

Department of Natural Resources and Mines

- Mining & safety home
- Mining, exploration & petroleum
- Geoscience & resource information
- Safety & health

<u>Mines home</u> > <u>Safety & health</u> > <u>Mining safety & health</u> > <u>Investigations, inquiries and inquests</u> > <u>Mining wardens inquiries</u> > Geoffrey Michael BARLING

Geoffrey Michael BARLING

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 serious injuries received by Geoffrey Michael Barling at Cannington mine on 27 june 1999 Warden's court of Queensland Townsville 28-30 march 2000

Before: Mr F W Windridge, esquire Mining Warden

Reviewers:

- Mr J Brady
- Mr W Elrick
- Mr P Henley
- Mr P Ball

To assist:

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

Appearances:

- MR R Traves (instructed by Allen Allen & Hemsley) for BHP Minerals Pty Ltd, the registered mine manager, Ms Julie Devine and BHP Steel (AWI) Pty Ltd
- MR C Newton (instructed by Messrs Carter Capner) for the injured person, Mr Geoffrey Michael Barling
- 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 <u>schedule "d"</u>

Report of mining warden: refer transcript and schedule "e"

Schedule "A" Witnesses examined:

Tuesday, 28 March 2000

- Robert Bruce O'SULLIVAN
- Anthony FARCICH
- Patrick Lars LARSSON
- Glen Raymond CISLOWSKI
- Simon David INGHAM
- · Geoffrey Michael BARLING
- John Ronald TOTMAN
- Graeme HAGGART
- Nigel WESTHORP
- Mark IRONSIDE
- Paul McGUCKIN
- Julie May DEVINE

Schedule "B" List of Exhibits

Exhibit No	Nature of Exhibit	Tendered By
1	Original Inspector's Report - Robert Bruce O'Sullivan	Mr J Tate
2	Sets 1, 2 & 3 of Colour Photographs	п
3	Accident Report Overview - R B O'Sullivan	п
4	Blue Back-Pack Equipment (Rescue Master System - by Moxham Industrial Pty Ltd)	
5	Bosun's Chair	"
6	Fabric Sling	п
7	Rescue Master Pulley System	п
8	Karabiner (for demonstration purposes)	
9	Mine Working Safety Belt	п
10	Waist Strap (with rope grab)	
11	Stainless Steele Key Ring (for demonstration purposes)	"
12	Identification Disk and Broken Ring	п
13	Rescue Master Portable Rescue System Manual	III

10/2014	Geottrey Michael BARLING Mining and safety Queensland Government	
14	Statement of Anthony Farcich dated 28 June 1999 Statement of Anthony Farcich dated 30 June 1999	lu .
15	Statement of Patrick Lars Larsson dated 29 June 1999	11
16	Statement of Glenn Raymond Cislowski dated 2 July 1999	"
17	Statement of Simon David Ingham dated 30 June 1999	п
18	Statement of Geoffrey Michael Barling dated 7 January 2000	"
19	Statement of John Ronald Totman dated 1 July 1999	п
20	Statement of Robert Michael Sturgeon dated 29 June 1999	"
21	Statement of Mark Derrick Prance dated 30 June 1999	"
22	Statement of Graeme Haggart dated 9 July 1999	ıı .
23	Statement of Nigel Westhorp dated 19 July 1999	"
24	Statement of Michael John Phillips dated 8 July 1999	"
25	Statement of Gary Thompson dated 9 July 1999	ıı .
26	Statement of Cameron Lee Ruddell dated 8 July 1999	ıı .
27	Statement of Wayne Michael Cordwell dated 8 July 1999	n .
28	Statement of Mark Ironside dated 19 July 1999	п
29	Statement of Paul McGuckin dated 21 July 1999	п
30	Statement of Julie May Devine dated 1 July 1999	п
31	Corrective Action Report	Mr R Traves
32(a) 32(b)	Incident Report - Cannington Mine #04259 Continuation of Incident Report - Cannington Mine #04259	Mr J Tate

Schedule "C" Findings:

We find -

Name of injured: Geoffrey Michael Barling

Date of injury: 27 june 1999

Place of accident: Cannington mine

Nature of accident:

Mr Geoffrey Michael BARLING received serious injuries at the BHP Cannington mine when he fell approximately 13 metres to the bottom of the Fowler shaft. The accident occurred at about 13.38 hours on sunday, 27 june 1999.

