Gary John WILSON

Findings and Recommendations

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

The *Coal Mining Act 1925* (as amended) -

Findings and recommendations of reviewers and mining warden following an inquiry into fatal injuries received by Gary John Wilson at Laleham No1 Colliery on 5 november 1996 Warden's Court 2-3 september 1997.

Before: Mr A J Chilcott, esquire acting mining warden

Reviewers:

- Mr J P Brady
- Mr R McKenna
- Mr D Reece
- Mr L Anderson

To assist:

Mr M Walker, inspector of coal mines.

Appearances:

- Mr S Williams, QC instructed by Messrs Blake Dawson Waldron, solicitors for South Blackwater Coal (Mr J Murdoch, junior counsel).
- Mr W M Allison for Construction, Forestry, Mining & Energy Union.
- Mr R Nathans, solicitor of Middletons Moore & Bevins for Joy Manufacturing Company Pty Ltd.
- Mr S Byrne, solicitor of Rees R & Sydney Jones for next of kin.
- Mr B A Harrison, barrister instructed by Messrs John Taylor & Co, solicitors for Australian Colliery Staff Association.

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:

- David Andrew Forbes MACKIE
- Kim ADDIS
- Graham Dennis GRIFFITHS
- David John Francis TORR
- Gregory Mark BIRD
- Craig James MAHONEY
- Stephen Gregory GILES
- Jeffrey Alan VOCK
- William Kevin KNIGHT
- David John SLAPE
- Anthony Charles HAZELDEAN
- Hugh Carlyle MORRISON

Schedule "B" List of Exhibits

No of Exhibit	Nature of Exhibit	Tendered by
1	Investigation Report by Inspector of Central Division	Mr Walker
2	Post-Mortem Examination Certificate (Form E)	"
3	State Analyst Certificate	"
4	Underground Employees Training Log Book	Mr Harrison
5	Certificate - TND008 Introduction to Training - S Giles Appointment as Trainer/Tester - S Giles	Mr Walker
6	Certificate - TND008 Introduction to Training - J Vock Appointment as Trainer/Tester - J Vock	"
7	Skills Audit - Operating Procedures for Continuous Miners - G Wilson	"
8	Australia/New Zealand Standard - Remote controls for mining equipment (AS/NZS 4240:1994)	"
9	Machine Operator Handouts Joy 12CM15-12D Continuous Miner	"
10	Statement of David John Slape	"
11	Statement of Anthony Charles Hazeldean	"
12	Statement of Hugh Carlyle Morrison	"

Schedule "C" Findings:

We find -

Name of deceased: Gary John Wilson

Date of fatal injury: 5 november 1996

Place of accident: Blackwater

Cause of death: From the medical certificate tendered:-

1. (a) Concussion & fractured skull

Nature of accident:

Shortly after 3-30 pm on the 5th november 1996 Mr Gary John Wilson was fatally injured when he was crushed between the right hand rib side of 0 heading, 9 to 10 cut-through, A500 panel, Laleham No. 1 Colliery and the Joy 12CM12 continuous miner, unit no. 47.

At the time of the accident Mr Wilson was working alone at the face, performing pre-start checks on the continuous miner.

The actual accident was not witnessed by any person.

At about 4-05 pm Mr Greg Bird checked the face area and discovered Mr Wilson pinned between the machine and the rib line. After a brief inspection Mr Bird alerted the remainder of the crew who were preparing to relocate a load centre.

Mr Wilson was found pinned by his head between the water filter housing, mounted on the right hand side of the continuous miner and the coal rib. He was located towards the rear of the machine in a position which strongly suggests on the balance of probabilities, that he was operating the manual controls to move the continuous miner.

The evidence would suggest that Mr Wilson positioned himself in the restricted space between the machine and the coal rib.

A reconstruction of the accident indicates that prior to the event Mr Wilson may have been in a crouched position with the right hand on the tramming levers and the left hand operating the brake override switch.

