Queensland Government Department of Natural Resources and Mines

Anthony MIHALJ

Findings and Recommendations

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

The *Mines Regulation Act 1964*

Findings and recommendations of reviewers and mining warden following an inquiry into fatal injuries received by Anthony Mihalj at at N-S Twelve-e-two stope, Cracow mine on 14 may 1991 warden's court of Queensland Mount Isa 7 august 1991

Before: Mr F W Windridge esquire Warden

Reviewers:

- MR K G BUCKLAND
- MR G B CHALMERS
- MR P DOLAN
- MR W J GORMLY

To assist:

MR R WHITE, inspector of mines.

Appearances:

- MR A MIHALJ for next of kin
- MR D PAPPIN, district workers' representative
- MR A HERBERT appearing for Cracow Mining Venture and registered mine manager
- MR D K BODDICE appearing for Costain Australia Limited and its employees

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:

- Darryl Glen FOYSTER
- Brian Frank LEWANDOWSKY
- Darryl Arthur LAUCHLAN

- Duncan Peter PAPPIN
- Gary Arthur GRAY
- Michael David JOHNSTON
- Rodney John GRAY
- Alan MITCHELL

Schedule "B" List of Exhibits

No of Exhibit	Nature of Exhibit
1	Statement - D G Foyster
2	Statement of Work History
3	Photographs marked 1 to 10 taken by W Elrick
4	Photographs (2) of accident scene taken by Inspector White
5	Photographs - accident scene taken by Inspector White
6	Police Report - Post Mortem Report
7	Statement - D A Lauchlan
8	Plan
9	Plan - E-two sill drive and production drive
10	Statement - G A Gray
11	Statement - M Johnston
12	Statement - R J Gray
13	Statement - A Mitchell

Schedule "C" Findings:

We find -

Name of deceased: Anthony Mihalj

Date of death: 14 may 1991

Location of death: NS 12 - e2 stope, Cracow mine

Nature and cause of accident:

The deceased was engaged in shrink stope mining on the morning of 14 may 1991. Two holes had been drilled in the back of the ore body with a sig machine and air leg. The deceased had commenced to drill the third hole when a large slab fell down, causing fatal injuries.

From the evidence we are satisfied that the deceased was using the wrong mining method in that flatbacking was the only way to advance the stope to the north.

We consider this accident was caused by a failure to work the job by an appropriate mining method resulting from inadequate direction by supervision.

Schedule "D" Recommendations:

The recommendations of the reviewers are as follows:

Because of the inherent dangers of shrink stope mining in the upper levels of the Cracow mine, only experienced managers and miners should be employed in this type of operation.

Suitable staging should be readily available for shrink stoping where required.

The lines of authority at Cracow is to be made clear to all employees and responsibility for directing and supervising the progress of each job is to be defined.

Schedule "E" Report of the Warden:

I would indicate that as warden, I concur with the findings and recommendations.

It has come to my attention that a number of witnesses travelled a considerable distance to attend and give evidence. I thank those concerned for their attendance.

I am also informed that a number of witnesses who are still employed by Costain have been informed they will not suffer any loss of wages due to their attendances at this inquiry. That gesture is appreciated.

I am also informed that Costain assisted in relation to this attendance of an interstate witness. I thank them for that assistance.

Copies of transcript will be made available.

The inquiry is closed.

Last Updated 21 October 2007
