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Barry Arnold ROOKS

Findings and Recommendations

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The *Mines Regulation Act 1964* -

Findings and recommendations of reviewers and mining warden following an inquiry into fatal injuries received by Barry Arnold Rooks at Deep Copper mine, Isa Lease on 27 october 1996 warden's court, Mt Isa 28-29 april 1997

Before: Mr F W Windridge esquire Warden

Reviewers:

- Mr John Patrick BRADY
- Mr Gregory Allan DALLISTON
- Mr Roy FORD
- Mr Trevor John HOOD

To assist:

Mr John TATE, barrister, crown law office.

Appearances:

- Mr R Lynch, barrister instructed by Messrs C A Sciacca & Associates, solicitors for next of kin.
- Mr N O'Connor, solicitor for MIM Holdings Limited and appearing on behalf of Mr T G Cooney (mine manager).
- Mr G Mousley, 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:

- Christopher Paul SKELDING
- William Stanley DONNELLY

- Michael Francis DURHAM
- Lee Michael DRYDEN
- Milan CINDRIC
- Ronald Joseph PIPPENBACHER
- Yves Henry POTVIN
- Thomas Gregory COONEY

Schedule "B" List of Exhibits

No of Exhibit	Nature of Exhibit	Tendered by
1	Post Mortem Examination Report	Mining Warden
2	Post-Mortem Examination Report	"
3	Preliminary Report - C Skelding	Mr J Tate
4	Final Report to Chief Inspector - C Skelding	"
5	Report of Registered Mine Manager	"
6	Set of Twelve (12) Colour Photographs	"
7	Letter dated 27/10/96 (C Day)	"
8	Plan No C5/1/234 - Scene of Fatal Accident (Sheet 2 of 2)	"
9	Plan No C5/1/234 - Scene of Fatal Accident (Sheet 1 of 2)	"
10	Folder of Documents - MIM Holdings Limited	Mr N O'Connor
11	Statement of William Stanley DONNELLY	Mr J Tate
12	Statement of Michael Francis DURHAM	"
13	Statement of Ronald Joseph PIPPENBACHER	"
14	Statement of Lee Michael DRYDEN	"
15	Statement of Milan CINDRIC	"
16	Statement of Matthew David WRIGHT	"
17	Statement of Colleen Joy CURRY	"
18	Curriculum Vitae - Yves Henry POTVIN	Mr N O'Connor
19	Curriculum Vitae - Thomas Gregory COONEY	"
20	Organisational Chart for Enterprise Development - 27/10/96	"
21	Action Taken Since Accident on 27 October 1996	"

Schedule "C" Findings:

We find -

Name of deceased: Barry Arnold Rooks

Date of death: 27 october 1996

Nature of accident:

On sunday 27 october 1996 Mr Barry Arnold Rooks was fatally injured when a rock fall of approximately 2 to 3 tonnes occurred pinning him to the platform of a Getman scissor lift tractor no. 2771.

Valiant attempts were made by Donnelly and Dryden to lift the rock off Mr. Rooks but their efforts were in vain.

After examination by a doctor on the scene, life was pronounced extinct at 11-00 am.

This accident occurred in the M62 conveyor access drive on 20 C sublevel at the Deep Copper mine, Mount Isa Mines.

Prior to the accident two employees were in the process of installing grouted rock bolts about

seven (7) metres from the face.

The standard method of installing grouted rock bolts was carried out as follows:-

- Holes are drilled. This had already been carried out during the times that the face had been drilled over the previous few shifts. It was not part of their job on the morning of the accident;
- Grout, consisting of a mixture of 8 litres of water and 20 kg of powdered cement, was introduced into the holes with a grout pump;
- A 20 mm diameter re-bar rock bolt was then introduced into the hole;
- A plate and nut was then placed loosely over the end of the bolt;
- The nut is not tightened immediately, but is done at some time after the grout cures.

Barry Rooks and Lee Dryden had spent approximately two (2) hours on this task and at about 10-20 am William Donnelly (contract project planner) and Michael Durham (supervisor Deep Copper mine) arrived on the scene.

At this time Dryden was cleaning the grouting gear and Rooks was fitting the last few nuts on the bolts. Evidence was given by Dryden that he heard a pinging sound emanating from the backs. Dryden states that Rooks stopped and sounded the backs with a bar and indicated to him that the pinging sound was not an uncommon sound and there was no cause for alarm. Shortly after a fall of rock occurred.

Dryden felt the impact of the fall and looked back and saw that Rooks had been pinned to the floor of the scissor lift.

Dryden stepped back and used the hydraulic lever to lower the platform. Dryden alerted Durham to go for help and Donnelly and Dryden commenced the initial rescue attempt.

