Brant NORTH

Findings and Recommendations

[Schedule A] [Schedule B] [Schedule C] [Schedule D] [Schedule E]

The *Coal Mining Act 1925* -

Findings and recommendations of reviewers and mining warden following an inquiry into serious injuries received by Brant North at Oaky Creek No1 mine, on 20 january 1999 Warden's Court of Queensland.

Before: Mr F W Windridge, esquire mining warden

Reviewers:

- Mr J P Brady
- Mr C Glazbrook
- Mr R Woods
- Mr L Anderson

To assist:

Mr W Isdale (instructed by crown law office) on behalf of the mines inspectorate and counsel assisting

Appearances:

- MR G Dalliston on behalf of the Construction Forestry Mining and Energy Union
- MR A S Mellick (instructed by Rees R & Sydney Jones) for
- Mr Brant North
- MR J E Murdoch (instructed by MIM Legal Department) for Oaky Creek Coal Pty Limited and Mt Isa Mines Limited and for the registered mine manager, Murray Wood, and for the undermanager, Mr Don Foster
- MR G C Paterson (of Messrs Macrossan & Amiet) on behalf of REB Engineering and Adam Clarke

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 - Tuesday, 26 october 1999

- Michael CAFFERY

Day Two - Wednesday, 27 october 1999

- Michael CAFFERY (Continuing)
- Thomas McDONALD
- Adam Michael CLARKE
- Leslie John BUNT
- Peter James McPHAIL
- Lesley STELLING
- Tony Melville GOODWIN
- Michael George DARMODY

Day Three - Thursday, 28 october 1999

- Les PARKER
- Greg BURGESS
- Don FOSTER
- Brant NORTH
- Murray WOOD

Schedule "B" List of Exhibits

No of Exhibit	Nature of Exhibit	Tendered by
1	Letter from Tony McGrady Requesting Inquiry	Warden
2	Interview of 14 July 1999 between Warden and Tony McGrady	Warden
3	HANSARD p.369, 370 of 12 October 1999	Warden
4	Copy of Investigation Report - Michael Caffery	Mr Isdale
5	Video Prepared by Michael Caffery	Mr Isdale
6	Lost Time & Fatal Injuries - Qld Government Statistical Report	Mr Isdale
7	Audit Report and Response from Mine Manager	Mr Isdale
8	Overview Investigation Report from Michael Caffery	Mr Isdale
9	Statement of Thomas McDonald	Mr Isdale
10	Statement of Adam Michael Clarke	Mr Isdale

11	Plan of Tailgate Drive - Oaky Creek No 1	Mr Isdale
12	Statement of Leslie John Bunt	Mr Isdale
13	Statement of Peter James McPhail	Mr Isdale
14	Statement of Lesley Stelling	Mr Isdale
15	Plan 354	Mr Isdale
16	Statement of Tony Melville Goodwin	Mr Isdale
17	Statement of Michael George Darmody	Mr Isdale
18	Supplementary Statement of Mr Les Bunt	Mr Isdale
19	Statement of Les Parker	Mr Isdale
20	Statement of Gregory Burgess	Mr Isdale
21	Diagram from Gregory Burgess	Mr Isdale
22	Statement of Donald Frederick Foster	Mr Isdale
23	Document "Underground General Familiarisation"	Mr Murdoch
24	Contractor ID Card	Mr Murdoch

Schedule "C" Findings:

We find -

Name of injured: Brant North

Date of injury: 20 january 1999

Place of accident: Oaky Creek No1 mine

Nature of accident:

On night shift of Wednesday, 20 january 1999 at approximately 0500 hours, trainee miner Brant North had both legs caught by the armoured face conveyor chain at the tailgate drive sprocket of longwall 14 at Oaky Creek No 1 mine.

Mr North and Mr Adam Clarke, a contract miner, were deployed to the task of unloading a mesh

basket of winches, placing some on the armoured face conveyor drive and the rest on the ground by the tailgate drive. After placing some winches on the armoured face conveyor tailgate drive, Mr North climbed up onto the armoured face conveyor drive to clear room for more winches.

