Glenn BURROWS

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 Glenn Burrows at Mount Isa Mines Copper Concentrator on 4 june 1996 warden's court 3-5 december 1996

Before: Mr A J Chilcott esquire acting Mining Warden

Reviewers:

- Mr John Patrick BRADY
- Mr Gregory Allan DALLISTON
- Mr William Barron ELRICK
- Mr Ben ELLIOTT

To assist:

Mr J Tate, barrister, instructed by crown solicitor on behalf of inspectorate.

Appearances:

- Mr G Gear, solicitor for next of kin, Mrs Samantha Burrows.
- Ms M Gibney, general manager MIM Legal.
- Mr R Needham, barrister instructed by LA Evans & Co for Schmider Barkly (sub-contractors).
- Mr G 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:

- Christopher Paul SKELDING
- John William HOWE
- Ian Michael ROBERTSON
- John Francis McNAMARA
- Andrew James RICHARDSON

- Kevin James HEALEY
- David Ross McKEWEN
- Kenneth William TURNER
- William James AWING
- George Bernard CRABBE
- John Joseph STABLUM
- Kenneth John NASH
- John Edwin GEDDY
- Gary Thomas GARDNER
- David Read CARR
- Eric Stewart BURTON
- John OWENS
- Peter ROHNER

Schedule "B" List of Exhibits

No of Exhibit	Nature of Exhibit	Tendered by
1	Inspector's Report - C SKELDING	Mr J Tate
2	Eleven (11) Small Colour Photographs	"
3	Set of five (5) Colour Photographs	"
4	Eleven (11) Large Colour Photographs	"
5	Interim Standard Company Procedure	"
6	Medical Record	"
7	Copies of Minutes - MIM	"
8	Statement of John Geddy	"
9	Statement of David Carr	"
10	Statement of Stewie Burton	"
11	Twenty Six (26) Police Photographs	"
12	Police Report (Part) Life Extinct Form 4,Form F, Form D, Deputy Coroners Report Order for Special Examination (Form 9)	"
13	Balance of Police Report	"
14	Copy of Record Book Entry - 4 June 1996	"
15	Original Report - J W HOWE (Mechanical IOM) Statements - AJ Richardson, KJ Healey, DR McKewen KW Turner, WJ Awing, GB Crabbe, JJ Stablum, KJ Nash & GT Gardner	"
16	CUCONC List of Completed Safety Jobs	Ms Gibney
17	Report from MIM to Inspector of Mines	Mr Tate
18	Original of Twenty Six (26) Police Photographs	"
19	"D" Roster Sectional Safety Meetings 14/01/96 and 04/02/96	Ms Gibney
20	Services Order S044378 20/07/96 (S. Burton) Job Number 7216 (Ken Nash) Job Number 8547 (Ken Nash)	Mr Needham

21	Work Order - Replacement Screens	Ms Gibney
22	Safety Procedures - Notice to Copper Concentrator Employees	"
23	Memorandum from Mount Isa Mines Limited (3/1/95)	"
24	Training Courses - KW Turner	Ms Gibney
25	Training Courses - G Crabbe	Ms Gibney
26 SENT TO IOM AT MOUNT ISA 28/4/97	SAA Conveyor Safety Code AS 1755-1975 SAA Code for Fixed Platforms etc. AS 1657-1985 AS Fixed Platforms etc. AS 1657-1992 SAA Loading Code AS 1170.1-1989 SAA Structural Steel Welding Code AS 1554.5-1989 SAA Structural Steel Welding Code AS 1554.4-1989 SAA Structural Steel Welding Code AS 1554.1-1991	Mr Tate
27	Interim Standard Company Procedure SCP 1405 Securing of Grid Mesh/Grating etc.	Ms Gibney
28	Training Courses - J Geddy	"
29	Wallchart - Safety Meeting Schedule	"
30	Trainees Module - Mount Isa Mines Limited Flotation Process and Control	"
31	Copper Concentrator - Morning Meeting Format	"
32	Plant Inspection Plan and Plant Audit Inspection Report (Sheets 1-9)	"
33	Training Record - Stewie Burton	"
34	Two (2) Organisation Charts	Mr Tate
35	Key issues for 1995/96 Progress made for the first half 1995/96	Ms Gibney
36	Key Safety/Hygiene Issues Safety/Hygiene Plan	"
37	Safety Audit Reports	"
38	"D" Roster Sectional Safety Meeting & Area Audit	"
39	Contributing Factors for High Potential Incidents 1991/96	"
40	Chart - ISA Process Management Framework	"
41	CSN-1557 Securing Floor Plates & Floor Gratings	"
42	Training Guidelines - Dept of Mines & Energy	Mr Tate

