



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Cameron John Goss

Find, pursuant to Section 28(1) of the *Coroners Act 1995*, that.

- a) The identity of the deceased is Cameron John Goss;
- b) Mr Goss died in the course of his employment in the circumstances set out further in this finding;
- c) The cause of Mr Goss's death was blunt trauma of the chest; and
- d) Mr Goss died, aged 44 years, on 23 January 2020 at level 1880 Darwin Mid Zone, Henty Gold Mine, Howards Road, West coast of Tasmania.

In making the findings above and those that follow I have had regard to the evidence obtained in the investigation into Mr Goss's death which includes:

- Police Report of Death for the Coroner;
- Affidavits confirming identity;
- Report – Dr Donald Ritchey, Forensic Pathologist;
- DNA Coronial Identification Report;
- Report – Forensic Science Service Tasmania;
- WorkSafe Tasmania investigation file;
- Police interview Dion Alford – General Manager, Henty Gold Mine;
- Affidavit – Leigh Gardham – Shift Supervisor, Henty Gold Mine;
- Affidavits of staff members of Pybar and HMR Drilling;
- Affidavit of Christine Goss – Wife of Cameron Goss
- Affidavits, photographs and drone footage – Senior Sergeant Mark Forteath;
- Affidavit and photographs – Senior Constable Michelle Rybarczyk;
- Running sheets – Henty Gold Mine;
- Incident Notice and Workplace Records – Worksafe Tasmania;
- Medical Records for Mr Cameron Goss; and
- Records – Operational Geotechs.

All that material, and my inspection of the scene on 24 January 2020, informed the following findings.

Introduction

1. Mr Goss was born in Queenstown, Tasmania on 2 June 1975. He was married to Christine and together the couple had two adult children.
2. After a varied and productive employment history, in 2017 Mr Goss commenced work as a truck driver at the Henty mine. In November of the same year, after completion of relevant training, Mr Goss commenced as an underground minor, operating loaders. He ultimately completed his qualifications in that regard in October 2019.
3. Mr Goss was popular with his workmates, known to be cautious and someone who enjoyed his work very much. His medical history was unremarkable. He had had some heart issues in the past, low back pain and gout but generally speaking was in reasonably good health. Certainly there is nothing in his medical history that may have caused or contributed to his death.
4. He was appropriately trained and qualified to carry out his assigned duties on the day of his death. An analysis of his work computer showed that Mr Goss carried out the necessary workplace safety checklist at level 1880 on 22 January. He did not report any safety concerns or issues prior to commencing bogging operations. The loader he was operating was in good mechanical condition. It had been serviced only two days before.
5. Mr Goss died as a result of massive injuries sustained by him while he was operating a loader (also known as a “bogger”) in the course of his employment on 23 January 2020 at the Henty Gold Mine.

The Coroner’s Jurisdiction

6. Before considering the circumstances of Mr Goss’s death in further detail, it is necessary to say something about the general role of the coroner. In Tasmania, a coroner has jurisdiction to investigate any death, and hold an inquest, in relation to that death if it that appears that *“the deceased died at, or 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".¹ The circumstances of Mr Goss's death meet this definition.

7. The requirement to hold an inquest (which is a public hearing) is subject to section 26A of the *Coroners Act* 1995 ('the Act'). That section provides that if the senior next of kin requests the coroner not to hold an inquest and the coroner is satisfied that it would not be contrary to the public interest or the interests of justice not to hold an inquest, then no inquest need be held. In this case Mr Goss's widow, the senior next of kin under the Act, made such a request and I was satisfied, having regard to the extensive investigation that it was appropriate to dispense with the holding of an inquest.
8. When investigating any death, whether holding an inquest or not, a coroner performs a role different to other judicial officers. The coroner's role is inquisitorial. A coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the Act asks. Those questions include who the deceased was, how they died, the cause of the person's death, and where and when the person died. It is settled law that this process requires a coroner to make various findings, but without apportioning legal or moral blame for the death.
9. A coroner is required 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.
10. It is important to recognise that a coroner does not punish or award compensation to anyone. Punishment and/or 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.
11. As was noted above, one matter that the Act requires, is a finding (if possible) as to how the death occurred.² 'How' has been determined to mean 'by what

¹ Section 24(1) (ea) of the *Coroners Act* 1995.

² Section 28(1)(b) of the *Coroners Act* 1995.

means and in what circumstances’,³ a phrase which involves the application of the ordinary concepts of legal causation.⁴ Any coronial investigation necessarily involves a consideration of the particular circumstances surrounding the death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

12. The standard of proof that a coroner applies 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. A coroner is not bound by the rules of evidence and may be informed in any manner the coroner reasonably thinks fit. The evidence must be capable in some way of assisting the coroner to determine the matters under section 28(1) or, in appropriate circumstances, to assist in making a comment or recommendation.

Circumstances of death

13. Mr Goss arrived at work as part of C shift on Wednesday, 22 January 2020. His shift was the commencement of a seven-day rotation of night shift. Night shift commences at 6.00 pm and concludes at 6.00 am the following day. At the front gate of the mine site Mr Goss completed a breath alcohol test which returned a negative result.
14. At the commencement of the shift, the acting shift supervisor Mr Lee Gardam⁵ conducted a pre-shift meeting on the surface of the mine before the crewmembers headed underground. The pre-shift meeting was a standard procedure during which shift members were assigned their respective tasks from the shift plan. Mr Goss was assigned to do telemetry remote bogging at the 1880 level – Darwin mid zone.
15. CCTV footage shows Mr Goss “tagging on” at the surface level tag board at 6.18 pm. Tagging on is the process which is a precursor to proceeding underground. He tagged on again, underground at level 2133 at 8.30 pm, indicating that he was proceeding further underground.
16. Mr Goss’s shift appears to have been without incident for several hours.

