Findings, Comment and Recommendation of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of

Nathaniel Owen Beesley

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Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Nathaniel Owen Beesley with an inquest held at Hobart in Tasmania, make the following findings.

Hearing Dates

25-29 October 2021, with final written submissions received 4 February 2022.

Representation

L Taylor – Counsel Assisting the Coroner

R Phillips – Mrs Katie Beesley, Senior Next of Kin

M Fordham SC – SRG Global Mining (Australia) Pty Ltd, Messrs Grant Tullipan, Damien Aspros, Timothy Herbert, Barry Morssinkhof and Kieran Toon

K Read SC, J Mullavey – Grange Resources Limited

S Nicholson – WorkSafe Tasmania

C Hoile – Mrs Maxine Beesley and family

Introduction

1. On 17 March 2017, Mr Nathaniel Owen Beesley died at the Savage River Mine site on Tasmania's West Coast. The mine was, and is operated by Grange Resources Tasmania (Grange). Mr Beesley was employed by SRG Global Mining (Australia) Pty Ltd (SRG), who had been engaged by Grange to carry out a scaling operation on the East Wall of the mine's North Pit.
2. The *Coroners Act* 1995 provides that where a person dies as a "result of an accident or injury that occurred at his or her place of work, and the coroner is not satisfied that the death was due to natural causes", an inquest is mandatory.[1] Mr Beesley's death occurred at his place of work, was the result of an accident and not the result of natural causes. The requirement to hold an inquest in workplace death cases is subject to a statutory exception.[2] The exception is that if the Senior Next of Kin of a deceased person who died as a result of injuries suffered at work asks a coroner not to have an inquest then,

[1] See section 24 (1) (ea) of the *Coroners Act* 1995.
[2] See section 26A of the *Coroners Act* 1995.

provided the coroner is satisfied that it would "not be contrary to the public interest or the interest of justice", an inquest can be dispensed with. No such request was made in this case. In fact, Mr Beesley's Senior Next of Kin under the *Coroners Act* 1995, his widow, Mrs Katie Beesley requested an inquest be held. Accordingly an inquest was held into Mr Beesley's death. I note that an inquest is a public hearing.[3]

Mr Beesley's background

3. Mr Beesley was born in Reading, England, United Kingdom on 28 November 1984. After completing his schooling, he enlisted in the Royal Marine Commandos on 24 March 2003. He saw active service twice in Afghanistan, before being discharged in the rank of Sergeant on 28 September 2016. He was discharged from the Royal Marines to enable him to enlist in the Australian Defence Force (ADF). On any view of it, Mr Beesley would have been an asset to the ADF.
4. During his service he married Katie and together the couple had two children together, Freddie (in 2013) and Rex (in 2015).
5. The family arrived in Australia in late June 2016, entering the country on a so-called 489 temporary visa. Various delays attended Mr Beesley's enlistment in the ADF, and so while waiting to enlist, he took a job with SRG as an interim measure to provide for his family.
6. It is evident that Mr Beesley was fit and healthy at the time of his death. He had no injuries – either physical or mental – from his British military service.
7. Mr Beesley obtained his International Rope Access Trade Authority (IRATA) accreditation on 14 January 2017, a matter of about 8 weeks prior to his death. The evidence was that IRATA was as at March 2017 (and presumably still is) the international working at heights trade organisation which issues qualifications and accreditations. SRG was described in evidence as an '*IRATA company*'.[4] I took this to mean that it was accredited by IRATA or at the very least complied with standards or protocols created by that organisation. I will return to IRATA qualifications later in this finding.

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[3] See section 3 of the *Coroners Act* 1995.
[4] Evidence of Grant Tullipan, Transcript page 250, line 35.

The functions of a coroner

8. Before considering in any detail the circumstances of Mr Beesley's death, something should be said about the manner in which the coronial jurisdiction is engaged and operates. As I noted above, a coroner in Tasmania has jurisdiction to investigate any death that 'occurs at, or as a result of an accident or injury that occurs at, the deceased person's place of work, and does not appear to be due to natural causes'.[5] Self-evidently, Mr Beesley's death meets this definition. When conducting an inquest, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. An inquest might be described as a quest for the truth, rather than a contest between parties to either prove or disprove a case.

9. When conducting an inquest a coroner is required to thoroughly investigate the death and answer the questions (if possible) that Section 28(1) of the *Coroners Act* 1995 asks. These questions include who the deceased was, how they died, the cause of the person's death and where and when the person died. This process requires the making of various findings, but without apportioning legal or moral blame for the death.[6] The task of the coroner is to make findings of fact about the death from which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.[7] The role of the coroner in making recommendations has frequently been acknowledged as especially important in the context of workplace deaths.[8]

10. The authorities make it very evident that there should be a clear connection between any recommendations or comments that a coroner makes and the circumstances surrounding the death into which the coroner is conducting an enquiry. Nathan J observed in the oft cited case of *Harmsworth v State Coroner* [1989] VR 989 at 996,[9] that the of power of a coroner to comment is "incidental and subordinate to the mandatory power to make findings related

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[5] *Supra.*
[6] *R v Tennent; Ex Parte Jager* [2000] TASSC 64.
[7] This function is important in Australia and overseas. As to the latter see 'Coroners' Courts- A Guide To Law And Practice', Third Edition, Dorries, at paragraph 10.13.
[8] See for example 'Death Investigation and the Coroner's Inquest', Freckleton and Ransom page 675.
[9] [1989] VR 989 at 996.

to how the death occurred, their causes and the identity of any contributory persons".[10] *Harmsworth*[11] has been applied in many cases and I should follow it.[12]

11. It is important to recognise that a coroner does not punish or award compensation to anyone. Punishment and compensation are for other proceedings in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation.

12. As was noted above, one matter that the *Coroners Act* 1995 requires, is a finding (if possible) as to how the death occurred.[13] 'How' has been determined to mean 'by what means and in what circumstances',[14] a phrase which involves the application of the ordinary concepts of legal causation.[15] Any coronial inquest necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by Section 28(1)(b) upon the coroner.

13. The standard of proof at an inquest is the civil standard. This means that where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.[16]

14. The final point that should be made is that a coroner is required to afford what is known as procedural fairness (or natural justice).[17] In simple terms this means that persons or entities who may be at risk of an adverse findings have a right to be heard, or to present their case, and bring matters to the coroner's attention which are considered important. The *Coroners Act* 1995 underlines the existence of this right[18] by giving people or entities the coroner consider

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[10] I note that the requirement for a coroner to identify any person who contributed to death in this State was repealed some years ago.
[11] *Op cit.*
[12] See for example *R v Coroner Doogan; ex-parte Lucas-Smith* [2005] ACTSC 74 amongst many others.
[13] Section 28(1)(b).
[14] See *Atkinson v Morrow* [2005] QCA 353.
[15] See *March v E. & M.H. Stramare Pty. Limited and Another* [1990 – 1991] 171 CLR 506.
[16] (1938) 60 CLR 336 (see in particular Dixon J at page 362).
[17] See *Annetts v McCann* (1990) 170 CLR 596.
[18] See section 52 of the *Coroners Act* 1995.

have a 'sufficient interest'[19] the right to be represented, receive copies of statements and affidavits and to question and call witnesses.

Issues at the Inquest

15. In advance of the inquest a number of issues, in addition to those mandated by Section 28 of the *Coroners Act* 1995, were identified as being matters to be particularly considered at the hearing. Those matters included:

    a) the manner and method adopted for "scaling" at the mine as at 17 March 2017 including:

        i. the method of work adopted to carry out the task;

        ii. any risk assessment or risk analysis carried out before 17 March 2017 in respect of scaling;

        iii. any training provided in relation to the method adopted to carry out scaling on or before 17 March 2017;

        iv. any alternatives available on, before or after 17 March 2017 to the method adopted to carry out scaling;

        v. what, if any, approvals were required and/or in place for carrying out the scaling, such approvals issued by WorkSafe Tasmania or any other relevant regulator; and

        vi. the regulatory regime in Tasmania for carrying out the scaling, as administered by WorkSafe Tasmania or any other relevant regulator.

