would have expected that he also would have checked with Deputy Schuster before writing the report. Yet Deputy Schuster deposed in any case that O'Connell was near at hand when he supposedly told Deputy Rawcliffe, page 130, "I spoke to Bob Rawcliffe. I told him what we had been doing, what had to be done, and I specifically pointed out the disturbed brattice. Even though I didn't have sufficient time to fix that brattice, I had second thoughts and I felt that there would have been a build up of CH4 in B heading and for that reason I didn't really want to fix it. I told Bob Rawcliffe that it needed immediate attention. I told him that I have not touched the stop in between the overcast and along wall eight, and his last words to Rawcliffe, according to him, were 'if I were you I would stop the section and get things right' page 131. Strange all this came from Schuster, who denied any responsibility, and the person he said was in charge and responsible was near at hand. It also seems odd that Deputy O'Connell also deposed that he spoke to Deputy

GORDON M (CONT'D) Rawcliffe at about the same time, after 7.00 o.m. and in a general conversation he told Rawcliffe that the face was okay. There was trouble with a minor. He told him that he was unsure what stage Schuster was up to, but it seems under all the circumstances, incredible that O'Connell did not tell Deputy Rawcliffe the following, of which he, O'Connell, at the time had knowledge:

(a) The presence of gas in B-heading,
(b) trouble with the brattice,
(c) brattice not checked since 4.00 p.m.,
(d) gas readings not taken since that time,
(e) did not tell him of the presence of crossed sticks.

Yet he signed the report, Exhibit 56, now that report was also counter-signed by Under Manager Walsh as having been examined by him. He has adopted the report of satisfactory ventilation notwithstanding the fact he has given evidence that Deputy Schuster had rung him in Control and informed him of the ventilation problems,that he had told Alchan from which he is supposed to have given rise to a statement that he would be first priority job for Rawcliffe. Yet he, if he had received that telephone call, would he have adopted the statement that ventilation was satisfactory? If that was the end of it, maybe it could, he could be given the benefit of the doubt, but there is more. Two, Exhibit 49, the Under Manager's Report Book. The entry made for K-panel on 24th July, 1979 by Under Manager Walsh, describes ventilation as adequate, which on the evidence before the Court could not be correct, because at the time of writing that, after coming up to the pit top, he would have been in possession of the information he said Deputy Schuster telephoned to him. That is, information to the effect that there was a very serious ventilation problem in respect of B-heading studd. Three, if the communication had been made by Schuster to Walsh and passed on to Under Manager Alchan, certainly Mr. Alchan did not react as though it was a potentially dangerous condition, one would have expected him to be on notice if Schuster's report had been made and there was liekly to be no ventilation in B-heading studd. I am of the opinion that as Deputies, O'Connell and Schuster fell well short of the duty of care they owed to others in the mine. That they and Under Manager Walsh through their neglect and

[illegible] (CONT'D) omissions have not fully appraised both Rawcliffe and Alchan of the potential danger that existed in A-panel. The reasons given, I am of the opinion that Schuster was not fully aware of the position and so unlikely to have been able to communicate it. That Messrs. Walsh and Schuster have covered for each other in regard to their own incompetance, Deputy O'Connell has not, as the Deputy in Charge, fully apporaised himself of the correct position to enable him to properly and adequately communicate it to Mr. Rawcliffe, that having regard to the nature of the evidence relied upon, such neglect of duty on the part of each of these persons, does not on the totality of the evidence prima facie amount to criminal neglect attracting criminal sanctions in respect of failure to provide proper ventilation. The blame laid at their feet is clearly that there had been a lack of communication to them of the development programme and steps in its implementation, particularly ventilation changeover and moreover their omission to fully acquaint themselves with it, having regard to the duties of their respective officers. They have not acted responsibily having regard to their positions in coming to a full understanding of it, combined with the fact that having regard to the evidence it is apparent that the plan advanced further than they were able to cope with. Instead they have sought to cover their imcompetence in the Court's view and neglect, by deceipt. The totality of the evidence supports a view that the explosive accumulation of gas which developed in B-heading came from the stubb by way of omission from the ribs, roof and floor and that under all the circumstances, even if number three cut through brattice had been removed it could have become evident in a short period of time. It is from this point of time that a great deal of speculation in reconstruction arises. On the expert evidence available there would have been a considerable make of menthane in B-heading stubb and having regard for the time lapse, it would appear that in any event gas was detected and cleared at some time during the three and a half hours duration to the time of the explosion. That this is so is supported by the following, it has been submitted, fact that there is evidence that Mr. Rawcliffe checked the gas in A-heading in long wall eight main gate, and therefore presumeably in B-heading, (b) given

[illegible] (Cont'd) the known facts to the time of shift change, there had to be gas in B-heading in quantities detectable; (c) there were no apparent urgent messages or situations reported to Control; (d) Mr. Burn made a delivery to Mr. Rawcliffe at about 9.15 p.m. Mr. Rawcliffe was in a good mood and no apparent problems, page 1481; (e) Mr. Oldcorn was on routine rounds on schedule to the other panels, his attitude and conduct not that which one would be expected that there was notification of an urgent situation; (f) the brattice had been removed at B-heading intersection in what appeared to be a normal final act of changeover to fan ventilation and the men were Cribb and (g) Mr. Statts was carrying out his normal maintenance during Cribb break. I don't intend to indulge in speculation as to how the ultimate situation of explosive mixture of gas being present arose and the totality of evidence before the Court I am unable to make such a finding. It has been canvassed by all the experts, witnesses have been cross examined at length in regard to it. No answer has been forthcoming and in any event there are alternatives each of which is based on a given set of facts. There is no evidence of a definitive nature to establish the circumstances which prevailed to lead to the presence of the explosive mixture of methane gas. These facts are known:
(1) the panel was left in a potentially dangerous condition because of the fact that Brattice No. 3 cut through had not been removed with the result that there was no ventilation of B-heading stubb for a period of time.
(2) there was no testing for gas over a period of time. Deputy Schuster did not test for gas, page 131, his explanation is that he personally didn't think, he had any responsibility to do so in the section. However, he is the person who has given evidence of the disturbed brattice, has at least six men under his control. He is charged with duties in B-heading. He has given evidence that he considered there was a build-up of gas to the extent in his belief that all power should be closed off. Mr. Dyson spent best part of the shift in B-heading and he did not see anyone testing for gas, page 170. Mr. Horvath and Sshuster, whole of the shift A and B-heading, and saw no-one test the gas, page 189. Various witnesses have given evidence that there was no testing for gas on

