

Queensland Government Department of Natural Resources and Mines

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Scott Robert JOHNSTON

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 Scott Robert Johnston at Enterprise mine on 23 november 1998

Warden's court of Queensland 24-27 may 1999

Before: Mr F W Windridge esquire Warden

Reviewers:

- Mr J P Brady
- Mr R Perry
- Mr P Henley
- Mr W B Elrick

To assist:

Mr J Tate, instructed by crown law office, with him MS D Silvester

Appearances:

- MR S Reidy, Solicitor of Messrs Reidy & Tonkin for next of kin
- MR P Hastie, instructed by Minter Ellison for Byrnecut RUC & Contractors
- MR N O'Connor, legal officer, Mt Isa Mines Limited
- MR S Yates, 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:

Day One

- Christopher Paul SKELDING
- Brian Douglas OATS

Dat Two

- Sergeant Darren Martin MURPHY (T'phone Evidence)
- Simon Leigh DORWARD
- Martin George AGNEW
- Thomas Frederick NEUHOLD
- Terence Raymond HAMMOND
- David Bruce BROWN
- William Rogers BLAKE
- Alan Mark ROWELL

Day Three

- Doctor Jeremy Steven HAYLLAR
- Professor Olaf H DRUMMER (Telephone Evidence)
- Derrick John BRAKE
- Christopher Paul SKELDING, recalled
- Phillip Howard GOODE

Schedule "B" List of Exhibits

No of Exhibit	Nature of Exhibit	Tendered by
1	Preliminary Report To The Chief Inspector of Mines - Investigating Officer Chris Skelding	Mr J Tate
2	Report to The Chief Inspector of Mines - Investigating Officer Chris Skelding	n
3	Colour Photographs "A" "B" "C" and Overhead Projections	n
4	Sixteen (16) Colour Photographs	п
5(A) 5(B)	Statement of Joseph Patrick Latham Statement of Christopher John Corbett	п
6	Book of Documents	Mr N O'Connor
7	Statement of Brian Douglas Oats dated 24/11/98	Ms D Silvester
8	Statement of Brian Douglas Oats dated 24 November 1998	n
9	Statement of Brian Douglas Oats dated 18 May 1999	Π

)/2014 I	Scott Robert JOHNSTON Mining and safety Queensland Government	
10	Police File - S R Johnston	Mr T Tate
11	Coroner's File - S R Johnston	Π
12	Video Cassette - Accident Scene	Π
13	Police Photographs (20)	Π
14	Statement of Simon Leigh Dorward dated 24/11/98	Ms Silvester
15	Statement of Simon Leigh Dorward dated 24 November 1998	n
16	Supplementary Statement of Simon Leigh Dorward dated 12/5/99	n
17	Statement of Martin George Agnew dated 24/11/98	n
18	Statement of Martin George Agnew dated 24/11/98	Ms D Silvester
19	Statement of Thomas Frederick Neuhold dated 24/11/98	Π
20	Statement of Thomas Frederick Neuhold dated 24/11/98	n
21	Statement of Thomas Frederick Neuhold dated 17/5/99	n .
22	Statement of Terence Raymond Hammond dated 24/11/98	"
23	Statement of Terence Raymond Hammond dated 2/2/99	
24	Statement of Terence Raymond Hammond dated 24/11/98	"
25	Statement of David Bruce Brown dated 3/12/98	"
26	Statement of William Rogers Blake dated 24/11/98	
27	Statement of Alan Mark Rowell dated 1/12/98	
28	Revised State Analyst Certificate dated 25/5/99	Mr J Tate
29	Statutory Declaration of Margaret Clare Woolcock dated 26/5/99	
30	Evaluation of Ethanol Concentrations in Decomposed Bodies (R W Zumwalt) Experimental Studies on the Mechanism of Ethanol Formation in Corpses (R	,

2/10/2	2014	Scott Robert JOHNSTON Mining and safety Queensland Government	
		Nanikawa, F Moriya and Y Hashimoto) A Review - Possible Sources of Ethanol Ante- and Post-mortem: its Relationship to the Biochemistry and Microbiology of Decomposition (Janet E L Corry)	
3	31	The blood alcohol curve and units of measurement	"
3	32	Curriculum Vitae - Professor Olaf H Drummer	Mr P Hastie
3	33	Report of Professor Olaf H Drummer dated May 14, 1999	Π
3	34	Statement of Derrick John Brake	Mr N O'Connor
3	35	Original Report of Registered Mine Manager - P H Goode	Π
3	86	Enlarged Colour Photographs	Ms D Silvester

Schedule "C" Findings:

We find -

Name of deceased:	Scott Robert Johnston
Date of fatal injury:	23 novemeber 1998
Place of accident:	M62 shaft 30B sub level Enterprise mine, Mount Isa, Queensland

Cause of death:

As per medical evidence tendered -

1(a) Rupture of left ventricle

1(b) Blunt chest trauma

Nature of accident:

On the day shift of monday, 23 November 1998, Scott Robert Johnston and four other miners performed normal drill and blast cycles of the M62 shaft approximately 532 metres below 20 level. After crib, the crew went to the bottom deck of the stage and commenced to bar down.

At about 1415 hours Scott Robert Johnston fell from the stage 6 metres onto the rill of the broken muck sitting on the bench and then fell a further 29 metres onto a muck pile at the bottom of the pilot raise at the 30B sub level. The injuries sustained were fatal.

Cause of accident:

From the evidence that we have heard, given that there was no actual eye witness, we are of the opinion:-

Mr Johnston was scaling the sides of the shaft on the north-eastern side of the lower deck of the shaft sinking stage just prior to the accident.

The stage was stationary at the time of the accident.

The nature of the work and the overbreak at this particular point meant that Mr Johnston could use a 1.8 metre scaling bar and effectively perform the task without the need to lean out or climb

over the railing.

While it is possible that Mr Johnston fell outside the stage, which had a conforming safety rail, it is more likely that Mr Johnston fell inwards through the kibble hole where the top section of the safety rail was missing.

The fact that Mr Johnston was not using a harness and lanyard and the limited floor space in this area, greatly increased the risk associated with the task.

Schedule "D" Recommendations:

The recommendations of the reviewers are as follows:

Similar tasks or any other task where there is an unacceptable risk of serious bodily injury or death must be addressed by a hazard management plan, developed and implemented in accordance with AS/NZS 4360:1995; Risk Management.

The chief inspector of mines encourage the establishment of an industry work group to develop generic guidelines for safe shaft sinking operations.

The chief inspector of mines in association with the mining warden develop generic guidelines for the investigation of serious mine accidents.

Schedule "E" Report of the Warden:

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

I do not intend to initiate any action under Section 45 of the Mines Regulation Act 1964.

There appears to have been some delay in notification of the accident to the next of kin. It is to be hoped that the mine owners, contractors and the police department will refine their procedures on this point and arrange for the appropriate person or authority to attend to the notification aspect as soon as possible after the accident.

I thank inspector Skelding for his report, and Mr Goode, the mine manager for his report.

I thank Mr Tate and Ms Silvester, and all those who have appeared at the bar table and participated in these proceedings for their assistance.

I thank the reviewers for their interest and assistance in the performance of their duties as required by Section 42 of the *Mines Regulation Act*.

The inquiry is closed.

27 may 1999

Last Updated 20 October 2007

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Great state. Great opportunity.