16. The list of issues, or 'scope', was distributed to all interested parties before the inquest. The evidence at the inquest was directed towards these issues, as well as answering the questions in Section 28(1) of the *Coroners Act* 1995.

Evidence at the Inquest

17. At the inquest evidence was heard from:

    a) Mr Craig Sault – WorkSafe Tasmania Inspector;

    b) Mr Andrew Tunstall – Chief Inspector of Mines and Major Hazards, WorkSafe Tasmania;

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[19] I observe that the right conferred by the Act is considerably wider than that identified in *Annetts v McCann*.

c) Mrs Katie Beesley– Mr Beesley's widow and Senior Next of Kin under the *Coroners Act* 1995;

d) Mr Christopher Johnson – General Manager Jayben Group;

e) Mr Gilbert Charles – Grange;

f) Mr Damian Aspros – SRG;

g) Mr Kieran Toon – SRG;

h) Mr Grant Tullipan – SRG;

i) Mr Timothy Herbert – Team Leader, SRG;

j) Mr Jahra Hose – SRG;

k) Mr Gregory Hutton – Grange; and

l) Mr John Crocket – Grange.

18. Some witnesses gave evidence in person; others, because of the ongoing situation with Covid – 19, by Zoom. In other cases, affidavits of witnesses were tendered without the makers being called to give evidence. In addition, a significant amount of documentary evidence was tendered, including the complete WorkSafe Tasmania investigation file.[20]

19. Notably, no expert evidence from a witness independent of the parties involved inquest was available to assist me. This was despite the fact that Counsel assisting and investigators made numerous attempts to endeavour to identify a suitable subject matter expert.

20. I observe, and this is in no way a criticism, that none of the interested parties involved in inquest called a witness who might be described as 'purely' expert in nature. Any person identified as having sufficient interest in the subject matter of the inquest and who is therefore granted leave to appear may call and examine a witness.[21]

21. Nonetheless, a number of the witnesses, although not independent, were clearly subject matter experts in their own right. The evidence several gave was helpful in casting light on the circumstances associated with Mr Beesley's death.

22. In addition to the evidence from those witnesses who gave evidence at the inquest, evidence in the form of affidavits from witnesses who were not called

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[20] Exhibit C30.

[21] See section 52 (4) of the *Coroners Act* 1995. And 'person' of course means 'legal persons' and thus extends to corporate or statutory entities such as Grange Resources, SRG or WorkSafe Tasmania.

to answer questions and other documentary evidence was tendered. The complete list of evidence received at the inquest appears at Annexure A of this finding.

The history of the mine

23. It is perhaps best to next say something of the history of mining at Savage River. Magnetite mineralisation was discovered at Savage River in 1887. Exploratory activity was carried out over a number of years and, finally, in the mid - 1960s, a joint venture of Australian, Japanese and American companies was formed to develop a mine at the site. After passing through a number of different corporate hands in 2009, Grange acquired a 90% interest in the operation. It has been operated by Grange since then.

24. As at March 2017, Grange employed approximately 576 people across 3 sites – the mine itself, Port Latta and the head office in Burnie.

25. The mine is one of two open cut mines in Tasmania, and by far the largest in scale. Iron ore is extracted from a massive ore body, via two pits. Once removed from the ground, the ore is crushed and then converted to slurry, essentially by adding water to the crushed ore. The slurry is then pumped through a pipeline to Port Latta on the state's North West Coast. At Port Latta, the slurry is made into pellets preparatory to export. Both the pipeline and pelletising plant date from the mid - 1960s.[22] None of this is of any particular relevance in respect of Mr Beesley's death, other than to provide a context.

26. At the time of his death, Mr Beesley was working as a member of a four man roping team, carrying out scaling operations on the East Wall of the mine's North Pit. Scaling, simply described, is the process of removing loose and therefore potentially dangerous rocks from the face of a wall. It is a proactive safety or control measure, in the sense that it is designed to render safe the wall of a pit, by addressing the risk of uncontrolled rock fall, so as to make safe the area at the base of that wall. Although a common activity at the mine (and indeed mines generally, if not universally), manual scaling was rarely carried out on the walls of the Savage River mine's pits. It is obviously an activity which has inherent risks.

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[22] Exhibit C30, Tab 41.

The risk of rock fall

27. The extent of the risk of rock fall and Grange's awareness of the risk were central issues at the inquest. It was common ground at the inquest that there was a lengthy history of rock fall in the North Pit of the mine. In this regard the mine would appear to be no different to any other mine. A most useful overview of the history of rock fall in the decade or so leading up to Mr Beesley's death was given by the mine's manager, Mr Matthew Anderson.

28. In his affidavit, Mr Anderson described a number of significant rock falls during that decade. First was a fall in 2009 of approximately 20,000 tonnes of rock.[23] The fall resulted in minor injury to the operator of a drill rig who was drilling horizontal depressurisation holes. In response to the fall, Grange introduced a remote production drill rig. It also implemented a radar-based slope stability monitoring system.

29. Next was a failure in the order of 500,000 tonnes of rock on the East Wall in June 2010. Of that fall Mr Anderson said "*we saw something with the radar prior to the failure at that time which predicted the failure and we had increased the exclusion zone at the bottom of the wall from 10 [metres] to 50 [metres] while we worked out what was happening. No one was allowed to go closer than 50 [metres] to the wall and while some equipment was damaged in the rock fall no one was hurt*".[24] In response to this fall, Grange introduced an ATS prism monitoring system used in conjunction with radar (which was already in use). The evidence from Mr Anderson was that using both systems together provided different spatial and temporal baselines were provided, which enabled a level of crosschecking of the data and accuracy of both systems and, it is to be inferred an enhanced level of safety.

30. In addition, Mr Anderson said that following the June 2010 rock fall, WorkSafe Tasmania (WST) "*required Grange to propose a mine plan that guaranteed no further rock failures would occur*". Mr Anderson said that he explained "*to the then Chief Inspector of Mines that there was no way to guarantee no rocks would fall and that control measures to ensure no rocks fell were not reasonably practicable*".[25] It is difficult to disagree with Mr Anderson's assessment of the situation. Assuming the requirement was made, and I have no reason to doubt Mr

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[23] Exhibit C39, affidavit of Matthew Anderson, sworn 22 October 2021.
[24] *Supra*, paragraph 4.2 (c).
[25] *Supra*, paragraph 4.2 (f).

Anderson's evidence on point (which was not challenged), then I have to say that the requirement by WST is rather difficult. However, nothing much turns on this in the context of Mr Beesley's death.

31. The next fall of significance was approximately 1.75 million tonnes in 2012. Mr Anderson said in his affidavit the "*failure was identified on the radar about 3 months beforehand. We were very careful with stable regions. We put backup systems in place with Prisms, so that we could verify that what we said was stable was actually stable, and that time it was. We continued to operate up until a couple of days before the failure. The actual cause of that failure was that we fired an ore shot right at the toe under the Section that was moving*".[26]

32. Mr Anderson said that following that rock fall a "*detailed geotechnical program to identify the potential for further larger wall failures and provide stable East Wall design parameters was approved in August 2012*".[27]

33. Finally, Mr Anderson said that in July 2014, a large rock fall of around 1 million tonnes occurred in the pit. Once again radar was apparently able to accurately predict the failure to "*within minutes of the actual time*".[28]

34. Of course, each of these falls were of a magnitude considerably larger than the fall of rock which killed Mr Beesley, which was less than 50 tonnes.

35. In 2015 work commenced 'pre-stripping' the East Wall of the North Pit from top down. Mr Anderson said that as part of that process there was progressive mechanical scaling which was, apparently, standard practice. At the time Grange had two 1200 S excavators that could do the work remotely.

36. On 8, 10 and 22 December 2016, there were rock falls on the East Wall of the North Pit. Mr Anderson described them (at least the first two) as "*small in a relative sense*".[29] Radar does not appear to have given any warning of any of the rock falls in December 2016, although Mr Anderson said the "*geotechnical department had been aware of some ongoing movement in advance of these falls, and had closed off the pit edge above... in advance*".[30]

37. More relatively, small rock falls occurred in the general area where Mr Beesley died on 20 January, 23 January and 30 January 2017. Radar did not give any

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[26] *Supra*, paragraphs 4.2 (h) – (i).
[27] *Supra*, paragraph 4.2 (k).
[28] *Supra*, paragraph 4.2 (l).
[29] *Supra*, paragraph 4.3 (c).
[30] *Supra*, paragraph 4.3 (f).

warning of any of the falls in January 2017. All of these falls were reported to WST. Even before the last fall, on 30 January 2017, Grange commenced the process of attempting to address the issue of those falls. Before I consider that aspect of the evidence at inquest, it is appropriate to look at the manner in which the risk of rock fall generally was managed by Grange.

