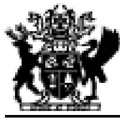

Queensland Government Department of Natural Resources and Mines

Alan MORGAN

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 Alan Morgan at Oaky Creek No1 mine, Isa Lease on 19 september 1996 warden's court 25-27 march 1997

Before: Mr Alec Jolliffe CHILCOTT esquire acting Warden

Reviewers:

- Mr Robert Francis PEARSON
  Mr Christopher John GLAZBROOK
  Mr John Patrick BRADY
  Mr Rodney Errol WOODS

To assist:

Mr John William SMITH, mechanical inspector of coal mines assisted by Mr Frederick Barrie BIGGAM for Department of Mines & Energy.

Appearances:

- Mr Larry Reginald PROFFITT appears for Mrs Caran Morgan, next of kin. (Mrs Caran Morgan in person).
- Mr Gregory Allan DALLISTON, CFMEU mining division.
- Mr Paul Martin Scarr, solicitor of MIM Holdings Pty Ltd, Fincoal Pty Ltd and Mr Alan L PAYNE.

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:

- John William SMITH
- Trevor GAFFEL

- Alan Leslie PAYNE
- Stephen James CLARK
- Stephen Dale RENWICK
- Glenn Angelo COPPO
- Leslie John BUNT
- Christopher Bernard BLACK
- Allen James KIRBY
- Kerry Arthur STOCKS
- Phillip Wayne SHORTEN
- Robin Graham WHITAKER
- Phillip Richard JACKSON
- Karl Jason BALLINGER
- Francis James CASEY
- John Allan SUTTON

Schedule "B" List of Exhibits

No of Exhibit	Nature of Exhibit	Tendered by
1	Form E - Post Mortem Examination	Warden
2	Letter from Robert John Shakespeare	Warden
3	Report - John William Smith	Mr.F.B.Biggam
4	Neutral Start Valve Hose	``
5	Engine Air Filter	``
6	Five (5) Brake Discs	``
7	Springs	``
8	Brake Test Certificate Tag (Green)	``
9	Orbital Valve & Steering Column Bearing	``
10	Set of Colour Photographs	Mr F.B. Biggam
		Mr G.A.Dalliston
11	Interview of Trevor Gaffel	Mr J.W.Smith
12	Statement of Trevor Gaffel (dated 21 March 1997)	Mr P.M. Scarr

13	Brief of Documents for Reviewers	``
14	Diagram - MPV Vehicle Dash Board	Mr J.W.Smith
15	Fitters Daily Report - Oaky Creek - 18 June 1996 (Day Shift Crew A)	Mr G.A. Dalliston
16	Fitters Daily Report - Oaky Creek - 19 June 1996 (Day Shift Crew A)	Mr P.M. Scarr
17	Fitters Daily Reports - Oaky Creek	``
	(A) 28 June 1996 - Afternoon Shift - Crew A	
	(B) 29 June 1996 - Day Shift - Crew C	
	(C) 1 July 1996 - Night Shift - Crew A	
18	Report of Alan Leslie PAYNE	Mr J.W.Smith
19	Report for Lighting Survey Oaky Creek Coal Pty Ltd	``
20	Report of Stephen James Clark	``
21	Statement of Stephen Dale Renwick	``
22	Statement of Glenn Angelo Coppo	``
23	Statement of Leslie John Bunt	``
24	Statement of Christopher Bernard Black	Mr.J.W.Smith
25	Statement of Robert John Shakespeare	``
26	Statement of Allen James Kirby	``
27	Statement of Kerry Arthur Stocks	``
28	Statement of Phillip Wayne Shorten	``

29	Statement of Robin Graham Whitaker	``
30	Minuts of Toolbox Meetings 29/6/95,6/11/95,18/12/95,11/3/96,3/5/96	Mr G.A.Dalliston
31	Statement of Phillip Richard Jackson	Mr J.W.Smith
32	Statement of Karl Jason Ballinger	``
33	Statement of Francis James Casey	Mr P.M. Scarr
34	Lighting Survey 24 March 1997	``
35	Statement of John Allan Sutton	``