JOHN L. (CONT'D) 24th July, 1979, see pages 194, 202, 205, 207 and 214.

(3) Under Manager Walsh expressed the following view at page 103 as to what the position would be if brattice stopping cut through number three was not taken down? Answer: I think it would have been a very dangerous situation. But I think that with no air flow going down B-heading at all for four to five hours, there could have been gas right down to the junction of Four Line, possibly even further, past the lowering stage. It could have been down to chest height and in quite a fair quantity too.

(4) There had to be a substantial build up of methane gas.

(5) There was a substantial leakage there that may have given a false impression that the ventilation changeover had been completed and that air flow may have deceived those present, that is if Deputy Rawcliffe had not already used number three cut through, brattice.

(6) There is evidence that Mr. Rawcliffe checked the gas and in two positions, therefore leading to a presumption that he also tested the gas in B-heading. Such a presumption is counter-balanced by a substantial evidence of complacency and breach of safety rules. No matter what else happened it is indisputable that Deputy Rawcliffe was in charge when the flameproofed enclosure was opened with power on and in a gassy place. The evidence reveals this to be a breach and of course, there is no reason why other breaches would not occur, such as failure to comply with general rules as for inspection of gas. The evidence before the Court is that, reveals that methane in an explosive quantity was present, that ignition did take place and that the initial explosion took place at the face of B-heading stubb. The post explosion reconstruction does give rise to two major possible causes of ignition. In my view they amount to two competing hypothesis, each supported by circumstantial evidence

3111/1/9 DLF
19th December, 1980.

CORONER (CONT'D): and relying upon expert evidence to explain it as a possible source of ignition. The known proven relevant facts are, in B heading, A. the power was onto 1. the fans, 2. the shuttle car, 3. the miner. B. That the starter switch box and the fan was in a non flame proof condition. These facts have been established by evidence of witnesses and particularly examination of in the reports of Mr. B. Caldon, electrical inspector of collieries, his reports being Exhibits '108' 7th September 1979, and Exhibit '109' of 20th September, 1979. B. That the condition as outlined in B above was a breach of the coal mines regulation Act because there is indisuptable evidence that the same occurred in a gassy place and that the power was on. B. the positions of the bodies and other items as found and depicted in the plan Exhibits "40" and "38" and photographs Exhibit "33". E. Deputy Mr. Rawcliffe had at the time and ~~else~~ oil safety lamp which was recovered in a damaged condition. Possible cause of ignition, fan switch box . The fan switch box to be the source of ignition, the evidence revealed that a number of conditions had to exist concurrently. There must be gas in explosive proportions inside and outside the box chamber. There had to be gas in the vent tube in explosive proportion the whole way along, For the gas to get into the box, A. the fan to be running with re-circulation, that is a condition dragging gas from B heading stub, with this gas then passing in-bye across the open switch chamber or B. stagnant air conditions with fan off, but because there is evidence that there was some air flow from leakages, this in itself was not likely to let the gas down as low as the switch chamber. That is to allow of an explosive mixture there. To do it would really have to show a condition of the fan having been started up ~~so~~ as to stir up layering, or ~~C~~, if there had been a collapse of the B heading brattice, bearing in mind of course the evidence that had been improperly affixed. It is to be noted that post-explosion evidence reveals that if the brattice number 3 cut through had been removed and B heading brattice was up, there would have been fairly

Finding

CORONER (CONT'D): equal balance between the two return sides and there would be far too much air to permit of a re-circulation condition near the fan switch box. The door of the switch box would have to be open, and at the same time the fan would have to be switched on or off. Therefore the following conditions or things would have to be concurrent. 1. Re-circulation condition. 2. Gas in switch chamber. 3. Gas outside switch chamber. 4. gas in explosive quantity in the whole of the tube. 5. Which means that the gas has to be low in explosive quantities to be at the same height as the switch box, otherwise it would be detected or persons in it would or may be overcome with dizziness. That is it has to be an (6 & 7?) explosive mixture around those working near the switch box. 8. Therefore there has to be a situation of no checking for gas, and ~~nine~~ 9. Non flame proof fan switch box in a gassy place with power on. 10. Starting and stopping of the fan with all those circumstances concurrent. Of the evidence before the Court in support of the fan starter switch box relies heavily on the experiments conducted at Londonderry Test Centre. Mr. Fisher and Mr. Lloyd have given detailed evidence of the tests conducted, and they have been well documented in the reports Exhibit "98". The facts which support the fan starter as a probable cause are first and foremost that the switch chamber was not in a flame proof condition at the time of the explosion, due to the fact that there was a gap because only one of the usual twenty four retaining studs was in position. This was only partly screwed in. Tests were carried out with the enclosure in that condition by igniting methane externally on operations of the contactor. That upon examination of the interior of the chamber, a dust pattern on the blanking ~~tape~~ plate was found which indicated that an internal explosion had taken place, and in the first test conducted at Londonderry, a similar test pattern on the blanking plate was reproduced with the door open against one of it's retaining studs. No similar pattern was thereafter reproduced. On examination there was charring of flammable material inside the chamber and from samples of dust within,