38. Before I do, I should note that in so far as the actual rock fall which killed Mr Beesley is concerned, and to place it in a proper context in respect of the risk of rock fall generally, I found the evidence of Mr Gilbert Charles particularly impressive. He said that in his 41 years working at the site, the rock fall which killed Mr Beesley was the first time he had seen "*a failure like [that] in the middle of the day with no rain inducement, no blast inducement and no protrusion on the wall where the rock has just let go*".[31]

Management of the risk of rock fall

39. The evidence was that a number of what were described as 'controls' were used to attempt to manage the ever present risk of rock fall at the mine. Those controls, in addition to scaling, included:

    a) 20 metre exclusion zones;

    b) Restricted areas – a work area at the toe of a high wall that has been subject to what has the high potential for rock falls or instability;

    c) Engineered cabin protection – heavy equipment used on site fitted with rollover protective structures and falling object protective structures;

    d) Geotechnical hazard maps and hazard alert register;

    e) The use of remote equipment, especially within the 20 m exclusion zone, at least as often as practicable;

    f) Radar;

    g) Automated tracking systems (ATS) and prisms. The former is a robotic survey instrument used, or at least designed, to detect larger scale long-term wall movement. Prisms are placed on the berms approximately hundred metres apart. The evidence was, and I accept, that used together ATS and radar provide a very good analysis of the wall and the risk of failure, at least in relation to large scale rock falls. It is apparent

[31] Transcript, page 275, lines 39 – 43.

from the circumstances of Mr Beesley's death that ATS and radar are less effective in giving warning of smaller scale rock falls;

h) Windrows – long piles of earth or rock that are used, amongst other things, to stop rolling rocks from travelling across a flat area such as a road or a working area;

i) Physical berm inspections, carried out by Geotech engineers on foot. The physical inspections were supplemented by using photographs. Since Mr Beesley's death, drones have also been utilised;

j) Rock catch fences – engineered to a low rating equivalent of a 25 tonne rock travelling at 100 km/h;

k) Drape mesh;

l) Slope depressurisation – designed to alleviate pressure by water from the high rainfall experienced in the area;

m) Cable bolting – used to secure individual blocks and oblique or wedges (no cable bolts were instilled in the area where Mr Beesley died);

n) Shear pinning – similar to cable bolting (no shear pins were in use in the area where Mr Beesley died);

o) Personnel performing the role of visual spotters;

p) Seismic ground monitoring;

q) Shotcreting – which was not used widely by Grange at Savage River for pit wall stabilisation due to its limited utility; and

r) Pre-split blasting techniques – such techniques had been used below, but not above, the area Mr Beesley was working on 17 March 2017.[32]

40. Some of the controls listed above were in use in the general vicinity of the area of the accident which claimed Mr Beesley's life on 17 March 2017. In particular, the evidence was that ATMs and Prisms, radar and spotters were all in use. The geotechnical hazard maps and hazard alert register were also relevant in that both had informed the decision to commence and continue manual scaling of the East Wall of the North Pit.

41. However it is to my mind clear enough, and I did not understand any Counsel to submit differently, that, leaving aside the use of remote equipment, Mr

[32] *Supra*, paragraph 3.4 (a) to (r).

Beesley's death was not the result of either a failure to use an available control or the use of an ineffective one.

The role of WorkSafe Tasmania

42. The evidence was that there was no requirement in any applicable occupational health and safety legislation in this State for the rock scaling activity to be approved by WST (or any other entity).33 It is at least worth observing that the absence of any regulatory standards at all in relation to scaling contrasts starkly with the roping component of the activity which is heavily regulated, albeit voluntarily by companies engaged in the industry by adherence to IRATA standards.

43. Nonetheless the evidence was that WST had numerous contacts with Grange in relation to the rock scaling activity and a period of time leading up to Mr Beesley's death on 17 March 2017. The first relevant visit was what was described as a 'proactive site visit' occurred on 6 December 2016.[34] The next relevant visit was on 6 January 2017 and was a follow-up to some reported incidents which it had included rock falls in the North Pit.[35]

44. Mr Andrew Tunstall, the Chief Inspector of Mines and Major Hazards at WST and Mr Willard Zirima, a Senior Inspector of Mines, visited Savage River next on 23 January 2017. Again this followed a report by Grange of a rock fall. Again, the rock fall had occurred on the East Wall of the North Pit. Rock had fallen onto the haul road 3 days before. Because of the fall, Grange closed the Haul Road as a precaution. A second rock fall, onto the same area on Haul Road, occurred the morning of Mr Tunstall's visit.

45. Discussions took place between Grange and WST as to a potential solution to the rock fall problem. Those discussions led to the engagement of SRG.

The decision to engage SRG

46. By the end of January 2017, it is evident that Grange reached the view that the only way to efficiently respond to the risk of rock fall on the East Wall of the North Pit was to have that wall manually scaled. The evidence was from Mr Anderson, the mine manager, that the decision to proceed to manual scaling

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[33] See affidavit of Andrew Tunstall, Chief Inspector of mines, Exhibit C32, page 10.
[34] *Supra*, page 9.
[35] *Supra*.

came about following discussions with Mr Tunstall and Mr Zirima, both of whom Mr Anderson described as being recognised "*throughout the mining industry for their mining industry experience and expertise*".[36]

47. It is apparent that by then other scaling methods were considered to be impracticable and inefficient. As I have already noted, prior to 2017, scaling of the East Wall of the North Pit had been undertaken mechanically. However the evidence was, and I accept, that it was not possible to scale mechanically because there simply was not enough room for the type of machinery previously used.[37] Mr Anderson said in his evidence on the subject (which was not challenged):

> *"it was not possible to re-scale mechanically because there is physically no access to the area for mechanical equipment. There had been rock falls and crest loss on many of the berms and they could no longer be used to access the area. We had used a long boom excavator previously on the southern part of the wall to attempt to scaling, but it could not access the northern part with a 17 March rock fall occurred.*
>
> *Even having access to the 200 and 230 RL would not have resulted in getting a machine up there to clean off because of the width of the berms. They are 12 [metres] wide and our EX1200s are nearly 6 [metres] wide and 15 [metres] long. They need to face the wall when scaling which means they do not physically fit on a berm safely to scale*".[38]

48. The evidence was that, historically, manual scaling (at least as it was carried out by the SRG team of which Mr Beesley was part) was rare at the mine. Mr Gilbert Charles, the Site Senior Officer at the mine, who I have already mentioned, gave evidence that he had worked at the mine for in excess of 40 years. I consider he was well placed to give evidence in relation to the history of operations at the mine. He said in his evidence that to the best of his recollection there had been only one other occasion in all that time when manual scaling of a wall, as carried out by the SRG team, had been carried out. He said it was rare and something only done when there were no other alternatives. I accept that this was so.

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[36] *Supra*, paragraph 5.
[37] Supra,
[38] *Supra*, paragraph 5 (j) and (k).

49. Not unreasonably reaching the view that it lacked the expertise to conduct the work itself, Grange contracted SRG to carry out the scaling of the East Wall of the North Pit. It did that only after it had received advice from consultants – Mining One – in the aftermath of three (3) rock falls from the East Wall of the North Pit in January 2017. Those rock falls made it very clear (if it was not already) that the East Wall of the North Pit had to have loose rock removed, to ensure that the area beneath in the pit could continue to be mined.

50. The advice from Mining One, in the form of the ubiquitous power point presentation, recommended manual scaling.[39] It recommended that manual scaling be considered only a short term solution and that once scaled, the East Wall of the North Pit should be secured by mesh. I did not understand anyone to suggest that the decision to engage Mining One and then accept and act upon its advice was inappropriate in some way. I do not consider that the approach adopted by Grange to endeavour to solve the problem was anything other than entirely appropriate.

