Wayne Anthony Corry JACKSON

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 Wayne Anthony Corry Jackson at Mount Isa Mines Limited Lead mine 17 level on 6 october 1996 warden's court 17-18 june 1997

Before: Mr F W Windridge esquire Warden

Reviewers:

- Mr John Patrick BRADY
- Mr Gregory Allan DALLISTON
- Mr William Barron ELRICK
- Mr Trevor John HOOD

To assist:

Mr John TATE, barrister, crown law office.

Appearances:

- Mr G B Fill, solicitor of Messrs Conroy & Conroy, solicitors for mother of deceased, Robin Patricia Charles.
- Mr G Mousley, district workers representative and for father of deceased, Corry Hartley Jackson.
- Mr N O'Connor, solicitor of MIM Holdings for Mount Isa Mines Limited and Mr A McIlwain.
- Mr G Gear, solicitor of Messrs Gary Gear & Associates for Brian Anthony Marshall.

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 HOWE

- Gavin Lloyd EVANS
- Pekka TUPPURAINEN
- Brian Anthony MARSHALL
- Gregory Paul HOWARTH
- Alan James RUSSELL
- Douglas FLEMING
- Kerry George Christopher PEUT
- Andrew Ivor Bruce McILWAIN

Schedule "B" List of Exhibits

No ofExhibit	Nature of Exhibit	Tendered by
1	Preliminary Report - John William Howe	Mr J Tate
2	Report - John William Howe (dated 21/3/97)	"
3	Folio of Photographs	"
4(a) (b) (c) (d)	Post-Mortem Examination Certificate (Form E) Post-Mortem Examination Report (Form 10) Certified Copy of Death Certificate State Analyst Certificate	"
5	Exhibit Summary - Pages 3,4 & 5	"
6	"DOCUMENTS TO BE REFERRED TO.." - Small Book	Mr N O'Connor
7	Plan - Cross Section of Bench	Mr J Tate
8(a) (b)	Plan of Bench Brow Reconstruction of EIMCO on Bench Brow	"
9	Statement of Gavin Lloyd Evans	"
10	Statement of Pekka Tuppurainen	"
11	Statement of Brian Anthony Marshall	"
12	Statement of Gregory Paul Howarth	"
13	Statement of Alan James Russell	"
14	Diagram Marked "A"	"
15	Statement of Douglas Fleming	"
16	Isafety - Daily Safety Check form	"
17	Statement of Kerry George Christopher Peut	"
18	Report of Lead Mine Manager - Andrew Ivor Bruce McIlwain	"

Schedule "C" Findings:

We find -

Name of deceased: Wayne Anthony Corry Jackson

Date of death: 6 october 1996

Place of death: 17d sub-level of the 16d8 stope in the Mount Isa Lead mine

Nature of accident:

On sunday 6 october 1996 Mr Wayne Anthony Corry Jackson, backfill mucker, sustained fatal injuries after the EIMCO 913 LHD mucking unit number 2510 he was operating on the 16D8 bench on 17E sub-level fell fifteen (15) metres into the stope to 17D sub-level of the lead mine, area 2 Mount Isa Mines.

Cause of death:

Severe penetrating/crush injury to upper chest with transection of thoracic spine.

Cause of accident:

At about 9.15 pm on 6 october 1996 Mr. Jackson was given instructions by supervisor Marshall to push off the loose material on 16D8 - 17E sub-level in preparation for the erection of a stop log.

The assigned task was covered by a M.I.M. work instruction dated 31 october 1995. No evidence was presented to the inquiry to show that this work instruction was passed on to Mr. Jackson either orally or in written form at the time of being given this task.

Mr. Jackson was last sighted at about 10.30 pm by Mr. Tuppurainen who was delivering timberman equipment (bricks). Mr. Tuppurainen gave evidence to indicate that Mr. Jackson was standing on the bench of 16D8 - 17E sub-level in front of EIMCO 913.

It appears from the evidence produced that whilst pushing the loose material from along the footwall side of the floor toward the void that Jackson inadvertently assumed a ledge left on the footwall side of the void was a continuation of the floor. Visibility on the EIMCO unit is limited. The driver is seated on the left hand side facing inwards towards the unit. Line of sight is forward and backwards along the left hand side. Little, if any, visibility is available on the right side of the unit. Jackson continued pushing until the unit was exposed over the void causing the machine to rotate in both vertical and horizontal planes.

There was no evidence produced to show that the brow of the void was unstable nor was there any mechanical failure of the EIMCO 913 unit number 2510.

Major contributing factors:

A second competent person was not deployed to the task of either assisting Mr. Jackson to mark up, or set up a strobe light as required by the standard work procedure MIM 0211 or to act as a spotter in accordance with the provisions of *Metalliferous Mining Regulation 1985 Part 7.15*.

Mr. Jackson being aware of these procedures did not find cause to take the necessary precaution to ensure his own safety by observing the requirements of the standard work procedures MIM 0211.

The evidence before us would strongly suggest that there was lack of effective control which would have prevented or at least minimised substandard practice, conditions, and human error and the realisation of the hazard associated with the task of removing the muck from the floor of the 16D8 bench on 17E sub-level prior to the erection of a stoplog.

Schedule "D" Recommendations:

The recommendations of the reviewers are as follows:

Where a vertical edge will be used as a backfill/tipping location, a stop log should be constructed in accordance with a procedure developed using a recognised risk management process.

Backfilling and tipping into stopes is to be carried out by competent personnel only and in accordance with the procedure developed by the above process.

Supervisors allocating tasks should ensure that those carrying out the tasks are fully aware of the risks involved, have the correct equipment and are aware of the correct procedures to carry out the task.

Supervisors must frequently audit use of correct equipment and procedures and must take appropriate action when non-compliance is observed.

Communications between management and employees must be improved to ensure that the commitment to and understanding of safe operations is mutual. It is recommended that a working group consisting of a cross section of all levels of employees be established to identify barriers to

effective communications and determine means of removing these barriers.

1. Current redrafting of standard work instructions should continue.
2. Formal auditing procedures should be implemented to ensure that the standard work instructions are soundly established, maintained and observed.

Schedule "E" Report of the Warden:

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

I thank inspector Howe for his report, and Mr. Tate for his assistance during this inquiry. I thank the reviewers for their participation and assistance during this inquiry.

As I indicated to you at the commencement of these proceedings, until my staffing resources are increased, only an uncorrected and uncertified transcript will be available to the parties. It is also highly probable that for the same reason, no further inquiries will be conducted at Mount Isa during 1997.

The inquiry is now closed.

18 june 1997

Last Updated 21 October 2007