In descending the armoured face conveyor tailgate drive, Mr North's legs were caught in the armoured face conveyor chain and a flight bar, dragging him for approximately seven metres.

Mr North was trapped for approximately 4 hours. The extent of his injuries required a surgeon to amputate both legs to free him before being transported to the surface of Oaky Creek No 1 mine and to Rockhampton hospital.

Cause of accident:

From the evidence presented to the Inquiry, we are of the opinion that -

- The normal access way to and from the tailgate end of the longwall chocks and the tailgate roadway was blocked by the positioning of the goaf flushing chains located on the tailgate side of the chock 133.
- As a result, persons accessing the tailgate face or the tailgate roadway were forced to use an alternative route.
- Mr North was exposed to unacceptable risk by remaining on top of the tailgate drive during the pre-start warning sequence and subsequent startup of the armoured face conveyor (AFC).

Major contributing factors:

The decision to install the goaf flushing chains on the tailgate side of Chock 133 was made without the benefit of a formal, comprehensive risk assessment and consequently the additional hazards created by this action were not recognised and appropriately addressed.

The tailgate drive was not isolated and it was not possible to isolate the AFC without first crossing the tailgate drive or the AFC.

Mr North and Mr Clarke, given their limited exposure to the workplace and the work to be performed, were not adequately trained and supervised.

The extent of the injuries and the duration of recovery operations were compounded by the excessive wear of the AFC flight bars and the modified cover which exposed a portion of the AFC sprocket and the lead section of the flight bar re-router channel.

There was no positive communication between the work team on the Maingate end of the face line which started the AFC and Mr North and Mr Clarke on the tailgate end of the face.

We are satisfied that no effective measure or hard barrier was in place to prevent the accident. We believe that verbally defining a work area and expecting a worker to stay within the defined area is not an effective control.

Schedule "D" Recommendations:

We acknowledge that many of the recommendations put forward by inspector Caffery have been implemented at Oaky Creek No 1 mine and we endorse the action taken to date. We endorse these recommendations for the whole of the Queensland coal industry and offer the following additional recommendations -

When there is a perceived need to modify equipment, alter the workplace or amend standard operating procedures, and such a change may impact on the health and safety of persons, a comprehensive formal risk assessment must take place.

When such a risk assessment has been undertaken, the risk treatment options must be in accordance with the hierarchy of control.

The development and implementation of an industry standard for the effective management of contract labour with particular emphasis on experience, qualifications and training.

Positive isolation for the tailgate drive be installed at a convenient and accessible location as close as possible to the nominated access path to and from the tailgate roadway.

Schedule "E" Report of the Warden:

On 20 January 1999, Mr BRANT NORTH received serious injuries whilst performing work at the tailgate of longwall panel 14 of the Oaky Creek No 1 underground mine in Central Queensland.

NO 1 underground mine is one of three mines operated by Oaky Creek Coal PTY LTD and is under the management control of Mount Isa Mines Limited. The mine has a permanent workforce of 160 employees with an additional 55 persons employed by a contractor developing a new section of the mine. The mine is served by the township of Tieri located about 13 kilometres from the mine site.

The members of the inquiry panel have conducted a site inspection. A number of witnesses have been examined over the past three days, and 24 statements and other documents have been admitted as exhibits.

Findings as to nature and cause:

The reviewers have delivered their findings as to the nature and cause of the accident. I concur with the findings. I note that the accident occurred on 20 january 1999 and the inspector's report was completed on 25 march 1999. It is a matter of regret that the Minister's desires were not made known until 14 July 1999, some six months after the accident and four months after the report was completed.