51. After receiving the Mining One report, Grange consulted with officials of WST about the recommendation. The evidence is that Grange received WST approval to proceed with manual scaling. I will return to this issue of 'approval' shortly, but observe that in fact no such approval was necessary.

52. The decision to manually scale the East Wall of the North Pit was, in my view, a reasonable decision on the part of Grange. Indeed, as things stood in the first part of 2017, having regard to the recent history of rock falls, the inability to scale mechanically and in light of the advice from both consultants and the regulator, it was probably the only decision open to Grange, apart from ceasing all work in the North Pit.

SRG Global Mining (Australia) Pty Ltd

53. In any event, having determined that specialist expertise was required, Grange contacted SRG. According to its website, "*SRG provides specialist contracting services and products for mining and civil projects throughout Australia and overseas including... Specialist applications including high region on slope situations. SRG [has] a huge range of reliable and innovative products equipment for ground support, ground monitoring, slope stabilisation and erosion control*".[40]

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[39] Exhibit C30, Tab 78.

[40] See Exhibit C30, Tab 1, investigation report, page 13 of 18 for an extract from SRG website.

54. In response to Grange's contact, SRG representative Mr Damian Aspros, the company's then project manager, visited the mine on 25 January 2017. Two days later on 27 January 2017, Mr Aspros provided a proposal to carry out the work by email to Mr Mathew Zanin, Grange's 'Senior Geotechnical Engineer'.[41]

55. The proposal dealt with a number of issues. Relevantly, it explained the suitability of Rope Access techniques for open pit stabilisation and identified that the benefits "of using SRG for Rope Access [included that it was] extremely safe, when combined with modern, industry standard techniques".[42]

56. Especially relevantly in the context of this inquest, the proposal dealt directly with scaling. It described manual scaling as requiring 'the use of the scaling bar and manual handling to remove loose material. Mechanical methods involve the use of rated lifting bags to jack the rock off the face. The bag is placed within a crack of loose rock and then inflated from a safe position until the rock is dislodged'.[43] The proposal included as Figure 1 below, scaling works being undertaken at a dam in Western Australia. It is useful I think to include that photograph as it illustrates very well the manner in which SRG's scaling teams, including those Mr Beesley was a member of at SRG, carried out their work.

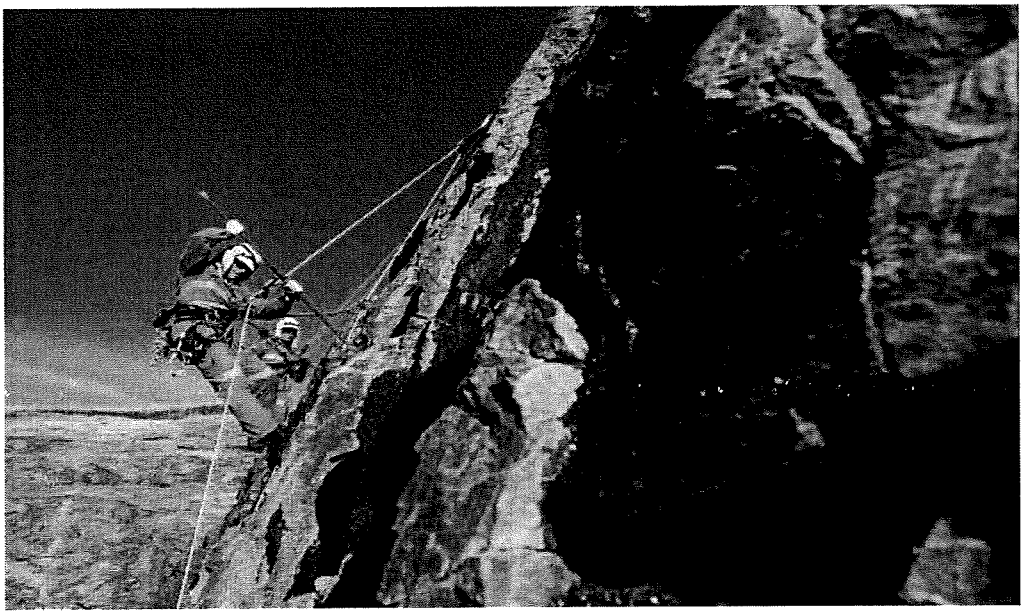

Figure 1, scaling works illustration

57. The proposal also dealt with Rope Access issues. It explained that SRG was a member company of the IRATA (which I have already mentioned) which

[41] See Exhibit C30, Tab 21.
[42] *Supra*, page 7 of 14.
[43] *Supra*, page 9 of 14.

provides training and certification to Rope Access technicians around the world and is considered 'best practice'.[44]

58. The proposal dealt with safety, systems, inspection equipment, rope rescue plans and the like. Those issues were dealt with in a Rope Access Management Plan which was also provided with the proposal.[45] The Rope Access Management Plan dealt with the nature and level of qualifications required of its Rope Access technicians. The plan required that all Rope Access technicians should be a trained and certified either Levels I, II or III,[46] and a Level III technician was required to be present and part of any Rope Access work team.[47] To achieve a Level III qualification, a Level II technician is required to have logged 1000 Rope Access hours over a period of no less than 12 months, before attending a Level III training course on passing the associated assessment.

59. SRG was duly engaged by Grange to scale the East Wall of the North Pit.

60. The method by which the team scaled the East Wall of the North Pit was to abseil from anchor points at the top of the wall and, using scaling bars and pneumatic air bags, clear loose rock from the face. Scaling bars are essentially crows bars, albeit a little larger.

The first SRG scaling team

61. On 12 February 2017, the first SRG scaling team arrived at Savage River. That team which consisted of team leader and supervisor Tim Herbert (a Level 3 IRATA qualified rope technician), Adam Gerrard (Level 1), Cameron Phillip, Stephen Henderson and Mr Beesley. The team received their site induction and were issued with access cards. The following day, 13 February 2017, the SRG team carried out a risk assessment process. That risk assessment process was carried out in consultation with Grange personnel. The evidence in relation to what occurred came principally from Mr Anderson. In fact, the risk assessment carried out on 13 February 2017 was effectively the end stage of an ongoing process that commenced on 2 February 2017. To understand what occurred it is useful, I think, to set out what Mr Anderson said about it:

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[44] *Supra.*
[45] Exhibit C30, Tab 31.
[46] *Supra*, page 15.
[47] *Supra*, page 16.

"On 2 February 2017 Mr Charles set up the scope for the work for the scaling risk assessment and I reviewed the scope.

The scope for the risk assessment was about:

I. *assess the wall condition above the 260 RL and applying any controls required.*
II. *installing anchors for rock scaling at 260 RL.*
III. *ensuring scaling worker qualifications are current.*
IV. *assessing "target areas" for wall scaling.*
V. *assessing means of safely removing larger rocks from berms to the 170 RL.*
VI. *determining safe work hours for scalers and spotters.*
VII. *determining safe communication strategies for all work crews[.]*
VIII. *determining any radar and camera monitoring requirements.*
IX. *assessing any evacuations if required during scaling work.*
X. *determining any FAR sheets for this operation.*[48]
XI. *maintaining access to the work area.*
XII. *working above and below the 260 RL and the 170 [RL.]*

(c) Hazard types identified in the risk assessment scoping document included nine energy sources and associated hazards. One of these was Gravity – falling or things falling.

(d) We sent out the materials via email on 8 February 2017 to Greg Hutton one of our more experienced supervisors, Stuart Birt our Mine Planning Coordinator, Harry Kumar our Assistant Mine Superintendent, John Stevenson from an operations perspective, Ivan Markota our ERT coordinator for his experience working at heights and mine rescue, Matt Wildelski[49] *and Kevin Dugan from Mining One and the SRG team (Jenny Macris, Kevin Toon and Chris Cairns).*

(e) We then conducted a group risk assessment on 13 February 2017 with myself, Mr Charles, Mr Barnes, Mr Ashley, Mr Birt, Mr Hutton, Mr Kumar, Mr Stevenson (all from Grange), Mr Widleski (Mining One) and Mr

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[48] First Action Response.

