

Department of Natural Resources and Mines

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Gary Michael MARTIN

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 Gary Michael Martin at Mount Isa mine on 26 january 1991 warden's court of Queensland Mount Isa 26 june 1991

Before: Mr F W Windridge esquire Warden

Reviewers:

- MR R A GLANVILLE
- MR D M HARRIS
- MR R H MACKENZIE
- MR D J SYMONS

To assist:

MR G SLEZIAK, inspector of mines.

Appearances:

- MR W M BOULTON for next of kin
- MR G MOUSLEY, district workers' representative
- MR C NOTHLING representing the company and the registered 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 <u>schedule "d"</u>

Report of mining warden: refer transcript and schedule "e"

Schedule "A" Witnesses examined:

- Christopher Judge CASTLEY
- Peter Clive HORNSBY
- Trevor Bruce HANNIGAN
- Wayne John GREENSILL

- John Francis BAWDEN
- Rodney Glen BUTTLE
- Darryl John MCLELLAN
- Peter James BERRY
- Robert PURDIE
- Sid DE SATGE
- John Murray THOMPSON
- Timothy Mark GILBERT
- Gary Alan VARLEY
- Trevor Patrick TIERNEY
- Thor HALVORSEN
- Gary William BUTLER

Schedule "B" List of Exhibits

No of Exhibit	Nature of Exhibit
1	Report - C J Castley
2	Post Mortem Certificate
3	Post Mortem Report
4	Report - P C Hornsby
5	Photographs Marked "A" and "B"
6	Record Book Entry
7	Record Book Entry
8	Record Book Entry
9	Plan of the Site
10	Report - T B Hannigan
11	Photographs Marked "A" to "H"
12	Record Book Entry
13	Photostat Sheet of Training Log Book
14	Statement - W J Greensill

15	Statement - J F Bawden
16	Statement - R G Buttle
17	Statement - D J McLellan
18	Statement - P J Berry
19	Statement - R Purdie
20	Statement - S De Satge
21	Statement - J M Thompson
22	Statement - T M Gilbert
23	Statement - G A Varley
24	Statement - T P Tierney
25	Statement - T Halvorsen
26	Statement - G W Butler
27	Record Book Entry

Schedule "C" Findings:

We find -

Name of deceased: Gary Michael Martin

Date of death: 26 january 1991

Location of death: R405 stope below 18b sub level, Isa mine

Nature of accident:

Gary Michael Martin received fatal injuries when a UGL loader which he was driving entered the void of R405 stope.

Cause of accident:

At about 12.20 am on 26 january 1991, Martin was instructed to muck V405 stope on 18E Level and to tip back to Q41 ore pass. Greensill was instructed to go to S404 cut off and muck to Q41 ore pass.

It appears that Greensill and Martin decided that Martin would muck from S404 stope to V405 stope and Greensill would muck from V405 stope to Q41 ore pass.

Although Martin had assured supervisor Butler that he was aware of the location of V405 stope, from the conversation with Greensill it appears Martin was less sure of the location of S404 stope.

This leads us to believe that Martin entered R405 stope in error.

Across the entrance of R405 stope there was a warning sign, "Danger OPEN STOPE - LANYARD REQUIRED". It is highly probable that this warning sign was not observed by Martin in that it may have been obscured by the position of the bucket of the loader.

It is highly probable that having turned right and sighting "R405" marked on the rubber flaps, Martin continued on looking for S404.

We consider Martin was in R405 stope because of a number of factors, namely -

- Some unfamiliarity with the location of S404 stope;
- · Lack of clear marking of S404 stope;
- Confusion over or a misinterpretation of Greensill's directions.

Schedule "D" Recommendations:

The recommendations of the reviewers are as follows:

Mine Management in consultation with the chief inspector of mines investigate the size and positioning of additional signs, particularly in relation to ore passes and open stopes.

We consider there are adequate rules and procedures in relation to signs and barricades, but it is imperative that personnel be instructed to observe those rules and procedures at all times.

Schedule "E" Report of the Warden:

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

The inquiry is closed.

Last Updated 21 October 2007

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Great state. Great opportunity.