John Charles BARBER

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 John Charles Barber at Deep Copper mine, Mt Isa on 4 june 1997

Warden's court 2-5 february 1998

Before: Mr F W Windridge esquire Warden

Reviewers:

- Mr John Patrick Brady
- Mr Simon Thompson
- Mr Ian Brown
- Mr Matthew Best

To assist:

Ms Margaret Maloney, barrister instructed by crown solicitors office for inspectorate

Appearances:

- Mr S Yates, district workers representative
- Mr N M O'Connor, Solicitor for Mount Isa Mines Limited and mine manager, Mr T Cooney
- Mr R Douglas, barrister instructed by V R Moffat and Associates solicitors for next of kin, Mrs L Barber
- Mr Gary Gear, Gary Gear & Associates solicitors, solicitor for Robert Allen Baird

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:

- Senior Constable Dennis Martin Murphy

- Raymond Anthony Alex Seymour
- Trevor Farnell
- John William Howe
- Raymond John McGill
- Robert Allen Baird
- Ronald George MacKenzie
- Christopher Brendan Murphy
- Gerhard Magar
- Colin George Butterworth
- Allen Henry Williams
- Thomas Gregory Cooney

Schedule "B" List of Exhibits

No of Exhibit	Nature of Exhibit	Tendered by
1	Statement of Mr D Cameron	Ms Maloney
2	Statement of Mr R Pippenbacher	"
3	Statement of Senior Constable D M Murphy	"
4	Police Photographs (1 - 39)	"
5	Video of Police Accident Investigation	"
6	Form 10 - Post Mortem Examination Report	"
7	Form E - Post Mortem Examination Certificate	"
8	Form 4 - Report Concerning Death By Member of the Police Service	"
9	Form 9 - Order for Special Examination	"
10	Notes taken by Senior Constable D M Murphy	Mr N M O'Connor
11	Original Report by Inspector of Mines	Ms M Maloney
11A	Interim Report by Inspector of Mines	"
12	Photographs taken by Inspector of Mines (1-15)	"
13	Risk Analysis Report - Deep Copper Mine - 17 April 1997	Mr N M O'Connor
14	Plan of Design Approval - Level 24A	"
15	Report of Mr Trevor Farnell - Hastings Deering	Ms M Maloney
16	Result of Analysis - Oil Test	"
17	Report on mechanical aspects of Elphinstone Unit - Mechanical Inspector of Mines	"
18	Photographs taken by Mechanical Inspector of Mines - John Howe (1-37)	"
19	Elphinstone R2800 Specifications	"
20	Original Statement of Raymond John McGill	"
21	MIM Statements of Raymond John McGill dated 6 and 13 June 1997	"
22	Statement of Robert Allen Baird dated 6 June 1997	"
23	MIM Statement of Robert Allen Baird dated 5 June 1997	"
24	MIM Statement of Robert Allen Baird dated 13 June 1997	"
25	MIM Statement of Robert Allen Baird dated 18 June 1997	"
26	Statement of Leslie James Wylie	"

27	MIM Statement of Ronald George MacKenzie dated 6 June 1997	"
28	Statement of Ronald George MacKenzie dated 30 June 1997	"
29	Statement of Christopher Brendan Murphy	"
30	Statement of Gerhard Magar	"
31	MIM Standard Work Instruction - 323701 - Cleaning a Stope/Vertical Edge	Mr R J Douglas
32	MIM Standard Work Instruction - 324111 - Construction of a Stop Log at Stope Edge	"
33	Statement of Colin George Butterworth	Ms M Maloney
34	MIM statements of Allen Henry Williams dated 6 and 23 June 1997	"
35	Mine Manager's Report	Mr N M O'Connor
36	Risk Assessment - Vertical Openings	"

Schedule "C" Findings:

We find -

Name of deceased: John Charles Barber

Date of death: 4 june 1997

Place of death: 26 level, Deep Copper mine, Mt Isa

Cause of death: From the medical certificate tendered:-

1. (a) Partial decapitation

Nature of accident:

John Charles Barber sustained fatal injuries at about 17:50 on 4 june 1997, when the Elphinstone R2800 load haul dump (LHD), unit No 1884, which he was operating, entered the open Q621 Stope in the Deep Copper mine section of the Isa Mine. At the time of the accident he was cleaning up in the Q621 access and drill drives on 24A sub-level and appears to have reversed the LHD into the stope. The unit fell about 125 metres to the bottom of the stope on 26 Level.