Schedule "C" Findings:

Warden:

The reviewers have considered the evidence tendered to the court over the last two days and i am authorised by them to read out their findings as to the nature and cause of the accident and their recommendation:

We the reviewers selected by the warden for the purpose of this inquiry find as follows:

We find -

Name of deceased: Aan Morgan

Date of death: 19 september 1996

Place of death: Tieri

Nature of accident:

On the afternoon shift of 19 september 1996, Mr Alan Morgan lost his life on the surface of the Oaky Creek No 1 underground mine.

Mr. Morgan's body was discovered in about 1.6 metres of water and at the bottom of the mine waste water lagoon, in close proximity to or partly under the partly submerged Noyes (boart longyear) multi purpose vehicle, serial number 186, mine unit number MV03.

During the shift of 19 september 1996, Mr. Morgan was assigned various tasks which entailed the operation of diesel vehicles both underground as well as surface.

At about 7-00pm. Mr C. Black, controller, asked him to replace the soluble oil tank (tellina) with a full pod located near the main drift conveyor.

Mr. Morgan was transported up the ramp to the running shed to collect MVO3 by Mr. S. Clark, a mechanical fitter. Clark left Mr. Morgan at about 7-30pm and Mr. Morgan was apparently not seen alive again by any person.

We are of the opinion that Mr. Morgan drove back down the ramp and proceeded along the access road adjacent to the toe of the low wall and towards the underground stone and rubbish dump with, what we believe, the intention of dropping the materials pod attached to MVO3, adjacent to the detachable implements for eimcos, myne dozer and multi purpose vehicles.

We believe that Mr. Morgan had travelled about one kilometre, down the ramp and an access road located within 25 metres of the portal complex in which a number of people were known to be present.

There was no evidence to suggest that any person heard or saw Mr. Morgan pass this area as he proceeded towards the lay down area.

At some stage after 7-30pm, crew members started to query the whereabouts of Alan Morgan. After checking the running shed area, the main workshop and the emulsion tank on the offside of the surface transfer belt, a search of the underground portal area was initiated. Fitter Steve Clark and miner Neil Smith were involved in the initial search of the running shed area, workshop and emulsion tank. Deputy Glenn Coppo and control officer Chris Black became involved in the search of the underground portal area with Steve Clark and Neil Smith.

At approximately 9-20pm fitter Steve Clark noticed an MPV in the lagoon, at a point between the pontoon and the longwall emulsion shed. Immediate rescue was started, the protection services officer (PSO) and open cut mines rescue summoned and recovery initiated. At approximately 9-45pm Alan Morgan's body was recovered via the lagoon pontoon. The PSO

Allen Kirby then transported the body under doctor Edward Foley's instructions to Tieri then Emerald hospital.

Cause of death:

From the medical certificate tendered

1.(a) Asphyxiation (under water)

Cause of accident:

We have concluded that Mr. Morgan lost his life due to the substandard condition of the workplace in that:

1. The existing rill adjacent to the edge of the excavation at the site of the accident, was of insufficient height to prevent the multi purpose vehicle, MVO3, from being driven or proceeding over the edge of the excavation.
2. There was inadequate lighting to provide a clear definition of the edge of the excavation.

Other observations:

1. We believe that the substandard condition of the lay down and vehicle parking area with respect to:
    - The absence of an adequate berm or barrier designed to prevent vehicle runaways into the mine waste water lagoon.
    - The poorly defined edge of the excavation which forms the lagoon.
    - Inadequate lighting on the portal side of the tellina tanks.
    - Absence of lighting in the equipment lay down area on the dump side of the longwall emulsion shed;

    has until some months prior to the accident, existed for many years without the serious potential hazards associated with this area being recognised by:

- Senior Company Officials;
- Statutory Officials;
- Occupational Health and Safety Officers;
- Other employees at the mine;
- Union Safety Inspectors;
- Department of Mines Inspectors;

with the result that no corrective action was taken to remove these hazards prior to the death of Mr. Alan Morgan.