CORONER (CONT'D): it was concluded that an internal explosion had occurred. Examination of the fan cable disclosed arcing where it was damaged in the explosion providing, proving conclusively that the electricity supply was on. The technical evidence revealed that there were marked on the back of the impellor(?) and it was concluded that in all probability the fan had been run just prior to the explosion, but the totality of the evidence does not enable the Court to conclude this fact with certainty. There is evidence that the brattice had been taken down at number 4 intersection of B heading, which is some evidence that there was in all probability commencement of a changeover from brattice ventilation to fan ventilation. I've considered the documentary evidence tendered to the Court in respect of the examination and testing of the plant which is submitted for that purpose. I examined very carefully the Exhibits in relation to the fan and the evidence given by the witnesses in respect of their opinions as to why the non flame proof fan starter switch box was the cause of ignition in particular, Mr. Kevin Fisher, approval inspection engineer, and Mr. M. Lloyd, the director of the Londonderry Centre. Mr. K. Fisher at page 1089, in answer to Sergeant McGoldrick, gave the following conclusions as a result of his experiment testing and examinations. Question "Mr. Fisher, do you know of your own knowledge that when the fan in question was found, the flame proof starter box was found to be in a non flame proof condition?" Answer "yes it was". Question "you received information that vent ducting had been connected running out-bye from the face of the stub to the fan?" Answer "yes". "Did you form any conclusion as a result of your tests how the explosion occurred?" Answer "yes, on the basis of the testing which was done at Londonderry, it was concluded that the explosion had propogated up the ventilation ducting and ignited a general body of gas at the face area". Question "was it possible to determine how the ignition took place?" Answer "yes, by the dust pattern observed on the blanking plate in the fan starter and that was clear

CORONER (CONT'D): evidence that an explosion had occurred inside the fan starter". Question "having occurred inside the fan starter, was it possible to come to a conclusion as to how the flame had then progogated to the vent tube?" Answer "yes, there's a number of paths which the flame can take to get inside the vent tube, one being through the exhaust or the other way is through openings in the vent housing itself". Now that is the basis on which it was concluded by Mr. Fisher that, Mr. K. Fisher, that the fan starter switch was the cause of ignition. That is, 1. it was in a non flame proof condition, 2. there was a dust pattern on the blanking plate which was clear evidence an explosion had occurred inside the fan starter. Now Mr. K. Fisher was ~~fa~~ severely shaken under cross examination as to the validity of his experimentation, testing on the fan starter switch which enabled him to come to the conclusions he did. Some of the matters which lead me to that view are these; the conditions that prevailed could not be re-created, A. as to the dust, the plate was cleaned off and a new dust was applied. The dust in the box relied upon for the first test was different because it had already been subjected to an explosion conditions. The new dust, as far as Mr. Fisher knew, came from Appin, but he was not sure of the size and arrangement because of the gap in the flame proof cover it would have to be very fine dust. His past experience in obtaining explosion patterns was with routine flame proof testing of new equipment, not with the equipment where there was dust, pages 1097 and 8. And limited because of the facilities, pages 1128 and 9. B. On all tests, the plate each time was removed and cleaned with solvent, pages 1108 and 1129. C. A matter affecting the method of generating a dust pattern on the blanking tape is the fineness and the adhesive properties of coal dust, and it is very difficult to get coal dust to adhere to metallic surfaces under experimental conditions. Page 1108. D. He agreed with Mr. Mould that having regard to the gap ~~left~~ less than twenty thou in the switch chamber, there was virtually no dust in the switch chamber under normal mining conditions. In any case it would be very

CORONER (CONT'D): fine dust. 2. The fan had been hurled a considerable distance and subject to trauma, the switch chamber drawer was not completely closed, so the chamber would have been exposed to explosion conditions including dust. F. The pattern he agreed could have been on the blanking tape prior to the explosion. Page 1100. G. The conditions of the experiment were not a proper duplication or reconstruction of those prevailing at the time of the explosion. H. He did not consider the practical situation underground, and how an explosive mixture could be around the fan starter. I. Answer "the only evidence which I've seen to suggest an ignition source is that which relates to the fan starter". Question "so in fact there is no question in your mind that it could have been anything els?" Answer "no". Question "are you satisfied that the flame safety lamp as you saw it could not have ignited gas?" Answer "yes". That is page 1106. However, later, under further cross examination by Mr. Thelan, page 1116, Mr. Fisher agreed that he could not exclude the lamp as the possible source of the explosion because the glass was missing etcetera. Question "so I take it that you would join with Mr. McKenzie-Wood in responsibly not excluding it as a possible cause of the explosion"? Answer "no I haven't excluded it as a cause of the explosion". This was a complete contradiction with his previous statement at page 1106 and of course must detract from the force of his stated conclusion on the fan starter switch box. J. He agreed that a lot more testing could be carried out in respect of ignition in the vent tubes and the propogation of flames down vent tubes, and of course in brackets (of course I have previously drawn attention to this aspect that testing was directed to the external forces on the vent tubing. No tests were conducted as to the scorching inside the vent tubing, despite the fact that all persons who worked on the assumption the vent was the main part). K. He agreed that he was not a ventilation expert, and was not looking at the assessment on that basis. His conclusion was based purely on the factual assessment of the condition of the equipment at the time. Page 1114. L. He was shaken under cross examination badly

CORONER (CONT'D): as to how he arrived at his conclusion that the monitor sensor came to be out of calibration. Pages 1118-19.

