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Thomas Douglas Lawrence ANDERSON

Findings and Recommendations

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The Mines Regulation Act 1964

Findings and recommendations of reviewers and mining warden following an inquiry into fatal injuries received by Thomas Douglas Lawrence Anderson at Mount Isa on 4 june 1990 warden's court of Queensland Mount Isa 2 october 1990

Before: Mr F W Windridge esquire Warden

Reviewers:

- MR A W SCHRANK
- MR R JAMIESON
- MR R H MacKENZIE
- MR G H HUTCHINSON

To assist:

MR R A SEYMOUR, senior inspector of mines .

Appearances:

- MS L DAWSON, next of kin
- MR G MOUSLEY, district workers' representative
- MR C NOTHLING, solicitor for employer and mine manager

Witnesses examined: refer transcript and [schedule "a"](#)

Exhibits tendered: refer transcript and [schedule "b"](#)

Findings: refer transcript and [schedule "c"](#)

Recommendations: refer transcript and [schedule "d"](#)

Report of mining warden: refer transcript and [schedule "e"](#)

Schedule "A" Witnesses examined:

- William Charles EDBROOKE
- James BROWN
- Ashley Donald TURRELL
- David Anthony FACELLI

- Barry James HASTED
- Brendan HOLDEN
- Douglas Lawrence McLACHLAN
- William WARDROP
- Phillip George SOWDEN

Schedule "B" List of Exhibits

No of Exhibit	Nature of Exhibit
1	Statement EDBROOKE
2	Post Mortem Certificate
3	Post Mortem Examination Report
4	Certificate of Analysis
5	Entry Record Book BROWN
6	Entry Record Book WATERMEYER
7	Surveyors Plan of Site
8	Photographs "A - E"
9A	Entry Record Book BROWN
9B	Entry Record Book WATERMEYER
10	Extract 1987 Shunters Handbook
11	Extract 1990 Shunters Handbook
12	Employment History
13	Award Record Card
14	Workplace Induction Checklist
15A	Letter dated 25 July 1990

15B	Extract 1989 Shunters Handbook
16	Letter dated 26 September 1990
17	Statement Turrell
18	Certificate of Competency
19	Statement FACELLI
20	Statement HASTED
21	Statement HOLDEN
22	Statement McLACHLAN
23	Statement WARDROP
24	Statement SOWDEN

Schedule "C" Findings:

We find -

Name of deceased: Thomas Douglas Lawrence Anderson

Date of death: 4 June 1990

Nature and cause of accident:

The deceased received fatal injuries while performing duties as a shunter on the Isa lease near the Gardenia Gate crossing.

Findings:

The inquiry has heard evidence from a number of witnesses including some who were in the immediate vicinity. From the evidence we are satisfied the deceased landed between the tracks and the first wagon passed over him. There are at least two possibilities which caused the deceased to leave the wagon. One is that due to the manner in which the locomotive and wagons were operating a surge could have caused the deceased to lose his balance. The other possibility is that the deceased voluntarily, for some reason, attempted to leave the wagon. However, we do not see that the latter situation is a real possibility as we do not consider a shunter would intend to demount in the manner reflected in the evidence from the witnesses. It is clear that the deceased was riding on the front of the leading wagon and a complicating factor was the failure of a switch which operated the warning lights at the Gardenia street crossing. This brought a number of vehicles into close proximity with the wagons being shunted. This caused the loco driver to ease off the throttle after being warned by shunter Turrell. It is possible the resultant surge may have caused the deceased to lose his balance and fall. However, in later testing it was not possible to reproduce any surge of significant effect.

Schedule "D" Recommendations:

The recommendations of the reviewers are as follows:

All persons involved with shunting operations must become conversant with the new rules as stated in the 1990 shunters handbook.

The switch system for warning lights should be upgraded by installing a fall safe system similar to a track circuit system currently operated by the Queensland Railways; and

For emergency procedures in the event of power failure a shunter shall walk in front of the locomotive or leading vehicle to protect road traffic.

Schedule "E" Report of the Warden:

I concur with the findings of the reviewers as to the nature and cause of the accident.

Last Updated 21 October 2007

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Great state. Great opportunity.