Evidence was presented to the Inquiry which strongly suggests that some employees raised the issue of poor lighting, however, we were not convinced that timely corrective action was taken.

The issue of a safety berm which was to prevent vehicle runaways into the lagoon was raised by the Underground Safety Advisor during May 1996, however, any action taken was inadequate.

1. Considerable evidence was presented to this Inquiry which would indicate that the maintenance of MVO3 was below standard.
2. Some attempt had been made to define the edge using white PVC pipes as guideposts, however, the plans provided to this inquiry indicate that these markers were spaced nine (9) to fifteen (15) metres apart.

Schedule "D" Recommendations:

The recommendations of the reviewers are as follows:

1. Every excavation in a mine whether at the surface or underground shall be securely protected by an adequate barrier and made safe for persons and equipment working in the area.
2. The chief inspector of coal mines vary, under the provisions of part 16.1 of the general rules for underground coal mines, part 16.3 of the said rules to include areas where bulky materials, equipment or implements are stored, with a view to providing good visibility in areas of vehicle activity.
3. A precise, practical and appropriate bake testing procedure shall be developed and implemented within a reasonable time period. This procedure shall include clear, pass/fail criteria and the provision for the training and accreditation of testing personnel.
4. That the chief inspector of coal mines establish an industry task group to investigate and develop guidelines for free steered vehicles, to include worlds best practice in:
    - Ergonomic design principles;
    - Maintenance, examination and testing;
    - Operating controls;
    - Operator security.
5. That a system be implemented as soon as practicable, whereby it is ensured, that all relevant notices, directions, or memoranda, be brought to the attention of all employees, within a reasonable timeframe.
   Any such system, once devised, should ensure that all personnel acknowledge having perused such relevant documentation by the dating and signing of same, respectively.

Schedule "E" Report of the Warden:

Having delivered the findings as to the nature and cause of the accident and the recommendations, I deliver the following report:-

At a previous inquiry, I recommended that to benefit and expedite inquiries in the future, much would be gained by having proposed documentary exhibits made available to the panel, a reasonable time prior to the commencement of an inquiry.

In this instance, some documentation was supplied to the panel prior to the commencement of such inquiry. It is evident that a panel has to consume a large volume of evidence during the course of most inquiries. To this end, it would be desirable that, in future, all documentation proposed to be tendered, be supplied to the panel at least seven (7) days prior to the commencement of an inquiry, to expedite same.

The manner in which statements were taken in this inquiry was of concern to the reviewers and myself. In many instances, there were a number of persons in the same room when a witness was

being interviewed.

This process is clearly unacceptable. The number of persons in such a room should be streamlined, as a matter of commonsense.

It would also be of benefit, if the inspectorate received additional training in the manner in which statements are taken.

Statements that are tendered to a court, by any party should be sworn, for obvious reasons.

Some inquiries, in the past, have been known to take in excess of twelve (12) months to be convened after a fatality has occurred. Because of the delay involved, it is often the case that crucial witnesses are not able to be located. If a sworn statement has been taken from a prospective witness, such a statement is more beneficial and of greater weight than an unsworn statement.

In relation to exhibits 4,5,6,7 and 9 which were tendered to the inquiry, I do order that they be held in safe custody by the inspector of coal mines (mechanical) Mackay for a period of twelve (12) months and then returned to the rightful owner unless he has notice of any claim and a request to hold the exhibits for any further period.

Further, I would like to express my sincere thanks to my reviewers and my clerk for their time and efforts during this inquiry. They were required to work very lengthy hours during the course of the inquiry.

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

The inquiry is now closed.

27/03/1997

Last Updated 21 October 2007

© The State of Queensland 2013.

Great state. Great opportunity.