Finding

CORONER (CONT'D): And he was shaken under cross-examination concerning how the insulation within the fan starter box came to be burnt, pages 1120-1122. Both these aspects of the cross examination, in my view, demonstrated an unscientific approach to the problems which could lead to a proper inference that in respect to the fan starter switch box Mr. K. Fisher found the dust pattern, decided it was there as a result of the explosion and worked that to make it fit the circumstances. However, it is evident that the other circumstances don't fit in with it particularly those matters previously listed by me that have to occur concurrently outside and inside the switchbox at the time of ignition. He is not concerned with the latter only his factual findings as to the equipment. And he agreed to Mr. King that a considerable number of conditions were different between those existing at the time of the explosion and his testing (or he didn't take them into account) when he produced the dust pattern number 1 upon which he relies in arriving at his conclusion. He fact it was clearly demonstrated during that cross examination that there were at least six variables not taken into account. Question: And don't you think that they might tend to rob the tests of some validity? Answer: No I do not. Question: Nothing robs of your test of validity is that right? Answer: Well I know we did the test and got the result and I don't think those factors would have been all that important in determining the outcome of the test. Question: Wouldn't you have thought it more scientific to try an attend to those matters and achieve as close a similarity as you could? Answer: That's what we attempted to do with the facilities which aexisted at the time. Page 1127. Question: Well if you attempted to, you failed in all those matters. Is that what you are saying? Answer. No I am not. What I am saying is that we did. The tests were carried out with the facilities we had at the time and the experience of the officers who carried out those tests. Now if those tests were done again then certainly they would be done differently. Question: And done for the better? Answer: May be so. Now Mr. Lloyd, the Director of Londonderry Testing Centre, in my view, was also shaken in cross examination as to the conclusion. Although he remained steadfast in regard to it. It was based on Mr. K. Fisher's work and his view was that the fan starter switch was the cause of admission. I refer to the following matters which arose during cross examination of Mr. Lloyd. 1) He conceded that the testing on the fan was

CORONER (CONT'D): not done exactly similarly as that existing at Appin Colliery. Pages 1194 and 1260. There were variable factors. Page 1199. 2) The dust pattern on the blinking plate could have occurred from a prior explosion. Page 1196. In answer later to Mr. Murray he indicated that there had not been any record of previous known explosions in that fan. However, one must comment that in this mine it is apparent that records not always kept correctly or in great detail. 3) Mr. Lloyd rejects the test carried out with models although he knew of them, page 1185. However, under further cross examination he conceded that to some extent the model test had some validity as implicating the lamp. Page 1196. 4) When he excluded the lamp he was unaware of the corrosion in the inner doors. Page 1202. 5) He is not a ventilation expert. Page 1195. He relied on Mr. Griffiths advisor to Judge Goran in regard to opinions in that regard. Page 1189. If there has to be a final word on Mr. K. Fisher's conclusions, having referred to those qualifications, there is one thing that he did say and Mr. Lloyd has also agreed. In respect to the dust pattern on the blinking plate, which he said was clear evidence of an explosion and occurred inside the fan starter and was the basis of his finding that it was the source of ignition and that it was this: the pattern on the blinking plate could have been there prior to explosion. Page 1100. And then constrained to make this observation that notwithstanding the obvious flaws now exposed in the arguments advanced by Mr. Fisher he steadfastly stands by ts conclusion and he finds continued support for it in his superior Mr. Lloyd. That is notwithstanding there are differences in the conditions prevailing at the time of the test conducted by him and those prevailing at the time the explosion at Appin. All those factors and the ones exposed in cross examination as far as he is concerned would not be important in determining the outcome of the tests. That in respect of certain tests carried out by personnel at the Southern Mines Rescue Station Unit, Mr Lloyd would not accept such tests as valid because models were used. I fail to see the difference between qualification on tests using models and those in which qualifications or doubts must arise where similar conditions are not recreated. Or was the opinion expressed out of a desire to protect the interests of the centre bearing in mind the videos of the

CORONER (CONT'D): model demonstration showed very clearly that when there was an addition(?) in the vent tube away from the fan it was then and only then that the fan was moved a considerable distance by the resulting explosion at the face. Now bearing in mind those factors that must be evident and concurrent. That the door to the switchbox would have to be open at the same time the fan would have to be switched on and off and that there would have to be a recirculation condition and gas in explosive quantities in the switch chamber and gas in explosive quantities outside the switch chamber .n)that means that the gas is an explosive mixture between 5% and 15% around the working area and as low, less than waist level which would mean that there has been no testing for gas or because the quantities it would seem that those very near to it would have been overcome with dizziness. See Under Manager Walsh, page 104. The extent that gas would be down to chest level bearing in mind the length of B heading would have to be such that anyone working there would have become dizzy and possibly collapse. Until such time as they drop down in wherever there was oxygen available because the C.H.$_4$ takes the place of the oxygen. And then next paragraph again Under Manager Walsh. If it reach this extent it must be discovered if testing took place. And further see witness Vassic at Page 1218 as to the affects of high concentration of gas in the body. Now of course, add to this the fact that those present, who have been described as competent men, would have to be in breach for not complying with the Act and Regulations in that there was the non flameproof fan switch box, power on in a gassy place. All those matters would have to be concurrent and then there has to be the means of the flame reaching a path to the face of the stub where the explosion occurred. Bearing those matters in mind I've examined Mr. K. Fisher's test subject to the qualifications of cross examination and the fact that Mr. Fisher doesn't rely on any criteria of ventilation factors for his conclusions. The matters have been raised and documented in the submissions of Mr. Phelan, Mr. Murray Q.C., Mr. King, Sergeant McGoldrick and Mr. Kininmonth which demonstrate clearly the problems for and against each of the alternative theories as to the source of ignition. Mr. Phelan's submission particularly highlights the weaknesses in the fan starter switch there. He exposed after cross examination of Mr. K. Fisher and Mr. M. Lloyd with which I concur. As I refer to later there are difficulties in respect of his of these theories and Mr. Murray Q.C. looking at these aspects