The manual tramming controls are mounted low on the right hand side of the machine and due to the confined space, estimated to be about 470 millimetres, it was likely that he was standing on approximately 300 millimetres of loose coal adjacent to the rib. As a result of this Mr Wilson would have needed to crouch lower than normal to reach the brake override device.

The machine was moved away from the rib side and valiant attempts were made by various members of the crew to revive Mr Wilson prior to and during transport to Blackwater hospital.

Evidence suggests that Mr Wilson may have decided that it was necessary to re-position the continuous miner to facilitate the task of completing the pre-start checks. A number of factors may have influenced such a decision:-

- having to work in the confined space between the machine and the rib;
- the closeness of the right hand cutter head to the rib line;
- fractured section of the rib adjacent to the right hand cutter head;
- a perceived inability to remove the scrubber filter screen due to the fact that the machine had been left parked close to the rib line.

Cause of accident:

Upon a consideration of the evidence presented to the Inquiry, we are of the opinion that Mr Wilson was fatally injured due to his perceived need to place himself in the confined space between the rib line and the machine.

By this action he put himself in a hazardous place.

This hazard was realised when he attempted to move the continuous miner using the manual tramming levers.

Major contributing factors:

The confined space hazard was created by the act of parking the continuous miner close to the rib line. Mr Wilson failed to recognise the risk associated with this hazard.

The company supplied machine operating manual does not adequately highlight the potential hazard associated with the manual operation of the continuous miner.

The design, installation and configuration of the manual controls on the various machines is substandard in that they lack consistency, create confusion and do not appear to conform to basic ergonomic principles.

The hazards created as a result of this had not been identified and assessed, therefore, no pro-active action was taken to eliminate or control the hazards by design changes or the installation of hard barriers which would have protected the operator from crush injury. (Refer to Australian/New Zealand Standard Remote controls for mining equipment 4240:1994 Section 3.5)

The training method and the learning outcome in this particular instance proved inadequate in that:

- record keeping was incomplete;
- the standard of the competency assessment provided was poor;
- some of the trainers had made a choice not to train in the manual mode when there was a requirement for manual controls to be fitted to this machine;
- Mr Wilson performed a task that he had not been trained or authorised to do.

Other observations

- We wish to acknowledge the work that has been done by the company and the employees of Laleham Colliery to address the hazards associated with the manual operation of the continuous miner.
- We are satisfied that a great deal of effort and money has been expended in the development and implementation of training schemes which are designed to make our industry safer, however, we are not convinced that these systems are fully effective.
- As an industry we need to question the reasons for this. Some concerns are:-
    - Are our expectations too high;
    - Fast tracking;
    - Skill versus next level of work model;
    - Apathy and complacency;
    - Assessment skills;
    - Lack of independent assessment;
    - Effective audits and internal review; and
    - Communication.

Schedule "D" Recommendations:

The recommendations of the reviewers are as follows:

Trainers and testers should not alter or omit training or testing material. This should be addressed through the established formal channels.

Training schemes should include a formal audit process for all facets of the scheme.

Operators have a responsibility to initiate action to rectify hazards in their workplace.

Competency based training should include some minimum time based component that is clearly indicated in training records.

Manufacturers should be pro-active in embracing the principles of the Workplace Health and Safety Act in the design and modification of machines and equipment.

Training programmes should be reviewed with increased emphasis on confined space awareness and the associated hazards.

Schedule "E" Report of the Warden:

Having delivered the findings as to the nature and cause of the accident and the recommendations, I deliver the following report:-

I commend the inspectorate for the professional manner in which their report has been compiled in relation to this inquiry. The reviewers and myself consider the report to be of a high standard.

I would like to express my sincere thanks to Mr Walker for his assistance during this inquiry.

I would also like to thank the reviewers and my clerk for their participation and assistance during this inquiry.

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

The inquiry is now closed.

3 september 1997

Last Updated 21 October 2007