[49] This man's surname was spelt differently in Mr Anderson's affidavit but it is evident that it is the same person.

Henderson, Mr Beesley, Mr Cameron, Mr Gerrard and Mr Herbert (SRG)."[50]

62. Following the risk assessment on 13 February 2017, a Job Hazard Assessment (JHA) was created. The risk level assessed was that of 'medium'. Mr Anderson gave evidence that the issue of SRG personnel being potentially hit by a rock falling from above was specifically discussed. He said he asked Mr Herbert and Mr Henderson about the risk assessment and "*how are we going to ensure the rock doesn't fall on the rope technician's heads?*". Mr Anderson said that Mr Herbert and Mr Henderson indicated words to the effect of "they were not going to go past anything that looks dodgy". They told [him] that they were not going to leave anything on the wall that looked like it could fall on their heads. It was agreed I accept following this that all parties accepted this to be an appropriate control. As a consequence it was included in the JHA.[51]
63. The following day, 14 February 2017, work commenced. It was the first time Mr Beesley had worked in scaling. That same day, he received an email from an officer within the Army Director of Career Management Integration Unit, advising Mr Beesley that his army interview and medical were being arranged. Accordingly, after completing that day's work, Mr Beesley left the mine site and returned home in anticipation of attending the ADF interview and medical. In fact, neither interview nor medical took place before his death. I am satisfied viewing the evidence as a whole that the reason Mr Beesley left the site was a general concern to avoid injury in advance of attending the ADF medical.
64. The remainder of the SRG team remained at the mine site. The job proceeded seemingly without incident until 2 March 2017 when Mr Gerrard's main rope failed, causing him to slide approximately 20 metres before his safety rope arrested his fall. In the course of the incident, Mr Gerrard suffered a rope burn to his hand. Grange immediately suspended scaling activity and commenced an investigation into what had occurred. Contemporaneously, WST were advised. In practical terms, Mr Gerrard's fall marked the end of the first period of scaling by SRG at Savage River.
65. On 4 March 2017, WST investigators Mr Andrew Tunstall and Ms Yvonne Veenendaal travelled to the mine site to investigate the incident. Mr Tunstall

[50] Exhibit C39, *op cit*, paragraph 7.1 (a) - (e).
[51] Exhibit C39, *op cit*, paragraph 7.1 (q)

said they "*discussed the incident and possible corrective actions with Grange and SRG staff, including Mr Tim Herbert, who was the SRG Rope Access supervisor and Mr Adam Gerrard, the injured worker. Mr Anderson [the mine manager] was at the meeting along with Ms Jenny Macris, SRG's health and safety manager and Mr Craig Cairns, SRG general manager – services, who had flown to Tasmania following an incident*".[52]

66. The conclusion that I think follows from that investigation is that the most likely explanation for Mr Gerrard's fall was that a rock had fallen and hit his rope. Another explanation considered was that the rope was already damaged. I do not consider this to be a likely explanation; a falling rock seems much more likely given the procedures in place for gear checking at the beginning and end of every shift.

67. Grange continued with its investigation. So did WST. On 7 March 2017, WST Inspectors returned to Savage River mine is to monitor the progress of that investigation and look at any mitigation controls.

68. On 14 March 2017, Grange sent a copy of its completed investigation to WST and SRG. In its covering email, Grange asked WST whether there were any additional controls required before work to complete the scaling operation on the East Wall on the North Pit recommenced. It indicated that it intended to have the scaling works start Friday after "*re-inductions and reviewing the risk assessment on Thursday*".[53]

69. The report (which appears to have actually been completed by SRG) concluded, as I have above, the most likely explanation for Mr Gerrard's fall was that his rope had been damaged by a rock fall. Included in the report is an assertion (which I have no reason to doubt) that the rope had been inspected the day before the incident by Level III supervisor (presumably Mr Herbert) before it was repacked. As I have already signalled, this to me lends support to the proposition that the cause of Mr Gerrard's incident was a falling rock rather than any defect in equipment, especially ropes.

70. An issue explored at the inquest was whether any concerns had been raised by any member of the SRG Roping Team (including Mr Beesley) about the safety

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[52] Exhibit C32, affidavit Andrew Tunstall, sworn 8 September 2021, paragraphs 68 and 69.
[53] Exhibit C32, Annexure N, email – Matthew Anderson to Tunstall and others, dated 14 March 2017 5.23pm.

of the scaling operation during the first period SRG was present at the mine. Several witnesses gave evidence in relation about the issue.

71. Mrs Katie Beesley said in her affidavit that she believed her husband had told Mr Kieren Toon, that he "*was concerned about the likelihood of obtaining [sic] an injury*".[54] That comment however needs to be seen in the light of the fact that Mr Beesley was undoubtedly focusing on, indeed concerned about, his forthcoming ADF interview and medical, as Mr Kieren Toon, who assumed the role of SRG Project Manager from Mr Damian Aspros, said in his evidence at the inquest. Mr Toon said, and I accept, that he did not recall Mr Beesley raising any specific safety issue. It was the evidence that Mr Beesley left the site early he did so in order to undertake an ADF medical and, I am satisfied, not because of any safety concerns, *per se*.

72. That having been said, there is ample evidence that Mr Beesley had some concerns about the safety of the job in a general sense. Copies of various text messages to friends and family sent by Mr Beesley during his first trip to Savage River were included in Mrs Katie Beesley's affidavit. In those texts Mr Beesley expressed some concerns about safety. Typical is one sent to a friend Steve Fraser (on or about 15 February 2017) which reads:

> *"I'm not particularly impressed by the safety but the lads on working with have been doing it for a fair time and seem happy enough*".

73. In a similar vein is a text message sent on Saturday, 18 February 2017 to another friend Samuel Trembath:

> *"took myself off the Tasmania job as it wasn't being run in a safe manner and the army want to interview me in the next month so don't want to get hurt before that".*[55]

74. I am satisfied that some concerns were expressed to Mr Toon by Mr Cameron Phillip (a member of the team on the first trip), but those concerns related mainly to clothing and equipment (issues with respect to pay were also raised, but are obviously not relevant in the context of this inquest). The issues were raised by Mr Phillips by email. The relevant email chain itself was in evidence.[56] I do note that Mr Phillips raised issue with respect to rock falls and geotechnical radar scans, but being as fair as I can, it is difficult to actually work out whether

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[54] Exhibit C18, affidavit of Katie Rose Beesley sworn 14 August 2017, page 6 of 15.
[55] *Supra*, pages 9 and 14.
[56] Exhibit C37, affidavit of Kieran Toon, Annexure A.

he was expressing concern about those issues or not. The thrust of the complaint seems to be directed to gear, PPE and payment arrangements.

75. Even with the benefit of hindsight, I do not think that anything Mr Phillips raised with Mr Toon was capable of being construed as drawing to his attention something that subsequently became relevant in relation to Mr Beesley's death.

The second SRG Scaling Team

76. The second roping team, consisting of Mr Tim Herbert (once again the team leader), Mr Jahra Hose (Level I IRATA qualified), Mr Grant Tullipan (Level 3 IRATA qualified) and Mr Beesley, arrived at Savage River during the evening of Wednesday 15 March 2017. The men had a meal and a general discussion about the job. Mr Herbert and Mr Beesley had of course previously been to, and worked at, the mine. The other 2 members of the team, Mr Hose and Mr Tullipan had not. The evidence was that most of the job had been completed during the deployment of the first SRG team and that perhaps only 2 days of work remained to be completed.