³ *Atkinson v Morrow* [2005] QCA 353.

⁴ *March v MH Stramare Pty Ltd and Another* [1990 – 1991] 171 CLR 506.

⁵ The usual shift supervisor was on leave.

17. At about at about 4.00 am, a co-worker, Mr Anthony Cahill, was operating a truck underground at the 1880 level. He received a bucket of material from Mr Goss's loader. After about 10 minutes past Mr Goss did not return to Mr Cahill's truck with a second bucket of material. This caused Mr Cahill to assume that the loader had perhaps suffered a mechanical failure as he was unable to hear the noise of the loader in operation. Mr Cahill called Mr Goss by radio but did not receive a response.
18. At about 4.10 am Mr Cahill walked around the area where Mr Goss had been operating the loader. He discovered a large void in the floor of the drive. The loader was upside down in the void. Mr Cahill called out to Mr Goss but did not receive a response. He looked but could not see him so returned to his truck and raised the alarm broadcasting an emergency call on the radio fitted to his truck. Various members of the shift arrived quickly at the scene. No signs of life of Mr Goss were detected. All underground workers return to the surface and mining operations suspended. Emergency services were notified at 5:52 AM.
19. The loader, and Mr Goss, had fallen about 10 metres into a void which had opened up in the drive.
20. Numerous attempts to rescue Mr Goss continued for a number of days. Eventually, footage obtained by a drone showed the cabin of the loader and the body of Mr Goss buried beneath approximately 2 metres of material. During this time I went to the mine and inspected the scene of the accident.
21. On Tuesday, 18 February 2020, 25 days after Mr Goss's death, there was a considerable shift of material in the 1880 level void which moved a significant quantity of material to the lower 1840 level. During that movement, Mr Goss's body also moved enabling it to be recovered. The loader – which weighed over 44 tonnes - was left *in situ*.

Investigation

22. Following recovery from the mine, Mr Goss's body was transported by mortuary ambulance to the Royal Hobart Hospital. At the Royal Hobart Hospital, a *post-mortem* examination was performed upon Mr Goss's body on 20 February 2020 by experienced forensic pathologist Dr Donald Ritchey.

23. Dr Ritchey provided a report after that post-mortem in which he expressed the opinion that the cause of Mr Goss's death was blunt trauma of the chest. I accept Dr Ritchey's opinion. It is unclear whether Mr Goss died inside the cabin of the loader or was outside the cabin. The absence of any material in Mr Goss's airways suggests he died almost immediately after the loader plunged into the void.
24. His body was identified through DNA comparison because Mr Goss was unrecognisable due to his significant injuries and the extent of decomposition. The result of that DNA comparison satisfies me, beyond any doubt, that the body recovered from the void was Mr Goss. I also note that Dr Ritchey saw tattoos at autopsy of the names of Mr Goss's children on the body's forearms.
25. Toxicological analysis of samples taken at autopsy showed elevated levels of alcohol to be present in those samples. I am however quite satisfied that that was attributable to the level of the body's decomposition and not the fact that Mr Goss had consumed any alcohol before commencing work or during his shift. Otherwise the toxicological analysis was unremarkable.
26. The circumstances in which Mr Goss's body was found indicate that he was probably not wearing the seat belt fitted to the cabin of the loader at the time of the accident which caused his death (although it is possible that he undid his seatbelt and exited the cabin as the void opened up underneath him). In the circumstances, I do not think the fact that he was not wearing a seatbelt caused or contributed to the happening of his death. Of course, if he had been wearing a seatbelt he would not have been ejected from the cabin. On the other hand, if he had been wearing a seatbelt he would have remained in the cabin which was completely overwhelmed and filled by rubble. Either way he would have, in my view, died.
27. An extensive investigation was carried out in relation to how it was that a void opened up beneath where Mr Goss had been working. In particular geotechnical evidence in this regard informed this finding.

Criminal proceedings

28. Following an extensive investigation charges were laid against Unity Mining Pty Ltd. Unity Mining pleaded guilty to one charge of failing to comply with a health and safety duty pursuant to section 32 of the *Work Health and Safety Act 2012*. The outcome of those proceedings was that Unity Mining was convicted and fined \$150,000.

Conclusion

29. The evidence satisfies me that a void opened up underneath where Mr Goss was operating his loader. The fact that he was operating his loader over an area with a frozen downhill rise (which failed) was not information available to him, his shift boss, or anyone in a position of management at Unity Mining because that information had been lost over time.

30. The loss of that information appears to have occurred as a result of mining activities being conducted by various mining companies over a 14 year period. That period saw a natural attrition of staff, changes in ownership and management as well as periods of care and maintenance. All that explains, but does not excuse, the loss of knowledge and information in relation to both history and work practices.

31. The recovery, identification of Mr Goss's body and the investigation in relation to the circumstances of his death was a complicated and difficult operation. Many people made significant contributions in very challenging circumstances. Particularly worthy of recognition are Inspector Shane LeFevre and Senior Sergeant Adam Spencer of Tasmania Police, Mines Inspectors Andrew Tunstall and Willard Zirima, and Henty Gold Mine personnel Dion Alford, Scott Evans, Andrew Burt, Marcus Rigby, Frank Pfab, Michael McDermott, Robert Jackson, Chad Mennitz, Glenn Snell and Kerry Bryan.

32. I do not consider any comments or recommendations are warranted in the circumstances of this investigation.

33. I express my sincere and respectful condolences to Mr Goss's loved ones on his untimely death.

Dated: 17 July 2025 at Hobart, in the State of Tasmania.

Simon Cooper
Coroner