CORONER (CONT'D): in a different clearly demonstrates that in his submission. There is room on the evidence for a competing hypothesis as to the source of admission. However, I am of the view that the evidence reveals and inquiries appear to have taken the course based on the premise that the starter fan switch was the cause of the ignition. The great emphasis appears to have been placed in the acitivies of the Londonderry Centre and the views of others given less emphasis. I refer of course, the view of Mr. Strang and after all he is the Superintendent of the Southern Mines Rescue Station, a unit set up by the Government under Statute. And others who were involved with him in experimentation especially in respect to the oil safety lamp. Others from university who later assisted police were shown to be able to make worthwhile contributions. Whilst some were along the way very, somewhere along the way various inspectors were involved but their inquiries became disjointed between Londonderry Centre, Lidcombe Laboratories and the Southern Mines Rescue Station with independent advice from the university. In my view there was a complete lack of discipline and direction and inquiry with no proper liason on the whole. This was highlighted by the movements of the Exhibits, lack of knowledge on the part of key witnesses to how those Exhibits had been dealt with or what effect such dealings had to their examinations or testing. There are the tests carried out by the person the Southern Mines Rescue Station which were very informative. notwithstanding the fact that models not strictly to scale were used. But they clearly demonstrated that when gas ignited in the vent away from the fan, more in position that it was likely that a deputy would be standing to break into a vent-tube, only then would the effect to move the fan has occurred and the actual explosion. Weight has to be given to that evidence in weighing these competing hypothesis as to the cause of ignition. Possible cause of the ignition, safety flame/lamp. The theory advanced on the known facts in relation to the deputies safety flame/lamp is not without its difficulties. The, it appears to me on the known facts that a number of conditions would have to prevail. 1) It would have to be with the vent-tubes broken open 2) The fan would have to be off so as to let gas in the tubes escape 3) Mr. Rawcliffe would have to be standing up high on the miner to work on the vent-tubes 4) The gas would have to come out of the vent-tubes in a spilling or swelling effect

CORONER (CONT'D): 5) On the evidence the fan could have been running and found to be in reverse phase. There is evidence to support that. 6) The deputy might have realized that it was in reverse after he had taken the brattice down and completed the changeover by putting the fan into operation and allowing the men to go off to crib. 7) He might have reason to believe that other than the fan working in reverse, bearing in mind the body of evidence reveals it is easy to ascertain if the fan is running in reverse, everything else was satisfactory. 8) The electrician could have been there at the time and Mr. Rawcliffe directed him to stop the fan and change the phasing. And I note the evidence of Mr.Caldon and others that in about fifty per cent of the cases where new electrical equipment is brought from other parts of the mine, the phasing is in reverse. The electrician was there. But on the evidence it would take about ten to fifteen minutes. The electrician had also gone off to crib in the time lapse to the completion of the change phase if that was the problem, would be approximately some thirty five minutes. That makes a possible time lapse of ten to thirty five minutes in which there would be an accumulation of gas in an unventilated stub. Deputy Rawcliffe with lamp standing on miner commenced to brake, a vent with steel wedge in order to release gas from the vents and to let the air in is an area that has been placed before the Court. There is evidence before the Court as to the various ways in which vent-tubes are broken, where it would be usual for that to commence and that because it is a difficult on occasions wedges are used. Such a wedge was found in the body of Mr. Rawcliffe. There are injuries occasioned to Mr. Rawcliffe which could be consistent with the view expressed that whilst standing on the miner breaking tubes, gas spilled out over his lamp which was attached to his belt at the time. There is evidence as to defects in the lamp which the evidence reveals would, if on his belt, where it was usual for it to be, at a height where escaping gas from the vent-tubes could have enveloped the lamp. The defects found according to the examination experimentation of Mr. McKenzie-Wood, page 640. 1) The intergorous(?) was badly corroded, large holes in the gauze and they existed before the explosion. 2) Two priclor(?) bars of fleet(?) material were in the light and mechanism. The effect of which is to increase the tension of this material on the flint wheel and it grinds off wall particles which can fall into the base

CORONER (CONT'D): of the lamp, you can get intense spark on key withdrawal. It was a contravention of regulations. 3) The glass burning plate was worn down on one side which was consistent with vigorous brushing. 4) No relie(?) to key with it. 5) It has loose space screws. Mr. McKenzie-Wood at page 640 said "I don't think the safety lamp can be responsibly excluded as a possible source or ignition". His opinion was that the flame could pass through the holes in the inner gauze, page 631. The effect was that the lamp had only one gauze. Two gauzes was a safety feature. The earlier lamps had only one gauze and it was found to be unsafe and so the second gauze was added as a safety feature, page 642. It was, there was further evidence from Mr. McKenzie-Wood that in tests they are able to propogate frame using a lamp with a defective glass lense and of course the evidence that nineteen gauzes which were found to be defective at Appin Colliery were withdrawn from service, page 646. I have considered carefully the material set out in two volumes, Exhibit "62" and "63", of the tests, experimentation research and readings of Mr. McKenzie-Wood particularly noting the effects likely if a flame was outside the lamp near a gassy place and air velocities. I have noted his evidence at page 652 to the effect that if Deputy Rawcliffe's lamp was up in a gassy atmosphere and it was suddenly moved or withdrawn owing perhaps to him slipping or overbalancing that was a situation in which ignition may have taken place. Experienced persons would not normally plunge their lamps or place it in the vent-tubing or gassy places but given circumstances it is possible for gas to overflow from the vent-tubing and there is a degree of difficulty in breaking the tubes. If a person standing on A miner he could slip or overbalance in the process. Mr. McKenzie-Wood agreed that it was dangerous to have a defective lamp near the end of a vent-tube under conditions where gas was present, page 655. Professor Keys has given evidence of the condition of the lamp was such that it was a one gauze lamp, page 1327. I have also considered the evidence of Mr. Strang in regards to the safety lamp and read his report Exhibit "72". Whilst I initially ordered that no publicity to be given to the material contained therein concerning the Protector Lighting Company at Manchester, England. I have changed that view.