77. The following morning, the team arrived on site at about 6.15 am. Mr Hose and Mr Tullipan received an induction to the mine from Mr Ivan Markota. There was nothing out of the ordinary about the induction. Following that, all equipment, ropes, lanyards, sender harnesses and other PPE were audited and checked and preparations made generally to commence work the following day.[57]

78. During the day of Thursday, 16 March 2017, there was approximately 10 mm of rainfall recorded on site. Those preparations included, in addition to equipment audits, a review of relevant JHAs and various discussions with relevant Grange personnel including Mr Anderson and Mr Markota. Mr Hose said in his affidavit, and I think he is correct, that he felt the full day before "*of not being on the ropes*" allowed the SRG team time to properly attend to all of the necessary safety checks and procedures prior to commencing on the wall.[58]

79. The following morning, Friday, 17 March 2017, after breakfast at about 5.30 am, the SRG team made their way to the mine site arriving there at about 6.30 am. A Grange employee, Mr Graham Higgins, was designated as a spotter for

[57] Exhibit C25, affidavit Timothy Herbert, sworn 21 April 2017, paragraphs 32 – 35.
[58] Exhibit C26, affidavit of Jahra Hose, sworn 19 April 2017, paragraph 116.

the SRG team. The team met with Mr Higgins at about 7.00 am. At that stage, it was 'dark and foggy' and so work was initially put on hold.[59]

80. Pre-start work checks were undertaken. Radios were tested and channels allocated. A discussion occurred between the members of the team as to the various hazards and risks.

81. At approximately 8.30 am, Mr Herbert confirmed with Grange geotechnical engineers that work could commence as no movement had been detected by radar in the wall over the previous 12 hours.[60] The weather was fine with no rain. Accordingly, the team commenced work. Using 4 wheel drive vehicles parked at the top of the wall as anchor points, the men abseiled down the East Wall of the North Pit from level 260 towards level 170.

82. Whilst on the wall the four men were approximately 10 to 12 metres apart, with four men anchored to one 4 wheel drive and two to the other. Mr Tullipan (Level 3) and Mr Hose (Level 1) were anchored to the first vehicle whilst Mr Beesley and Mr Herbert were anchored to the other. Looking at the wall from the other side of the pit (where the spotter Mr Higgins was stationed), the positions on the wall were Mr Hose, Mr Tullipan, Mr Beesley, and Mr Herbert. Thus Mr Beesley was working between two Level 3 qualified rope technicians.

83. Initially the team scaled between the 260 RL and the 230 RL. The scaling proceeded without incident.

84. The team then commenced scaling between 230 RL and 200 RL. While scaling in that area on the wall, Mr Herbert noticed a large crack. He said it went further than he could see.[61] He described it as being about an inch wide and being so long that he could not see where it ended. Mr Herbert said he checked the crack by inserting a scaling bar but there was no movement. He was satisfied that the crack presented no danger. Mr Herbert and Mr Tullipan both gave evidence at the inquest that they had discussed the crack and both concluded it was no risk. The evidence of Mr Tullipan about this issue was particularly persuasive to my mind. He said in effect that if the crack had caused him any concern at all he would not have gone past it.

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[59] Exhibit C8, affidavit Graham Paul Higgins, sworn 19 January 2018, page 1 of 2
[60] Exhibit C29, WST Investigation Report, page 4 of 18.
[61] Exhibit C25, *op cit*, paragraph 90.

85. There is no evidence that would support a conclusion that the crack identified by Mr Herbert and Mr Tullipan caused or contributed to Mr Beesley's death. It is possible that it did, but also equally possible that it did not.

86. The team took a break at about 11.00 am and shortly after a rock fell from the batter above the four workers and fatally crushed Mr Beesley. Mr Hose described what happened:

> *"We had been on the ledge for between approximately 5 and 15 minutes when rock started falling from above. It's really hard to estimate times as you are not looking at a watch. I couldn't see where exactly the rocks were coming from. Quite a few small loose rocks were coming down over us. Initially I thought that maybe Tim's rope was flicking rocks as he was doing a fair bit of movement.*
>
> *Grant was on the ledge to my right and slightly behind me. More rocks started coming down quicker, Grant yelled: "fucking run".*
>
> *I looked up and it sounded like a whip crack. I heard a whole piece of rock crack. A big piece fractured along with a lot of small pieces.*
>
> *I think this rock that I heard crack and saw move was in the 30 meters above being between the second ledge that we were standing on the first ledge above but I cannot be sure how far up it went.*
>
> *This piece that I saw was fracture [sic] was a huge chunk of the size of the house. It then started to crumble as it fell. There were big rocks and also little rocks all falling down all around us.*
>
> ...
>
> *I started moving to my left. Your rope only let you go so far but I was running and slipping over as I ran. When I looked back and saw Nathan hit by a big rock which took him over the edge. The biggest rock that hit Nathan was possibly the size of the [sic] car but it also had other rocks around it.*
>
> ...
>
> *The rocks that hit Nathan on the ledge with the sizes of fridges and small cars. The one that I saw hit him was the size of a small car and I think that he would have died with the impact of being hit with such force by rocks that large".*[62]

[62] Exhibit C26, *op. cit.*, paragraphs 74 – 81.

87. Subsequent evidence suggested that the rock which struck and crushed Mr Beesley weighed in the order of approximately 44 tonnes. I am quite satisfied, as Mr Hose described in his evidence, that he died instantly.

Body recovery and forensic pathology evidence

88. Police, emergency services and WST were notified virtually immediately of the fact of the accident. The Coroner's Office was notified and the Duty Coroner, Magistrate Fairley, travelled to the site with a Coroner's Associate for a briefing and inspection. Efforts were immediately commenced and continued to recover Mr Beesley's body. At the same time investigations were commenced by both Tasmania Police and WST into the circumstances associated with and surrounding Mr Beesley's death. Part of the police investigation involved securing biological samples for DNA comparison.

89. Efforts to recover Mr Beesley's body took several days. First, it was necessary to make safe the area where the rock fall occurred. It was then necessary to determine where Mr Beesley's body was located. It was not until about 3.00pm on 21 March 2017 that Mr Beesley's remains were finally recovered.

90. His body was removed from the mine and then taken by mortuary ambulance to the Royal Hobart Hospital. At the hospital mortuary, highly experienced Forensic Pathologist Dr Donald Ritchey performed an autopsy. Following the autopsy, Dr Ritchey provided a report which was tendered at the inquest.[63] He expressed the opinion that the cause of Mr Beesley's death was multiple traumatic crash injuries sustained in a rock fall. I accept Dr Ritchey's opinion.

91. Toxicological analysis of samples taken at autopsy showed the presence of a low level of alcohol. I am affirmatively satisfied that the presence of alcohol in the samples is attributable to post-mortem decomposition. I am satisfied neither drugs nor alcohol played any role in Mr Beesley's death.

92. Formal evidence in relation to identity took several forms including most persuasively a report from Forensic Science Service Tasmania which established identity by reference to DNA.[64] I am quite satisfied that the remains recovered on 21 March 2017 from the mine site were those of Mr Beesley.

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[63] Exhibit C6, affidavit of Dr Donald MacGillivray Ritchey, sworn 2 June 2017.
[64] Exhibit C3, report – Forensic Science Service Tasmania 30 March 2017.

93. It is to my mind beyond argument that Mr Beesley died virtually instantly. The injuries he sustained were so extensive that no other conclusion is rationally open. It is possible that his fall from height killed him before he was crushed but the distinction appears to me at least to be one without any meaning, as his fall from height was caused by the rock fall which also crushed him.

Was there any warning of the rock fall which killed Mr Beesley?

94. The evidence does not support a conclusion that there was any warning prior to the rock fall.

95. Nor was there any evidence that there were any particular signs or warnings of the likelihood of the particular rock fall that were ignored, overlooked or missed by the SRG roping team or any of the Grange personnel involved in monitoring the rock faces.

Did any member of the SRG scaling team dislodge the rock which killed Mr Beesley?

96. This is no evidence that this was the case.

97. I do not accept the suggestion that Mr Herbert in some way was responsible for dislodging the rock which fell and killed Mr Beesley. Specifically, there is an absence of evidence that would support a conclusion that the crack Mr Herbert identified in his affidavit was in some way causally related to the rock fall.[65]

98. In reaching this conclusion I do not overlook the Monthly Geotechnical Report March 2017 prepared by Mr Nathan Ward, Mr Stephen Lamprey, Mr Matt Zanin and Mr Daniel Silalahi, all of Grange.[66] That report expresses a conclusion that "*a roughly triangular block of material (approximately 43 tonnes) and some partial in situ material (9 tonnes) was dislodged (or disturbed) by SRG rope scaling activity.*" However, the conclusion is just that – a conclusion. There is no material in the report that I can see which supports the conclusion. It is not apparent to me, at all, how the authors of the report reached the conclusion. It is not evidence that would enable me to be satisfied to the requisite legal standard that this was in fact the cause of the rock fall which killed Mr Beesley.