Despite their efforts they were unable to slide the rock slab off Rooks. The size of the slab was estimated to be approximately 2.25 metres in length, 1.5 to 2 metres in breadth and varying in thickness from a few millimetres to 250 millimetres.

Dryden and Donnelly continued to support this slab by using various means until help arrived.

Durham accompanied by Colleen Curry, a registered nurse employed by Mount Isa Mines, arrived at the accident site at 10-37 am. Curry commenced examination for vital signs and after a period of time advised those present that she was unable to detect any signs of life.

Doctor Matthew Wright arrived on the scene and pronounced life extinct at 11-00 am.

Cause of death:

From the medical certificate tendered:-

1(a) Chest injuries

Cause of accident:

We are of the opinion that the basic cause of this accident was the practices adopted with regard to the installation of rock bolts and the serious potential hazards which are present in a development drive of any type.

We believe that one, or a combination of these potential hazards was realised with the result that Mr. Rooks lost his life.

Factors which may have contributed to this fall of ground include, but are not limited to:-

- Localised stress anomaly;
- Vibration due to shot firing;
- Drilling of rock bolt holes and water ingress;
- Pumping of grout into the drill holes;
- Exothermic reaction of the grout;

- Natural weakness in the rock mass;
- Rattling or scaling.

We are satisfied that the rock support system in use at the time offered no immediate protection to persons engaged in the installation process or employed on other duties in the face area.

Other observations:

We are satisfied that this unsafe state, which finally resulted in the death of Mr. Rooks was most likely present for some time and therefore, a constant threat to all persons engaged in any activity forward of the last line of effective supports.

The failure of this section of the access drive which has been continuously referred to as competent ground, demonstrates the need for effective procedures, training and controls which will eliminate the need to advance too far forward of the last line of effective supports.

We are satisfied that a comprehensive risk assessment and hazard management process has not been completed for this accident and we are confident that had this process been carried out, then proper controls, procedures or standards would have been developed prior to this Inquiry.

We wish to draw attention to recommendation 3 of the Glenn Burrows fatal accident inquiry held in Mount Isa on 4 June 1996.

Schedule "D" Recommendations:

The recommendations of the reviewers are as follows:

Clearly defined minimum support rules should be developed and implemented for the Deep Copper mine.

1. These minimum support rules shall specify:-
 - Maximum drive widths;
 - Maximum distance from the face to the last line of effective support;
 - The number, type and pattern of the supports required;
 - Safe work procedures for the installation of these supports.
2. Safe work procedures should be developed and implemented with input from, and in co-operation with, a vertical cross-section of the workforce affected by, and competent in the work to be performed. Safe work procedures should include audit mechanisms.
3. That an industry group consisting of representatives from the Deep Copper mine management team and employee representatives with input from the Department of Mine's Inspectorate, investigate, select and implement an effective rock bolting system. An effective rock bolting system should provide immediate protection for persons engaged in the installation process and effective support for persons employed on other duties in the face area.
4. That the Getman scissor-lift platform and other devices, used to elevate persons be fitted with falling object protection and guard rails as required by Part 7.32.1 of The *Metalliferous Mining Regulations of 1985* (as amended).

Schedule "E" Report of the Warden:

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

I note that a legal representative of the employer was present during some of the interviews conducted by the inspectorate, albeit at the request of the interviewee. I do not accept this as good practice on the ground that the witness should be interviewed in a free and open environment more conducive to ascertaining nature and cause without any pressure, real or perceived, from the employer. I am not imputing an improper conduct, merely attempting to regulate the investigation process.

As a practice, the inspectorate should develop a procedure where each witness can be interviewed out of the presence of the employer. It is a matter for the witness if he or she desires his or her own solicitor or union representative to be present, as long as such persons do not

interfere in the interview process.

I am advised that a representative of next-of-kin raised the question about the experience and appointment of reviewers in these matters.

Reviewers are selected by the warden, and the warden alone, as authorised by the Act. All reviewers are selected because of their experience in the industry, particularly where they have skills, qualifications and current occupations relevant to the accident under investigation. I also look for past regulatory, inspectorial or managerial experience, with an overlay of union representation, and lately, mines rescue representation. A further consideration is a high interest in health, safety and training issues. This must continue in the future, as to restrict my right of choice will severely inhibit the function of the whole inquiry process.

I thank inspector Skelding for his report, and Mr. Tate for his assistance during this inquiry.

I thank the reviewers for their participation and assistance during this inquiry.

This inquiry is now closed.

29 April 1997

Last Updated 21 October 2007

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Great state. Great opportunity.