To arrange for these inquiries to be completed in a timely manner, it is essential that the warden receive a copy of the inspector's report at the earliest practicable time for the following reasons -

- The court has to schedule the inquiry to fit in with other circuit duties.
- Timely notice should be given to witnesses who may have to re-schedule work and family commitments.
- Copies of documentation must be prepared and distributed to all legal representatives.
- Dates of hearing must be arranged to suit the availability of court facilities in country centres.
- Potential witnesses may change address or employment and often move interstate, creating problems with the service of subpoenas.
- The greater the delay, the higher the chance of memory fade or memory failure.

It is a matter of regret that the Mines Inspectorate have not seen the need to advise the warden of any serious accident for a number of years. The basis of this apparent reluctance is unknown, and is not supported by any reasonable interpretation of Section 74 of the *Coal Mining Act 1925*, in my opinion. I reject the approach of the Director of Safety and Health, Mr Dent, that the warden must play "hide and seek" with him over accident reports. Such action would appear to transgress the separation of power principles. In addition, it indicates a curious attitude of the department to death and injury to miners. If there is such confidence in the competency of the accident reports and the judgment of senior and chief inspectors, why is there some apparent reluctance to produce a copy of the report in order that the warden may exercise his discretion as provided in their own legislation. Perhaps the inquiry report into the death of Kenneth SLATER, known as the Tick Hill Inquiry, is the basis of some concern. Nevertheless, I would be re-assured if the Director of Health and Safety and the Chief Inspector of Mines was to advise my office that these adverse comments in the Tick Hill report had no bearing in the practice of non-supply of reports to the Warden over the past years.

I do point out that recently some reports have been received, as referred to by Mr Dent (p369 of Hansard 12 October 1999). I reject the implicit assertion that because I have determined that inquiries will not be held into these accidents for certain reasons the action of withholding the reports is justified. It is not, and if the protocol referred to by Mr Dent breaks down (again), I will direct the Director of Health and Safety and the Chief Inspector of Mines to deliver to the office of the warden all reports in respect of serious injuries suffered by any person over the past five years, except for those recently provided.

Whilst it may be a short time before a full transcript is available, the report and recommendations will be available within a week or so on web page warden.qld.gov.au as are a number of previous inquiry results. It is planned that all reports will be available in due course for perusal and downloading. I recognise that there are some logistical problems with the distribution of results in hard copy to the industry as a whole. It is hoped that provision of the reports through the web page will assist to raise the level of awareness of inquiry reports and recommendations within all levels of the mining industry.

It has been brought to my attention that as recently as last week, Dysart Rescue Station represented by Southern Colliery Rescue team won the Australian Mines Rescue Competition at Musselbrook Dartbrook mine in New South Wales. Queensland teams came first, third, sixth and seventh out of nine teams competing. Southern Colliery team also won the trophy for the combined surface exercises. Members of this panel have some in depth experience with mines rescue and congratulate all those who participated.

In respect of this inquiry, I thank Mr Isdale for his assistance as counsel assisting. I understand that he took over the file at extremely short notice. I thank those legal representatives who appeared for various parties for their assistance during the Inquiry.

The preparation, recording, and finalisation of administration matters is a large and stressful part of the duties of Ms Susan Jayne Weller and Mr Max Parr, and I thank them for their assistance. We are also indebted to Mr Trickett, president of the land court for releasing Mr Parr, his deputy registrar, to assist at this inquiry. Ms Robyn Black at Oaky Creek No 1 assisted the inquiry by arranging the delivery of subpoenas to those witnesses employed at the mine. I thank her for that assistance.

Finally, I thank the Reviewers who assisted the inquiry, in particular, Mr John Brady who made himself available at short notice. Whilst the selection of reviewers by the warden has been the subject of some recent comment, I can assure the parties that reviewers are selected by the warden and the warden alone. I can indicate that I am entirely satisfied that all reviewers have approached their tasks and devoted themselves to their duties in an exemplary manner without fear, favor or affection. I have never doubted their commitment to the health and safety of all those employed in mines in Queensland.

The Inquiry is now closed.

29 October 1999

Last updated 20 October 2007
