Ian William HAIGH

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 Ian William Haigh at Base Hospital, Rockhampton on 16 december 1992 warden's court, Emerald, 5 may 1993

Before: Francis William WINDRIDGE esquire Warden

Reviewers:

- MR R T Coyne
- MR S W Young
- MR P R Forbes
- MR D C Reeve

To assist:

MR D MACKIE, inspector of mines.

Appearances:

- MR M T BEST, district workers' representative
- MR T D NORTH, barrister, instructed by solicitors Messrs Quinlan Miller & Treston for widow and next-of-kin
- MR R BANNERMAN, legal officer with BHP Australia Coal for Gregory Joint Venture

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:

- Ronald William STOKES
- Alan George THORNE
- Lance Stewart MATSCHOSS

- John Patrick DONNELLY
- Ian David FINNIS
- Rodney John FLAVEL
- Daniel Patrick DOYLE
- Martin Cuthbert DAVIS
- Phillip Arnold NIXON
- Steven Trevor MOORE
- Barry William RYAN
- Kenneth Ivor TAYLOR
- Andrew Cameron BLACK

Schedule "B" List of Exhibits

NO	DESCRIPTION
1	Report Inspector of Mines
2	Photographs 1 - 18
3	Sketch
4	Plan - Location (Deceased and Tools)
5	Plan - Location
6	Copy - Police Report
7	Post Mortem Report
8	Post Mortem Certificate
9	Statement - R W STOKES
10	Statement - A G THORNE
11	Statement - L S MATSCHOSS
12	Statement - J P DONNELLY
13	Statement - I D FINNIS
14	Statement - R J FLAVEL

15	Statement - D P DOYLE Statement - Martin Cuthbert DAVIS (Not formally admitted as an Exhibit)
16	Statement - P A NIXON
17	Statement - S T MOORE
18	Statement - B W RYAN
19	Statement - K I TAYLOR
20	Special Instructions
21	Statement - AC BLACK

Schedule "C" Findings:

We, the four reviewers selected by the warden under the provisions of Section 42 of the Mines *Regulation Act 1964-1989* to inquire into the nature and cause of this fatal accident, and whose names appear below, announce our findings as follows:

Name of deceased: Ian William Haigh

Date & time of accident: Thursday, 15 december 1992

Date & time of death: Friday, 16 december 1992 08.30 hours

Location of accident & death: Main workshop, Gregory mine base hospital, Rockhampton

Nature of accident:

In late 1992 two D-11N caterpillar dozers were delivered to the Gregory mine some sixty kilometres north-east of Emerald by Hastings Deering. One dozer was delivered in parts, assembled on site in the workshop, commissioned and handed over. The second dozer was delivered in parts and was in the process of being assembled on the fifteenth day of december 1992. Assembly was being carried out by Ian William Haigh, an employee of Hastings Deering, assisted by Ronald William Stokes, an employee of Gregory mine. The deceased was observed by a number of persons to be working on the dozer after nine a.m. on fifteen december 1992, and in particular he was seen working in the vicinity of the right hand blade left-cylinder trunnion.

Sometime later there was the sound of tools falling on the concrete floor, and a short time after that Mr Haigh was found on the floor. The alarm was raised and first aid was rendered very quickly. An ambulance then conveyed Mr Haigh to the Emerald hospital. He was later transferred to the Rockhampton base hospital where he passed away at zero eight-thirty hours on sixteen december 1992.

Cause of accident:

The deceased was observed to be standing at some stage on a small platform towards the front of the D-11N dozer on the right hand side, apparently engaged in loosening bolts in the blade left-cylinder trunnions. The last known position is uncertain as it is possible Mr Haigh attempted to loosen the bolt while on the platform or changed his position and moved into the bonnet of the machine. No person observed the fall and the exact cause is unknown. Later testing showed that one bolt required approximately four hundred foot pounds of pressure to loosen, and it is feasible that the deceased was attempting to loosen this bolt. At the time and for that purpose it appears

the deceased had placed a pipe over the bar attached to the socket to achieve greater leverage. It is highly probably that the socket slipped from the bolt when pressure was applied causing the deceased to lose his balance and fall.

Contributing factors may have been -

- The conditions of the tools including the wear in the socket, the bend of the bar and the fitting of the bar to the ratchet head;
- The angle of the trunnion heads;
- The tightness of the back bolt;
- The socket not sitting properly on the bolt head;
- The position that the deceased may have adopted to work on the bolt;
- The height at which the deceased had been working; and
- The lack of identification of risks including heights while working on assembly or disassembly of machines.

Schedule "D" Recommendations:

Mine management must ensure that contractors coming on site must have appropriate safe working procedures and practices in place for the work to be performed.

In future tender documents should match specific provision for the safe method of work based on a detailed risk assessment of the proposed project.

Management should seriously consider that workplace inductions should take place in addition to general induction.

Hastings Deering through the caterpillar system should advise all D-11N operators of potential hazards due to sockets not able to be correctly fitted to bolts on blade lift cylinder trunnion caps.

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
