Tony Daniel John TREVOR

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 Tony Daniel John Trevor at Mount Isa Mines on 15 march 1995 warden's court Mt Isa 14-16 april 1996

Before: Mr F W Windridge esquire Warden

Reviewers:

- Mr John Patrick BRADY
- Mr Ben ELLIOTT
- Mr John Arthur TORLACH
- Mr William Barron ELRICK

To assist:

Mr W Isdale, barrister, crown law office, appears for inspectorate.

Appearances:

- Mr T D North, barrister, instructed by Messrs Conroy and Conroy, solicitors for Toni Danielle Gregory, infant child of the deceased
- Mr R M Cooke, solicitor for MIM Holdings Pty Ltd
- Mr Graeme George Mousley, district workers representative

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:

- Constable Moreen Evelyn Peever
- Ray Anthony Alex Seymour
- Illona Maureen Casey

- Anthony James Wild
- Robin Arthur Herringe
- Graham Bernard Fuller
- James Coghlan
- Phillip Howard Goode
- Detective Inspector Brian Allan Richardson
- Peter Reginald Little

Schedule "B" List of Exhibits

No of Exhibit	Nature of Exhibit	Tendered by
1	Post-Mortem Examination Certificate - 16/3/95	Mr W Isdale
2	Post-Mortem Examination Report - 16/3/95	"
3	State Analyst Certificate - 9th May 1995	"
4	Statement of Constable Moreen Peever + Set of Ten (10) Black & White Photographs	"
Ex. "A" for Ident.	Photocopy of Map used in Interview with "CASEY"	"
5	REPORT - R A A SEYMOUR dated 20 October 1995	"
Ex. "B" for Ident.	Copy of CAUTION Sign	Mr R M Cooke
6	Statement of Medical Officer - Michael Robin DUGDALE	Mr W Isdale
7	Statutory Declaration of Mark STEPHENSON - 9/4/96	"
8	Record of Interview - Illona Maureen CASEY	Mr T D North
Ex. "C" for Ident.	Locality Plan - Scene of Accident 19 Level Plan - Scene of Fatal Accident - Hudson Bottom Discharge Rocflo Trucks (C5-1-231)	Mr W Isdale
9	Transcript of Interview - Anthony James WILD	"
10	Booklet - Underground Safety Instructions 1985	Mr R M Cooke
11	Photocopy of Receipt signed A J WILD	"
12	Booklet - Standard Work Procedure for Mules and Locomotives	"
13	Statement of Robin Arthur HERRINGE - 28/3/96	Mr W Isdale
14	Statement of Graham Bernard FULLER - 27/3/96	"
15	Statement of James COGHLAN - 28/3/96	"
16	Transcript of Interview - Anthony James WILD	"
17 Form. Ex "A" for Ident.	Photocopy of Map used in interview with "CASEY"	Mr W Isdale
18 Form. Ex "C" for Ident.	Locality Plan - Scene of Accident - 19th Level Plan - Scene of Fatal Accident - Hudson Bottom Discharge Rocflo Trucks (C5-1-231)	"
19	Photocopy of Employees's Training History - T D J TREVOR	Mr R M Cooke
20	Copy of Operation of the Gemco and Mancha Mules Descriptor - Trainer Module	"
21	Underground Safety Instructions 1989 - Booklet	"

	Receipt for Safety Instructions - TDJ TREVOR	
22	Underground Induction - Program Guide 1. Introduction to Working Underground 2. Personal Safety Requirements - U/grd Induction 3. Emergency Procedures - Underground Induction 4. Travelling and Communicating - U/grd Induction 5. Hazard Control - Underground Induction 6. Isolation, Lockout and Out of Service Procedures - U/grd Induction 7. Handling Materials - Underground Induction 8. Explosives Awareness - Underground Induction 9. Barring Down - Underground Induction	"
23	Copy of MEMO signed P H GOODE - March 20, 1995	"
24	Three (3) Coloured Signs	"
25	Safety Reminder (Laminated)	"
26	Set of Ten (10) Colour Photographs	"
27	Copy of Entries made in the Record Book	"
28	Investigation Report - B A RICHARDSON	Mr W Isdale
29	Form 4 - Report Concerning Death by Member of the Police Service	Warden
30	Copy of Application 1050 of 1996 Application for Declaration of Paternity by Toni Danielle GREGORY in the Supreme Court	Mr T D North
31	Skills Audit Pre-Questionnaire Tony Daniel John TREVOR - 24/3/92	"
32	Locality Plan - Scene of Accident - 19th Level Plan - Survey Office (C5-1-231) Locality Plan & Plan combined Report of P H GOODE dated March 21, 1995 Four (4) B & W Photographs Original Locality Plan & Plan combined Copies of Statements from Anthony Wild, Illona Maureen Casey & Joanne Bartholomai	Mr W Isdale
33	Colour Map General Arrangement Showing Parking and Shunting Areas for Haulage Trucks	Warden
34	Copy of Correspondence from Wardens Court dated 30 November 1995	Mr P R Little
35	Copies of Correspondence from Registrar Mount Isa	"
36	Copy of Three (3) Letters from Wardens Court Copy of Correspondence from Conroy & Conroy	Warden

Schedule "C" Findings:

We find -

Name of deceased: Tony Daniel John Trevor

Date of death: 14 march 1995

Place of death: Mount Isa base hospital

Nature of accident:

On afternoon shift 14 march 1995 Anthony Wild (Team Leader) Tony Trevor and Illona Casey proceeded to 5928 crosscut in the 059 workshop area at approximately 9-15pm. Wild reversed loco number 1783 into 5928 crosscut from the 5902 crosscut and coupled up to a rake of five trucks which were parked in the 5928 crosscut. Trevor and Casey walked from the workshop to the 5928 crosscut and Trevor proceeded down the southside of the rake to a position between the second last and third last truck. Casey walked down the north side of the rake to a position on the other side of the rake from Trevor.