Schedule "C" Findings:

We find -

Name of deceased: Glenn Burrows

Date of death: 4 june 1996

Place of death: Mount Isa base hospital

Nature of accident:

Glenn Burrows was walking or standing on the flotation level western walkway in the Mount Isa Mines copper concentrator building when an unsecured grating gave way beneath him. He fell 8.25 metres to the concrete floor below, possibly striking a floor joist and pipe in the process.

The injured person was found first by Schmider Barkly Engineering employee Jeffrey Andrew Lane who heard a loud bang and went to investigate. He found the injured person and having little or no first aid training himself summoned Mount Isa Mines Limited shift supervisor John Francis McNamara to assist.

The Mount Isa Mines Limited ambulance and the Queensland ambulance service arrived shortly afterwards and the injured person was transferred to Mount Isa base hospital where he died as a result of his injuries the same day, 4 june 1996.

Cause of death:

From the medical certificate tendered:-

1(a) severe multiple skull fractures & head injuries

Cause of accident:

We have concluded that Mr Burrows lost his life due to the substandard condition of the walkway, in that a mesh floor plate was not securely fixed in accordance with reasonable engineering standards and practice and the requirements of Australian Standard 1657 which states; amongst other things,

"Boards and plates shall be securely fixed to the supporting structure and shall not rely on adjacent sections of flooring for the prevention of lateral movement. They shall be fixed so that the removal of any section of flooring will not affect the security of the remaining sections.

All floors should be evenly laid, and variation in height between adjacent boards or plates which could form a tripping hazard shall be avoided".

Major contributing factors:

We were unable to determine when the western side stairway was removed and the stairwell covered by mesh grating. It is probable that this activity took place in about 1988.

At this time the stairwell grates were not securely fixed to the supporting beams.

It would appear that there were no safe work procedures in place to perform this task or to monitor the satisfactory completion of that work.

In addition to this, workplace inspections and safety audits conducted on an `adhoc' basis failed to detect this potential hazard.

The poor condition of the floor on the entire western side of the copper concentrator was raised at a safety meeting in april 1996 and we are of the opinion that had a detailed inspection been carried out at this time, the unsecured floor plates may have been discovered and correction action taken.

No evidence was presented to indicate that supervisors and employees have received training in hazard identification and formal auditing procedures.

Schedule "D" Recommendations:

The recommendations of the reviewers are as follows:

Safe work procedures should be developed and implemented with input from and in co-operation with a vertical cross section of the workforce affected by and competent in the work to be performed.

Safe work procedures should include audit mechanisms.

Company safety management systems be expanded to include training for a wide cross section of the workforce in relation to hazard identification and risk management.

That a specific training module on hazard identification be included in the induction and refresher training for all employees.

A means of tracking work carried out on items of equipment or delineated areas of structures be instituted.

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 procedures and work in accordance with the methods in which they were trained.

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:-

It has become evident to the panel during this inquiry that to benefit and expedite inquiries in future, there would be much to be gained by having proposed documentary exhibits made available to the panel, a reasonable time prior to the commencement of an inquiry.

We acknowledge that the evidence at this inquiry has revealed that since the fatal accident to Mr Burrows, the company has taken some steps to prevent a re-occurrence of an accident of this nature.

In addition, an inquiry which I headed approximately twelve (12) months ago at this centre was critical amongst other matters of the inspectorate and the standard of the report submitted. I would add that Mr Skelding was not the inspector involved in that report.

This panel commends Mr Skelding for the professional and timely manner in which he has compiled his report in relation to this inquiry. Indeed we consider his report to be of a high standard.

I would like to express my sincere thanks to my reviewers and my clerk for their time and efforts during this inquiry.

In conclusion, I concur with the findings and recommendations of the reviewers as to the nature and cause of the accident. The inquiry is now closed.

5 december 1996

Last Updated 21 October 2007

Great state. Great opportunity.