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[65] *Op. cit.*, paragraph 90.
[66] Exhibit C 30, Tab 2.

Did any member of the SRG scaling team express any concern directly relevant to the risk of the rock fall which killed Mr Beesley?

99. There is no evidence, at all, which would support a finding that any member of the SRG team, or anyone for that matter, had any specific concerns that were directly relevant to the risk of the rock fall that occurred at approximately 11.00am on 17 March 2017. In fact, the opposite is the case. Mr Hose, Mr Tullipan and Mr Herbert all gave evidence that they considered all appropriate safety protocols and requirements had been addressed and that there was nothing that gave any cause for particular concern in the immediate lead up to Mr Beesley's death.

100. Probably the best evidence in relation to whether or not there were any safety concerns articulated by any member of the SRG scaling team prior to the rock being dislodged came, I thought, from Mr Graham Higgins. Mr Higgins was an employee of Grange who on 17 March 2017 was acting in the role of 'spotter' for the SRG scaling crew. He was in constant two-way radio contact with them. He was specifically asked to be heard any member of the team voice any concern over any safety issues as they went about their work on that morning. His evidence on the point was unequivocal (and unchallenged). He said that it was "*all work was normal until the actual emergency call*" was made and that he heard nothing from any member about any safety issue.[67]

101. In addition, as Mr Fordham SC submitted, Mr Tullipan gave his evidence in a forthright manner and matter-of-fact way. I accept his evidence. He was an experienced scaler. He had no concerns about the manner in which work was being conducted on the East Wall of the North Pit on 17 March 2017. In fact he said, and I accept, "*from previous experience and all my years of scaling and working in mine sites there was nothing that we could have done on the day of the incident that could possibly [have] caused or in any way contributed to a rock fall of [the] size*" that killed Mr Beesley.[68]

Issues falling within the scope

The method of work adopted to carry out the task

102. This issue has been dealt with extensively in this finding already, in particular at paragraphs 56 – 60, and 81 – 85 above.

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[67] Transcript, page 162, line 4.
[68] Exhibit C24, affidavit Grant Owen Tullipan, sworn 20 April 2017, paragraph 12.

Any risk assessment or risk analysis carried out before 17 March 2017 in respect of scaling.

103. The general approach in relation to risk management, which needs to be understood before risk assessment and risk analysis in relation to Mr Beesley's death is considered, were set out in detail by Mr Anderson in his affidavit.[69] He described 4 levels of mining industry risk management that were replied at Grange namely:

    a) Enterprise Risk Register;
    b) Project level Risk Assessment/Change Management;
    c) Job Hazard Analysis; and
    d) Point of Work Risk Assessment/Safety Check.

104. Those principles guide risk assessment and analysis at the mine and did so in relation to the scaling undertaken by the SRG team. The evidence was Grange had in place a "major Hazard Management plan" that dealt expressly with ground control and particularly geotechnical risks.

105. Mr Anderson said that the process of risk management was:

    a) The Geotechnical Department prepares and updates Geotechnical Hazard Maps and a geotechnical Hazard Register. The maps designate all pit edge mining areas, restricted areas, exclusion zones as well as indicating the location of any specific hazards.
    b) A comprehensive Mining Department Communication structure is detailed in the Ground Control Management Plan.
    c) Rock falls were considered with multiple consequences in the enterprise risk register, including the possibility of the fatality.
    d) Our site risk register is usually reviewed about once a month and a more formal review is conducted about once a year.
    e) Our safety team meet weekly.

106. It is apparent on the evidence that SRG undertook a risk assessment prior to the arrival on site. The initial risk assessment carried out by SRG was considered by Grange to be deficient in that it addressed generic issues such as bullying but did not touch upon the actual risks associated with manual scaling by abseiling down the a mining pit. Grange indicated to SRG an additional risk

[69] *Op. cit.* paragraph 2.5(d).

assessment would need to be conducted when SRG personnel actually came on site.

107. Evidence was that that risk assessment took place on 2 February 2017. Mr Gilbert Charles gave detailed evidence in relation to the manner in which that risk assessment process was conducted. I do not consider it necessary to go into it in detail. I did not understand any Counsel to criticise the manner in which the assessment was conducted nor the conclusions that arose from it. My view of the evidence about that additional risk assessment was that it addressed the earlier deficiencies in SRG's risk assessment.

108. Mr Charles said SRG raised during the risk assessment on 2 February 2017 "*that there might have been a couple of spots on the wall that they could not safely scale*".[70] The danger of being hit by a rock while team members was on the wall was expressly discussed. Mr Charles said he was told by SRG that this such a risk was "*inconceivable as they don't go places where there is that kind of chance. Their control was; they just don't go into those kind of places and take that risk. They clean in front of themselves before proceeding. They had the same opinion that I had; that it was a very unlikely risk*".[71] I accept Mr Charles' evidence about this point (and generally), his evidence was unchallenged. He impressed me as a careful and honest witness.

109. As a result of the risk assessment meeting on 2 February 2017, a document entitled 'North Pit East Wall Scaling Risk Assessment' was prepared.[72] The document was in evidence. It speaks for itself. It expressly identifies a risk of scalers being hit by a falling rock. It identifies various control measures to address that risk.

110. Once the first SRG team was on-site, a Job Hazard Analysis was prepared.[73] That document was also in evidence. It also speaks for itself. The evidence was that it was prepared with input from both SRG and Grange personnel. It was specifically created for the scaling works that the SRG team was about to commence.

111. After work was suspended and before it was re-commenced by the second SRG scaling team, that JHA was reviewed and revised.

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[70] Exhibit C42, affidavit of Gilbert Charles, sworn 22 October 2021, paragraph 7(h).
[71] Supra, paragraph 7 (d).
[72] Exhibit C30, Tab 80.
[73] Exhibit C30, Tab 82.

112. In my view the evidence overwhelmingly supports a conclusion that the approach to safety by both Grange and SRG was entirely appropriate.

Any training provided in relation to the method adopted to carry out scaling on or before 17 March 2017.

113. Each member of the roping team required IRATA certification. Other than that, there was no training as such. Such training as there was for scaling was 'on the job'. Mr Tullipan said, "*Scaling is not an activity that requires any trade or qualification. It is really just a case of moving some loose rocks... As time goes by you get to hear and know a little more but it is basically just pushing off rocks... In this kind of task it is necessary to be shown or taught by someone initially as to how to do it but in terms of complexity it is very minor*".[74]

Any alternatives available on, before or after 17 March 2017 to the method adopted to carry out scaling.

114. I am satisfied on the evidence that there was no reasonable alternative available to carrying out the task of manual scaling. Viewing the evidence as a whole, I do not see that there was any reasonable alternative or indeed any alternative.

115. The evidence is that since Mr Beesley's death, a fit for purpose machine has been developed. When in use, it will avoid, altogether, the need to manually scale. At the time of the inquest, that project was undergoing its final field trials. The evidence seemed to suggest that the remote scaling machinery which had been developed, the Jayben S60 Scaler, was extremely promising. The general manager of the company involved in the development of the scaler, Mr Christopher Johnson, gave oral evidence at the inquest. He said, and I accept, that he did not think there was any area within an open cut mine where it could not be used. The only limitation on the remote scaler was a vertical range limit of 130 metres.

What, if any, approvals were required and/or in place for carrying out the scaling, such approvals issued by WorkSafe Tasmania or any other relevant regulator?

116. This issue has been dealt with earlier in this finding at paragraph 42 above.

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[74] *Supra*, paragraphs 15 – 18.

The regulatory regime in Tasmania for carrying out the scaling, as administered by WorkSafe Tasmania or any other relevant regulator.

117. There is no regulatory regime specifically dealing with scaling administered by either WorkSafe Tasmania or any other entity.

Formal Findings

118. On the basis of the evidence at the inquest I make the following formal findings required pursuant to Section 28 (1) of the *Coroners Act* 1995:

    a) The identity of the deceased is Nathaniel Owen Beesley;
    b) Mr Beesley died in the circumstances set out further in this finding;
    c) The cause of Mr Beesley's death was crush injuries; and
    d) Mr Beesley died on 17 March 2017 at the Grange Resources Iron Ore Mine, Savage River in Tasmania.