Finding

CORONER (CONT'D): In view of my examination of all of the evidence before this inquest I revoke my prior order. It is in the public interest that the material be published. It is contained in the document that it has been compiled by a very experienced official and having regard to the evidence before this Court it is very fair comment. I have considered that document carefully in my deliberations. Again in regard to quality control of lamps, notwithstanding the issue of directions after the Court of Coalmines Regulation it is interesting to note that Exhibit "120" in these proceedings concerning defects found in lamps supplied to the Appin Colliery during 1980. These matters are of considerable weight when determining this question of reliability or dangerous defective lamps used in conditions as they existed at Appin on 24th July, 1979. I have examined and considered the document Exhibit "70" concerning experimental gas explosions and the conclusions that be drawn therefrom,

Finding

CORONER (CONT'D): particularly as to the principles of gas explosions, as was demonstrated in the video tapes and subject to the report, Exhibit "7". Further, in regard to the matters raised concerning safety flame lamp in the vent tubing, I have given consideration to Exhibit "64 and "69" in my deliberations, together with the oral evidence of the various Witnesses concerning same. Now the safety flame lamp was extensively damaged, and therefore could not be re-assembled fully, so therefore can't be excluded as a source of ignition. In respect to the theory of advance (?) it is interesting to note the evidence concerning the extent of damage to the continuous miner in B heading, the one which is contended, Deputy Rawcliffe may have been standing on it to break open the vent tubing. Especially the areas opposite the driver's seat. Also see the evidence of Mr. Gray-Spence at page 537. I do not discount the evidence contained in volume 1 of the report of Mr. McKenzie-Wood, where it is indicated that there have been fifteen reports overseas on ignitions from safety lamps. I studied those reports in respect of instances where explosions have been reported to have occurred in those circumstances. I have referred also to the instances of the Courts in New South Wales where flame has propogated outside the gauze safety lamps. It has been submitted that the breaking of the vent tubes whilst standing on the miner with the lamp at his side is fanciful. However, the evidence in support of it, in my view, is as cojent and as forceful as the evidence that is available in support of the fan as the probable source of ignition. The evidence reveals that it would be a natural and usual event for a person to stand on a miner to break vent tubes. The evidence reveals that the breaking of vent tubes is a usual practice, and whilst there are no exact directions issued by Mr. Fisher, Manager at Appin Colliery, he did give evidence of the usual practices existing at Appin. The evidence reveals that the position where the continuous miner was in B heading, was a natural and obvious position for a Deputy to commence the breaking operation. A steel wedge found in the Deputy's body is one of the type that a bye practice has been used to break vent tubing. That such an operation is very physical. The lamp is usually carried on the belt. Varies from right to left in the belt. These are matters of record and they have been recounted in evidence by experienced miners. In the Court's view they are not fanciful.

3111/1/11 BW
19th December, 1980.

CORONER (CONT'D): There is precise evidence given by Detective Sergeant Wakefield as to reconstruction based on factual scientific medical evidence, which in the Court's view lead to a conclusion that Deputy Rawcliffe was standing on the miner directly below the vent tubing at the time when the explosion occurred. Pages 1445 to 1449. It is very persuasive when taken in conjunction with the evidence concerning the Defective's statement here (?). The main argument against the lamp is that lamps at Appin were well maintained. That Mr. Barnes, the lamp attendant, has been described as the best lamp attendant in the State. Despite that claim, nineteen defective lamps were found in service in Appin Colliery, and withdrawn from service. Prior to the explosion, all maintenance and inspections were done by a naked eye. However, since there has been new instructions and a magnifying glass is used, and according to Mr. Barnes, there has been a vast improvement. His evidence is that deterioration is now immediately picked up and parts withdrawn earlier than before. Be The four holes to the gauzes caused by corrosion could not be seen by the naked eye. No record of daily maintenance was kept, no quality control was practiced at the time, and I was not satisfied that there was proper testing as to the side of the glasses used or as to whether the glass in the lamps were tested properly to see if they were out of parralell. Pieces of bristle could get caught in the gauze and be missed by the naked eye. Mr. Rawcliffe's lamp had double flint which was a contravention of the type approved, and Mr. Barnes had knowledge of that fact. Indeed he talked of double and triple flints. I bear in mind his is a statutory appointment which imposes upon him duties in that regard. The Manager, Mr. A. Fisher, only thought records were kept, but he hadn't really examined them, despite his duty to see that competent persons are carrying out their duties in the provisions of the Act and Regulations. (See the Sixth Schedule). I have spent considerable time on my deliberations concerning the question of source of ignition, and referred to many aspects both in support and against each of the alternatives advanced. Other alternatives were excluded, on consideration of the evidence, and another raised by Mr. Lloyd, as to a spark caused by friction on the use of steel wedge, has been left up in the air. However, I have determined, that such a proposition is less likely as a probability in the fan starter switch in B heading,