Trevor disconnected the brake air line and safety chain between these two trucks. Casey then took a crow bar and unclipped the coupling between these two trucks. Wild received a signal from Trevor and after checking to see that Casey was clear he drove the loco with the first three trucks attached slowly forward for about two metres and then stopped to ensure that the trucks had parted.

Trevor and Casey climbed onto the back of the third truck.

Wild got out on the side of the loco and looked back over the trucks waiting for their signal. When Wild received their signal he moved the loco slowly forward to take the three trucks around to the east side of the workshop. The slow speed was necessary because of the track condition and the curve.

During this time the two trucks left behind rolled down the grade of 1 in 220 and into the back of the rake. Casey felt something touch her lightly on the back and she took evasive action. Trevor was crushed between the truck bodies. The automatic coupling between the third and fourth truck did not engage and as the loco moved the rake forward the third truck pulled away from the fourth truck and the fourth and fifth trucks came to a halt.

Trevor fell off the third truck and collapsed beside the track.

Cause of death:

From the medical certificate tendered:-

1. (a) Rupture of right atrium of heart

   (b) Crush injury to thorax

Cause of accident:

We have concluded that Mr Trevor lost his life and Ms Casey was exposed to serious risk due to a failure to observe safe working practice by:

1. failing to effectively chock or prevent hudson rockflo trucks numbers 1 and 46 from rolling down a grade; and
2. positioning themselves on the outside rear of truck number 47.

We are satisfied that the three persons present, namely Messrs A. Wild, T. Trevor and I. Casey, failed to identify or recognise the hazards associated with this work. They did not use any initiative and therefore, failed to exert any corrective influence on the hazards which were present.

Major contributing factors:

We find that the instruction and training given in relation to this particular phase of their work, namely shunting operations, was inadequate and not conducive to the maintenance or provision of a safe work place and scheme of work.

We saw no evidence to support a belief that the senior members of this crew received any formal training in shunting operations. Management relied on on-the-job training whereby experienced persons passed on both good and bad habits with no follow up by supervisors, management or safety department.

The supervision of normal day to day work functions is provided by team leaders.

The role and function of this position is poorly defined with the result that the team leader is unclear of what responsibility, authority and accountability goes with this position.

We have determined that this position in it's present form contains a number of challenges namely:-

1. the employees nominate and appoint their own team leaders;
2. the position is rotated throughout the entire crew;
3. no formal supervisory or leadership training is provided;
4. team leaders have no authority in relation to work or safety matters.

Team leaders in the workshop area of 059 level have no responsibility under the *Mines Regulations Act 1985* and therefore are not accountable under the provisions of any statute governing the supervision of others.

We have concluded that the provisions of the *Mines Regulations Act 1985* in relation to section 35, Daily Supervision, have not been fully complied with in that personal supervision of all working parts of the mine is not carried out every day.

Management is therefore not aware of the methods of work or poor work practices which may be used by the employees.

We are of the opinion that management has failed to develop sound policies and management systems to effectively implement controls and follow up to ensure that people are adequately trained and that they work in accordance with the methods in which they are trained.

Schedule "D" Recommendations:

The recommendations of the reviewers are as follows:

1. The chief inspector of mines should under the provisions of Part 14.3.3 of the *Metalliferous Mining Regulations 1985* modify locomotive operator training to include the provision of an approved training scheme for shunting.
2. Management should devise and implement an effective scheme which will prevent the unplanned movement of rail mounted trucks. We are concerned that a period of thirteen months has expired since this fatality without the effective implementation of suitable chocking devises.
3. The protective cover for the dump rail wheel should be modified to prevent its use as a platform or step. The foothold that is available on the bottom frame of the truck above the dumping door should be modified to prevent its use as a foothold.
4. We are concerned about the effectiveness of responsible supervision for the working of various parts of the mine and would recommend that team leaders are appointed in accordance with the provisions of Section 34(A) and 35 of the *Mines Regulation Act 1985* and this would require instruction in their responsibility, authority and accountability.
5. We are concerned about the level of non-compliance with present regulations, mine site rules and standard work procedures. We strongly believe that management and all persons employed should comply with these rules and proceedings and work in accordance with the methods in which they were trained.
6. It is recommended that in the event of any incident resulting in injury or death to any person, members of the inspectorate exercise the provisions of section 25 of the *Mines*

Regulation Act 1964..

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.

18 April 1996

Last Updated 21 October 2007