Recommendation and Comment and Conclusion

119. I have already touched upon the fact that one of the coroner's statutory functions is to 'make recommendations with respect to ways of preventing further deaths'. I observe that it seems to me as Mr Sault said in his evidence that the only way to absolutely avoid the high level of residual risk which attaches to manual scaling as was carried out by Mr Beesley and his colleagues on 17 March 2017 is not to scale.

120. I specifically accept the submissions of Mr Taylor to the effect that manual scaling itself is one of a number of controls that may be implemented by any mine operator, including Grange, to address the ever present risk of rock fall. I note the evidence from Mr Johnson about the 'Jayben S60 Scaler' which, assuming it is able to be effectively utilised, and there is no reason to think that it will not be, will obviate, entirely, the need for manual scaling to be carried out in the future.

121. I also accept Mr Taylor's submissions in relation to the *Mining Work Health and Safety (Supplementary Requirements) Regulations* 2012, part of the Work, Health and Safety suite of legislation in this State. Under those regulations, mine operators are required to have in place a major hazard management plan in

respect of any 'Principle Hazard' identified at any mine[75]. The *Mining Work Health and Safety Act* 2012 empowers the Chief Inspector of Mines to issue 'Guidance Material' in order to provide guidance and assist with decision-making at the mine[76]. Some years ago, in 2013, guidance material was issued to assist mine operators with developing Principle Mining Hazard Management plans. That material, which presumably has binding effect, states that the Safety Management System of any mine must include at a minimum, Principal Mining Hazard Management Plan(s) for the following areas:

a) Ground/Strata instability
b) Inundation and inrush;
c) Mine Shafts and Winding Operations;
d) Rhodes, other vehicle operating areas and traffic management;
e) Air quality, airborne dust and other airborne contaminants;
f) Fire and explosion;
g) Gas outbursts; and
h) Spontaneous Combustion.

122. In contrast the *Mining Work Health and Safety (Supplementary Requirements) Regulations* 2012 only specify four types of Major Hazards which require Major Hazard Management Plans – mobile plant, electricity, airborne dust, and inrush or flooding. Self-evidently, there is an obvious discrepancy between the guidance issued in the regulations. In the context of this case, the issue of ground strata instability was what prompted the engagement of SRG and led to Mr Beesley's death.

123. Nonetheless, I consider it appropriate to **comment** that there is considerable merit in the regulations being amended to specifically mandate that all mining operators have in place a Principal Mining Hazard Management Plan with respect to 'Ground/Strata instability'.

124. In addition, Mr Tunstall's helpful evidence indicated that a 'Mine Safety Steering Committee' existed on paper only. If that committee does not meet shortly, (at the very least some time this year) the *Mining Work Health and Safety (Supplementary Requirements) Regulations* 2012 will be repealed by virtue of operation of Section 11 (2) of the *Subordinate Legislation Act* 1992. Once again, I

[75] See part 3 of those regulations, generally.
[76] Section 33.

do not suggest that the apparent lapsing of the Mine Safety Steering Committee had any causal relationship to Mr Beesley's death. Nonetheless, it may, if operated appropriately, prevent further death. To that end, I **recommend** that the committee meet as soon as practicable to consider, *inter alia*, comment that I have made above in relation to the amendment of the regulations.

125. I wish to extend my thanks to all Counsel, and in particular Mr L Taylor, involved in this matter.

126. In conclusion I wish to offer my sincere and respectful condolences to the family of Nathanial Beesley on his death.

Dated 21 April 2022 at Hobart in Tasmania

Simon Cooper

Coroner

These findings have been amended by an order under section 58 of the *Coroners Act 1995* dated 31/08/22 by:

1. Identifying SRG Global Mining (Australia) Pty Ltd as Mr Beesley's employer. So removing the name "SRG Global Limited" from the original findings and replacing with the name "SRG Global Mining (Australia) Pty Ltd".
2. Including all the parties that Mr Fordham SC appeared for. So confirming that Mr Fordham SC appeared for SRG Global Mining (Australia) Pty Ltd and Messrs Grant Tullipan, Damien Aspros, Timothy Herbert, Barry Morssinkhof and Kieran Toon.

Annexure A

1. Police Report of Death for the Coroner, Senior Constable J Ebsworth; exhibit C1;
2. Affidavit of Life Extinct, Dr A Britcliffe, exhibit C2;
3. Affidavit of Identification, Dr C Connor, exhibit C3;
4. Affidavit of Identification, Senior Constable J Ebsworth, exhibit C4;
5. Affidavit of Identification, C O'Connor, exhibit C5;
6. Post Mortem Report, Forensic Pathologist Dr D Ritchey, exhibit C6, reported 22 June 2017;
7. Toxicology Report, Forensic Scientist M Connor, exhibit C7, sworn 10 May 2017;
8. Affidavit of G Higgins, exhibit C8, sworn 19 January 2018;
9. Affidavit of G Ling, exhibit C9, sworn 17 January 2018;
10. Affidavit of D Dannals, exhibit C10, sworn 17 January 2018;
11. Affidavit of I Markota, exhibit C11, sworn 17 January 2018;
12. Affidavit of M Anderson, exhibit C12, sworn 17 January 2018;
13. Affidavit of B Stammers, exhibit C13, sworn 17 January 2018;
14. Affidavit of R Haines, exhibit C14, sworn 17 January 2018;
15. Affidavit of G Hutton, exhibit C15, sworn 17 January 2018;
16. Affidavit of J Crocket, exhibit C16, sworn 24 July 2017;
17. Affidavit of B Morssinkhof, exhibit C17, sworn 22 November 2017;
18. Affidavit of K Beesley, exhibit C18, sworn 14 August 2017;
19. Affidavit of G Charles, exhibit C19, sworn 17 January 2018;
20. Affidavit of Senior Constable J Ebsworth, exhibit C20, sworn 31 July 2017;
21. Affidavit and photographs of First Class Constable M Johnston, exhibit C21, sworn 14 April 2017;

22. Affidavit and photographs of Constable L Needham, exhibit C22, sworn 6 April 2017;

23. Affidavit and photographs of Senior Sergeant M Forteath, exhibit C23, sworn 11 April 2017

24. Affidavit of G Tullipan, exhibit C24, sworn 20 April 2017;

25. Affidavit of T Herbert, exhibit C25, sworn 17 May 2017;

26. Affidavit of J Hose, exhibit C26, sworn 19 April 2017;

27. Correspondence between WorkSafe Tasmania dated 28 August 2018, exhibit C27;

28. Swipe events and visitor log, between 16 March 2017 and 21 March 2017, Grange Resources Tasmania, exhibit C28;

29. Investigation Report, Inspector C Sault, WorkSafe Tasmania, exhibit C29;

30. Complete WorkSafe investigation file, exhibit C30;

31. Affidavit of A Tunstall, exhibit C31, sworn 1 September 2021;

32. Affidavit of A Tunstall with annexures, exhibit C32, sworn 8 September 2021;

33. Affidavit of C Sault, exhibit C33, sworn 11 February 2020;

34. Affidavit of W Zirima, exhibit C34, sworn 20 August 2021;

35. Affidavit of Y Veenendaal, exhibit C35, sworn 18 August 2021;

36. Email correspondence, Grange Resources Tasmania, exhibit C36;

37. Affidavit of K Toon, exhibit C37, sworn 28 October 2021;

38. Notes of A Tunstall and Y Veenendaal, exhibit C38;

39. Affidavit of M Anderson, exhibit C39, sworn 22 October 2021;

40. Email correspondence, 9 – 23 February 2017, SRG Global Limited, exhibit C40;

41. Photograph of Mr Beesley, exhibit C41;

42. Affidavit of G Charles, exhibit C42, sworn 22 October 2021;

43. Swipe event of Mr Beesley, 12 February – 16 March 2017, exhibit C43;

44. Site photos and videos, Grange Resources Limited, exhibit C44;

45. Affidavit of C Johnson, exhibit C45, sworn 22 October 2021; and

46. Transcript of inquest proceedings, 25 – 29 October 2021.