CORONER (CONT'D): or the oil flame safety lamp in the possession of Mr. Mawcliffe. Of it, if it was the former, then it is probable that some person now deceased was at fault. If it was the latter, such act or omission, not being deliberate or without exercise of reasonable care, in the cause of the ignition, could have been without fault or accidental. On examination of the evidence in respect of those two alternatives disclosed, in one the fan starter switch chamber, there was a higher probability of ignition source and less probability of gas being present in explosive proportions, with a readily ascertainable flame path to the face of the heading, and in the other, the Deputies defective oil flame safety lamp, there is a higher probability of gas in explosive proportion being present, with a readily exposed flame path, that is the vent tube or layering, with a less probable source of ignition than that available in the case of a live electrical source. In my view neither can be responsibly excluded on the evidence before this Court. The evidence educed does not enable me to say what was the source of ignition which caused the explosion of methane gas at the face of B heading. Therefore, I am not able to determine what was the approximate or direct cause of the explosion, but I have concluded that there was a condition existing, for a period of time whereby the B heading stub was not properly ventilated. The precise reason for that has not been disclosed on the evidence, but on the balance of probability there is evidence that the accident admission of persons on the previous shift, contributed to the inadequate ventilation. On the totality of the evidence, I am satisfied that the owners of the mine, Australian Iron and Steel Proprietary Limited, supplied equipment. Criticism raised in the Courts concerning the Company being in breach or contravention concerning equipment, Exhibit "103", relates in the main to not stamping equipment, and modifications to equipment which on the evidence has been shown not to render such equipment unsafe. Mr. Morling, Q.C. referred to these breaches as "nit picking" and gave the explanation or excuse that it would be impossible for the Company to check gazettes or notices for such numbers. Having regard to circumstances, I am of the view that it is a poor excuse when viewed in the light of the requirements of legislation to protect people in dangerous places. There is evidence from management that the Company at all times provided equipment and ample staff when

CORONER (CONT'D): requested to do so by the Management. Whilst the fan was in a position contrary to written development approval, and it was authorised to be put in that position by the Manager, Mr. A. Fisher, without first obtaining written approval for variation. The evidence reveals that the fan had been inspected beforehand, by a qualified Mine's Electrician. I have also weighed carefully the evidence given by both Mr. A. Fisher and Mr. Murrell, as to the conversations that took place prior to Mr. Fisher acting, to place the fan in the position mentioned without written approval. The weight of the evidence is in favour of Mr. Fisher acting on a verbal approval, pending the written application being submitted. Just as the Management of the mines has acted on other verbal approvals given by the members of the Mines, Inspectorate, concerning other matters. The criticism concerning loose wiring found in the fan starter switch has to be viewed in the light of the effect of the explosion hurling the fan the distance and through the environments of the mine with great force. Such criticism in my view was unjustified. The Company had a safety policy of tagging the cable end plugs at the gate box end, when same were removed, and there is evidence that this safety policy has been departed from and personnell had varying interpretations of it. Certainly there was variation from that policy, in that the power was on to the fan whilst it was being worked in a gassy place. However, it cannot, on the evidence, be said that the fan was a direct or approximate cause of ignition. The evidence of Mr. Galton, Electrical Inspector, reveals that all other electrical equipment, which was inspected in the mine, was found to be free from fault. The company had issued a manual instructions for its electrical staff, Exhibit "105" which was referred to in evidence, as adequate for the purpose. There is evidence of planning conferences being called regularly and plans of development being kept at the office of the mine. Mr. A. Fisher and Mr. Metcalf each gave evidence that in their view adequate instructions were given concerning the changeover. There is evidence that Mr. Metcalf gave verbal and written instructions on that same day. There is evidence that some of those instructions had been received and acted on. Mr. Metcalf expressed surprise that Mr. Oldcorn was not at the panel earlier, and he had expected

3111/1/11 BW
19th December, 1980.

CORONER (CONT'D): him, Mr. Oldcorn, to have been there for the changeover. There is clear evidence of a weakness in the chain of communication from management to the deputies and the workers. There is evidence that enables me to find each of the deceased persons as being positively identified and the evidence is that each died on 24th July, 1979 at Appin Colliery, Appin. There is clear evidence from the postmortem reports, supported by the oral evidence of Doctor LeBroy, that each of the deceased persons, James Arthur Oldcorn, Robert Edward Rawcliff, and Alwyn Paul Brewin, had received injuries consistent with the violence of the explosion. They had each been found in B heading. Mr. Carl Statts was in A heading, and he died from the affects of poisoning by carbonmonoxide. Mr. Alwyn Brewin, according to the medical evidence, survived the initial blast, and his injuries resulting therefrom, for a period of time, and he died from the effects of poisoning, by carbonmonoxide. Francis James Garritty, Ian Victor Gifford,

CORONER (CONT'D) Geoffrey Ernest Johnson, Jurgen Lauterbach, Alexander Hardy Lawson, Peter Andrew Peck, Roy Rawlings, John Lesley Stonham, Roy Williams and Gary John Woods who were in the crib-room at the time, all died from poisoning from carbon monoxide. I intend to sign certificates of my findings in accordance with that finding and each will individually be signed in that way. Mr. Morling, Q.C., made two final submissions in regard to the Mines Inspectorate and their relation to the management at Appin Colliery. First that is, and I quote, "It is not fair to deduce from any of the evidence that the Inspectorate were acting otherwise than completely responsibly and in accordance with the wishes of their superiors insofaras, I am now talking about up to the Chief Inspector, and I am not suggesting there is any criticism of him either, there isn't". And second "There is certainly no basis for suggesting that the Inspectorate were so to speak having some cozy arrangement with the management at Appin for the disadvantage of anybody." I have quoted Mr. Morling as to the phraseology used. Now in regard to those submissions I am of the view that what I have said here today fairly states the position as I have determined it in the light of the evidence before this inquest. Indeed fair minded people can now look at that evidence and judge themselves. It has been made public and it is part of my function as a Coroner. I have expressed my concern during the course of this finding and I have weighed those matters in the exercise of my function as a Coroner. I refer to my opening remarks concerning the grave conflict between the provisions of the Coroners Act and the Coal Mines Regulation Act 1912, that is not something which has just come into existence, problems have existed for many years in that regard and if the position appears to favour persons employed in and attached to mines, then that is a matter for public comment. It has been highlighted here because the enquiry was held beforethe inquest. Since I have been invited by Mr. Morling, Q.C., not to be critical I feel it important to make the following comments to assist members of the public to judge for themselves whether any criticism is justified.