Immediately prior to the accident, Mr Barling was suspended in a bosun's chair in the Fowler shaft at the tail rope change area at the 629 metre level where he was attempting to gain access to the top of the cheese weights.

The work to be performed included the removal of pipes from the guide ropes attached to the cheese weights. When this was completed, the guide ropes were to be cleaned and lubricated.

Mr Barling was being supervised and assisted on this task by Mr Anthony Farcich, a person appointed under the provisions of *Section 34A* of the *Mines Regulation Act 1964* .

Immediately prior to entering the shaft, Mr Barling and Mr Farcich had inspected the area and filled in a job safe analysis (JSA) Sheet.

A new moxham rescue master portable rescue system including a bosun's chair was suspended in the shaft. This was slung from a beam in the centre of the shaft using a two metre long polyester sling.

Mr Barling had strapped himself into the bosun's chair and associated harness and lowered himself into the shaft.

After descending a short distance, he stopped to make some adjustment to the ropes when the bosun's chair parted from the rope pulley system. Mr Barling fell to the bottom of the shaft some 10 to 13 metres below and received serious injuries.

Cause of accident:

From the evidence presented to the Inquiry, we have concluded that -

- Mr Barling inadvertently attached the lower karabiner of the Moxham Rescue Master to an identification tag split ring which was located immediately adjacent to the appropriate attachment point at the top of the Bosun's chair.
- We are satisfied that the Bosun's chair was attached to the identification tag split ring which failed because it wasn't capable of supporting his weight.

Major contributing factors may include -

- Mr Barling and Mr Farcich were not trained in the use of this particular equipment.
- Mr Barling and Mr Farcich failed to recognise or address the hazards associated with the use of this equipment.
- The Bosun's chair was delivered with an identification tag and split ring located immediately adjacent to the top "D" ring attachment point.

We are satisfied that the following procedures and standards were not adhered to -

- CAN-PS-5.42 Health and safety specifications covering the introduction and use of new equipment.
- CAN-PS-2.47 Safety harness and fall arrest devices.

- CAN-SM-004 Hazard identification and JSA process.
- CAN-SM-006 Working at heights.

The registered manager of Cannington issued what we believe were clear instructions regarding the assessment of Mr Barling's competence in the use of the bosun's chair and associated equipment. These instructions were not carried out.

Schedule "D" Recommendations:

The recommendations of the reviewers are as follows -

- We concur with the elements identified in the corrective action report No #04259 and would recommend that the Chief Inspector of Mines commission a comprehensive physical and systems audit to ensure that this corrective action has in fact been fully implemented.
- In situations where persons are exposed to significant hazards or unfamiliar tasks, an appropriately qualified supervisor should be provided to ensure that safety procedures and safe work methods are followed.
- That lifting gear registers contain all relevant information and are signed by the person who carried out the inspection.
- That the Chief Inspector publish and distribute a hazard alert regarding the inappropriate attachment of identification tags on lifting or like equipment. This hazard alert should be distributed to all manufacturers, suppliers and users of industrial safety belts and harnesses.
- That all employees be exposed to competency based training in hazard identification and appropriate control actions.

Schedule "E" Report of the Warden:

On Sunday, 27 June 1999, Geoffrey Michael BARLING received serious injuries whilst performing work in the Fowler Shaft at the CANNINGTON MINE.

The Cannington mine is owned and operated by BHP Minerals. The mine is located some 75 kilometres south south-west of McKinlay in north west Queensland. The mine operates on a "fly in fly out" basis.

A number of witnesses have been examined over the past two days, and 32 exhibits including statements and other documents have been admitted into evidence.

Findings as to nature and cause:

The Reviewers have delivered their findings as to nature and cause of the accident. I concur with the findings.

Having perused the documentary evidence and having heard the oral evidence, I am not of the opinion that there is any cause to recommend any action under Section 45 of the *Mines Regulation Act 1964* against the registered manager, Ms Julie May Devine.

I thank Mr Tate for his assistance as counsel assisting, and those legal representatives who appeared for various parties at the Inquiry.

Finally, I thank the reviewers for their assistance at this inquiry.

The inquiry is now closed. 30 Mach 2000

Last updated 20 October 2007

© The State of Queensland 2013.

Great state. Great opportunity.