There were no witnesses to the accident.

Cause of accident:

At about 16:30 on 4 june 1997, Mr Barber was instructed to clean up the Q621 access and drill drives on the 24A sub-level in preparation for the installation of a bulkhead. These instructions were issued by Mr Robert Allan Baird, shift supervisor and Mr Raymond John McGill, shift supervisor - production support.

We are satisfied that Mr Barber was given verbal instructions and shown an A4 design drawing of the existing and proposed bulkhead locations.

The quality of the task instruction and the design drawing could have created confusion as to the nature and location of the work required.

Mr Baird had not inspected the site at 24A sub-level Q621 access or drill drives. Mr McGill had visited the site earlier in the day but did not conduct a detailed inspection.

From the evidence we have concluded that Mr Barber had cleaned the floor in the Q621 access

drive and had cleaned some rubble from the floor of the Q621 drill drive. It would appear that after tramming and dumping several loads into the Q616 truck tipple Mr Barber reversed the Elphinstone R2800 LHD into the drill drive and towards the open stope in order to clean up the remaining rubble in the drill drive.

There was no physical barrier that could have prevented the LHD from entering the open stope. It appears that on the final tram Mr Barber reversed into the open stope.

MAJOR CONTRIBUTING FACTORS:

From the evidence it would appear that Mr Barber did not adequately assess the risk of working so close to an open stope.

The visibility afforded to the operator of an Elphinstone R2800 LHD is limited in this application.

The stope edge was not illuminated by equipment or other lighting.

The supervision was less than adequate in that:-

- Detailed inspections of the work site had not been carried out prior to issuing the task instructions;
- There was no check of work in progress;
- Mr Barber was not given any written instructions or a copy of the design drawing;
- The location of the proposed new bulkhead was not marked on the back or the walls of the drive.

It is likely that Mr Barber was confused as to the exact location of the proposed bulkhead and therefore cleaned up the entire floor area.

We accept that the mechanical condition of the unit was satisfactory given the age of the machine. However, we are unable to say if the oil leaks and pools of oil near the stope edge are associated with any undetected mechanical failure.

Schedule "D" Recommendations:

The recommendations of the reviewers are as follows:

(1) Physical Barriers

Substantial physical structures or barriers should be installed, to prevent mobile equipment falling into open stopes or hazardous openings.

(2) Job Instruction

A formal task or job instruction process should be implemented for work in hazardous areas, for example within 20 metres of open stopes.

This instruction should include an easily understandable and up-to-date plan or job sketch which clearly shows the location and job specifications. The original job instruction should be maintained by the supervisor and a copy issued to the employee.

(3) Job Inspection

All jobs in hazardous areas should be inspected by the supervisor prior to the issuing of a job instruction. This inspection should include an assessment of the likely hazards and how these hazards are to be controlled.

(4) Hazard Assessment

Management should actively promote and enforce the need to formerly assess hazards at the commencement of every new job and provide employees with appropriate training to enable them to identify and assess such hazards.

Once trained, employees should undertake thorough and ongoing checks of their workplace and

equipment to identify potential hazards and implement appropriate controls.

(5) Competency of Supervisors

Management should implement a formal process to ensure the ability of supervisors to competently undertake their duties.

(6) Visibility around Hazardous Openings

Wherever possible suitable lighting should be installed to effectively illuminate the edge of hazardous openings.

Where mobile equipment is to operate in the vicinity of hazardous openings the selection of equipment should include consideration of both operator visibility and equipment lighting.

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 Ms Maloney and all who appeared before the inquiry for their assistance. I thank the reviewers for their participation and assistance.

This inquiry is now closed.

05/02/1998

Last Updated 21 October 2007