(1) There were tolerances allowed by the Mines Inspectorate in a number of areas concerning mining activities at Appin Mine. The evidence reveals then as it also reveals that the

CORONER (CONT'D) Management of the Colliery took advantage of such tolerances. In particular there is evidence of disclosure of excessive gas omissions, defective instruments for measuring gas readings, high readings on units, use of continuous mining machines with the automatic censor devices in defeat to mention some. There is evidence of oral discussions about detecting breaches between inspectorate and management, these not always being subject to written reports. These discussions and oral approvals otherwise in strict accordance with the act for approvals have been shown to have taken place as high up as the Chief Inspector of Mines. And if I might say in that regard, I haven't referred particularly to the evidence of each of those inspectors as saying that is what they have done, I have referred to Mr. Fisher and he is the manager of the mine, he acted on it, see page 3188 for instance and the file Exhibit 121 and my previous comments in this finding. Notes of them were in some instances some tendered in evidence made by the inspector but not in all instances, were they subject to reports. There were discussions between management and inspectors about continuing contravention. These on the evidence of Mr. Fisher were tolerated and he implicates the inspectors up to the chief inspector of mines.

(2) The people who work in this mine are in a hazardous occupation and therefore rely upon the upholding of the legislation for their protection and safety. One can't lose sight of the fact that they earn a living from the mines and they have a reluctance to open to be open in forthright concerning the state of affairs in the mine particularly if it may effect their employment. Further one can't lose sight of the fact that the company is in the business of winning coal and that if the letter of the law is applied strictly then that would mean that in the case of Appin in all likelihood there would be continued disruption of proper production. But that does not mean that the workers should forego their rights and protections under the law, where the legislation is out of date, proposed to be amended or just stretched by purported use of discretion does not matter. In all

3111/1/12 DGP
19th December, 1980.

CORONER (CONT'D): similar situations of dangerous or hazardous occupations or involvement of persons whether it be in employment or social intercourse, the law must be complied with and enforced.

(3) The persons in the inspectorate, who have been shown to have tolerated variance from the strict letter of the law or directions or approvals that pursuant to the law are the same persons who by virtue of that law exercise fairly exclusive powers in duties thereunder. They have the responsibility to answer to the Minster as to their activities, just as the Minister is responsible for their actions. Inspectors Kininmonth and Mould have been open and frank about their actions and have indicated the reasons why they so acted. The chief inspector of mines was openly implicated in evidence, but no explanation or answer has been given by him, although the Minister and his servants were represented by Counsel.

(4) These are the same officials who have the powers under the Act and in particular I refer to those who are empowered to investigate and report of matters such as arose in this instant, quite obviously on the evidence before this Inquest, some of them in my opinion, had a self interest.

(5) The Coal Mines Regulation Act, 1912 in this case through its provisions gave the inspectors of the Mines Department exclusive powers of investigation, to keep material evidence confidential as against those, who under the Coroner's Act 1980 had been directed to carry out an investigation. In respect of deaths in mines, as far as my research can reveal, this is a first time that an enquiry under the Coal Mines Regulation Act 1912 was conducted before the Inquest. In my opinion there are inescapable inferences disclosed on the evidence that those states of affairs as raised by Mr. Morning Q.C. did exist and because the manner in which the legislation has been framed further protection is afforded to them. These are in my opinion matters of social and public importance. It is my intention to make a recommendation for amendment of the Coroners Act 1980 and the Coal Mines Regulation Act 1912 in respect of the matter of one proceeding where an inquiry is to be held besides the Inquest. It is my understanding that the Government has moved a legislate in that regard. However I would recommend to the Government, that they examine these

Findings

3111/1/12 DGP
19th December, 1980.

[redacted] (DPP'D): problems particularly in respect of the aspect of investigation. It seems to me that if amendments are to be made the provision ought to be made for skilled Police investigators to be given access to the mines at the same time as rescue workers. I feel that consideration ought to also be given to allowing medical practitioners, government medical officers and scientific officers into the mine at the earliest possible occasion as part of those rescue teams so the important forensic evidence can be accurately obtained. It seems to me that if special training programmes are to be available at Londonderry Centre or elsewhere that the time might now be opportune to train these categories of persons. Such recommendations in my opinion could well be applicable to the appointment of specialist coroners to deal with such inquests or of whom the mining warden who has expertise in this area and also holds the commission as a Coroner. As I have indicated - have signed the formal document of finding in regard to each person as I have found it.

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Findings

# CERTIFICATION OF TRANSCRIPT

I/We the undersigned being (a) Transcription Typist(s) authorized to prepare transcripts of hearings ~~wholly recorded at the Coroner's Court at Petty Sessions~~ Coroner's CAMPBELLTOWN do hereby certify that the within written transcript is a correct transcript of the depositions so recorded in the matter of

INQUEST TOUCHING THE DEATHS OF THOSE IN APPIN MINE DISASTER.

Dated at LIVERPOOL
this FIFTEENTH day of JANUARY, 1981.

| NAME | PAGES | SIGNATURE |
|---|---|---|
| M. V. BARRY. | 1-10;48-54; | M V Barry |
| D. PIEFKE. | 11-15;62-63; | D Piefke |
| B. WORBOYS. | 16-20;32-36;55-59. | B Worboys |
| J. RYAN. | 21-25;37-41;60-61. | J Ryan |
| D. FRANKLIN. | 42-47;26-31. | D. Franklin. |