Michael John GOREY

Findings and Recommendations

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

The *Mines Regulation Act 1964 - 1989*

Findings and recommendations of reviewers and mining warden following an inquiry into fatal injuries received by Michael John Gorey at Mount Isa Concentrator on 22 may 1991 warden's court of Queensland Mount Isa 30 september 1991

Before: Mr F W Windridge esquire Warden

Reviewers:

- MR JOHN MOORE
- MR DAVID HARRIS
- MR IAN MacLEOD-CAREY
- MR GEORGE HUTCHINSON

To assist:

MR RAYMOND SEYMOUR, inspector of mines.

Appearances:

- MS SONIA HATCHARD - next of kin
- MR GRAEME MOUSLEY - district workers' representative
- MR ADRIAN VAN DER KAMP - contractor
- MR RICHARD WOOD - solicitor for mine 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:

- Peter Clive HORNSBY
- Malcolm LEWIS
- Darren John LUTZE

- Juoro Olati LEHTI
- Robert Phillip VAN RYT
- Donald Robert FERGUSON
- Arty John HANNILA
- Christopher Roger FITZGIBBON

Schedule "B" List of Exhibits

No of Exhibit	Nature of Exhibit
1	Police Report - Constable Hornsby
2	Post Mortem Certificate
3	Post Mortem Report
4	Government Analyst Report
5	Copy of Record Book Entry
6	Manager Report
7	Statement - Darren John LUTZE
8	Statement - Juoko Olati LEHTI
9	Statement - Robert Phillip VAN RYT
10	Statement - Donald Robert FERGUSON
11	Statement - Kevin Rahin BOCOS
12	Statement - Arty John HANNILA
13	Statement - Christopher Rodger FITZGIBBON
14	Photographs x 3

Schedule "C" Findings:

We find -

Name of deceased: Michael John Gorey

Date of death: 21 may 1991

Location of death: New mullock bin at Copper Concentrator, Isa mine

Nature of accident:

At approximately 10.00 am on wednesday, 22 may 1991, the deceased, Michael John Gorey, a boilermaker employed by the contracting firm of Barkly Welders, was gas-cutting an opening in the floor chequer plate beneath the head snubber drum of the new conveyor extension at the top of the mullock bin. This installation had been commissioned only three days previously and it was found that fines ahering to the belt were causing a build-up on the floor beneath the conveyor. The purpose of the opening was to allow the spillage to fall into the bin.

Assisting deceased was Darren John Lutze, another boilermaker also from Barkly Welders. Just before the accident, these two were joined by Juoko Oltai Lehti, an MIM beltman who came across from the crude ore bins to find out how long it would be before he could restart the belt.

Lutze took over from deceased to finish the cut while the deceased and Lehti held a wire rope sling attached to the section of floor plate being removed so that when detached it would not fall into the bin. Both men were standing on four unsecured steel acrow plants spanning the discharge opening in the floor beside the conveyor. Neither man was secured by safety belt and lanyard.

As Lutze completed the cut and the section of plate fell free, Gorey and Lehti were pulled forward, dislodging one of the acrow planks. Gorey fell through the gap, temporarily grasped the conveyor stop line and then continued his fall 26 metres to the bottom of the empty bin where he came to rest in the west discharge chute. Lehti fell spreadeagled across the remaining Acrow planks but managed to get clear. The deceased died almost instantaneously due to cardio-respiratory arrest due to massive internal injuries and lung collapse.

Cause of accident:

The section of floor plate being removed which had a mass of 73kg was not properly secured to a suitable anchor point.

The acrow planks spanning the conveyor discharge opening and on which deceased and Lehti were standing were not secured in any way.

Neither deceased nor Lehti were attached by safety belt and lanyard.

Schedule "D" Recommendations:

The recommendations of the reviewers are as follows:

When removing structural sections in elevated position and it is not desirable for the member to fall free, the section to be removed must first be properly secured to a solid anchor point. Chain blocks, pull-lifts or slings and shackles, all of adequate strength, are considered suitable for this purpose.

In elevated positions, planks used as temporary cover for openings must be secured to prevent there being accidentally dislodged.

Also, personnel required to work where there is a risk of falling must use safety belt with lanyard or other approved means of restraint.

Steps should be taken by managers and supervisors to ensure a greater appreciation and awareness of general safety issues on all construction sites by those people employed thereon.

Schedule "E" Report of the Warden:

I'd indicate that as warden I agree with the findings as read out. I wish to thank the reviewers for their assistance in the conducting of this inquiry. And as there's no further matters to attend to, the inquiry is formally closed.

Last Updated 21 October 2007

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Great state. Great opportunity.