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## Rick John TURNBULL

### 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 Rick John Turnbull at Mount Elloit mine on 10 december 1996 warden's court Townsville 12-14 august 1997

Before: Mr A J Chilcott esquire Acting Mining Warden

#### Reviewers:

- Mr J P Brady
- Mr W M Allison
- Mr R R Ford
- Mr A E McMaster

#### To assist:

Mr J Tate, barrister, instructed by crown solicitors office, for inspectorate.

#### Appearances:

- Mr J A Griffin, QC instructed by Messrs Welsh and Welsh Solicitors for next of kin.
- Mr G Mousley, district workers representative.
- Mr N B Conroy, solicitor Conroy & Associates for Faminco.
- Mr J Bond, barrister instructed by Allen Allen & Hemsley for Arimco Mining Pty Ltd.

**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:

- John William HOWE
- Michael Leigh PROELSS
- Richard Charles MORTESS

- Ross James THOMAS
- Murray Roy HARRIS
- Patriag Simon DENNIS
- Graeme Charles SKAROTT
- Donald Keith CAMPBELL
- Steven Wardale WINGHAM
- Stewart James SMITH
- Gary Peter CRESWELL

## Schedule "B" List of Exhibits

No of Exhibit	Nature of Exhibit	Tendered by
1	Report of John William HOWE	Mr J Tate
2	Set of Ten (10) Colour Photographs	"
3	Video Cassette	"
4	Set of Colour Police Photographs	"
5	Set of Training Records	"
6	Post-Mortem Examination Certificate (Form E)	"
7	Post-Mortem Examination Report (Form 10)	"
8	Appendix 6 - Registered Mine Managers Report	"
9	Original Statements:- Jim Parenti Christopher Gerard John Frommolt Alistair John Skey Keith Gavine Noy Marianne Lucy Rogers Joanne Stacey Moss Caroline Helen Trezise John Michael Trott	"
10	Video Cassette - Barring Down	Mr J Bond
11	Handwritten Statement - Michael Leigh PROELSS	Mr J Tate
12	Handwritten Statement - Michael Leigh PROELSS 11/12/96	"
13	Typed Statement - Michael Leigh PROELSS 10/12/96	"
14	Statement of Richard Charles MORTESS dated 11/12/96	"
15	Statement of Richard Charles MORTESS dated 13/12/96	"
16	Report of Ross James Thomas	"
17	Statement of Murray Roy HARRIS	Mr Bond
18	Sketch/Plan - M R HARRIS	"
19	Statement of Padriag Simon DENNIS 11/12/96	Mr Tate
20	Statement of Graeme Charles SKAROTT	"
21	Workplace Inspection and Scaling	Mr Conroy
22	Statement of Donald Keith CAMPBELL	Mr Tate
23	Statement of Steven Wardale WINGHAM	"
24	Plan - 'Wedge Failure' from intersecting structures	Mr Griffin
25	Statement of Stewart James SMITH	Mr J Tate
26	Statement of Gary Peter CRESWELL	"

## Schedule "C" Findings:

We find -

Name of deceased: Rick John Turnbull

Date of death: 10 december 1996

Place of death: Selwyn airstrip via Cloncurry

**Nature of accident:**

At about 10-00 am on tuesday 10 december 1996, Mr Rick John Turnbull received fatal injuries when he was crushed by a rock which fell or was dislodged from the back of the Corbould slot drive in the Arimco Mining Pty. Ltd., Mount Elliott mine.

Immediately prior to this event Mr Rick John Turnbull (miner/operator) and Richard Charles Mortess (surveyor/miner operator) were engaged in the task of secondary check scaling or barring down of loose material from the back of the Corbould slot drive, 1130 level and adjacent to the brow of the C1 stope.

To facilitate this task, they were working in the basket of a JCB loadall unit, plant number 587 which had been set up as an elevating work platform. This unit was operated by Mr Padriag Simon Dennis who was in the cabin of the unit and observing the activities of Turnbull and Mortess.

Dennis had positioned the JCB unit close to the brow of the stope before elevating the work platform containing Turnbull and Mortess to a height of about 2.0 metres above the floor.

Shortly after check scaling operations commenced a large rock with a mass estimated to be in excess of one tonne fell or was dislodged from the back striking Mortess and crushing Turnbull before finally trapping him by the lower left foot.

The elevated work platform was lowered and withdrawn before Dennis ran for help.

The evidence indicates that it took some time to remove the rock trapping Turnbull's foot and to recognise the true extent of the injuries he sustained, however, there was no evidence which indicated or suggested that this would have had any bearing on the final outcome.

**Cause of death:**

1. (a) Exsanguination

**Cause of accident:**

We are of the opinion that the basic cause of this accident was a combination of the suspect condition of the workplace and the practices performed by the persons employed in what proved to be a hazardous place.

Primary support in this workplace was provided by 2.4 metre split sets and butterfly plates set to a pattern with additional split sets installed as required at the time.

The work practices adopted in this particular instance were substandard in that the scaling operations commenced in what proved to be unstable ground. There is a clearly defined and well known standard operating procedure for scaling or barring down operations, however, in this instance a subjective analysis of what constituted good ground was flawed.

We believe that no clear directions or instructions were given to Mortess, Turnbull or Dennis at the commencement of the shift or at the time that this particular task was allocated to them.

**Other observations:**

We are satisfied that the use of an elevating work platform can under certain circumstances provide a number of advantages for the scaling or barring down process, however, we are concerned about the lack of protection from material which may fall from the backs.

A number of similar accidents have occurred in this State which have caused both fatal and serious injuries and we believe that there is a need to eliminate or at least minimise the risks by design changes to this equipment.

Present practice is to rely on the effectiveness of and adherence to safe operating procedures

#### **Schedule "D" Recommendations:**

The recommendations of the reviewers are as follows:

1. Arimco, industry and the mines inspectorate should investigate the possibility of providing overhead protection for people conducting scaling operations from baskets or elevated platforms.
2. When scaling, consideration should be given to having only one person in the elevating work platform to reduce the risk of exposure to hazards and to provide greater personal manoeuvrability. Should there be a need to have two persons in the elevating work platform only one person should carry out scaling.
3. Prior to the commencement of work the areas should be inspected by an experienced supervisor following production or major blasting in zones of geological structural weakness or identified hazardous conditions.
4. Following a fatal or serious accident the mines inspectorate investigation should, where possible, include a controlled reconstruction of the accident with a view to assisting the inquiry process.

#### **Schedule "E" Report of the Warden:**

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

It has only become recent practice that directions hearings have been conducted by this court in relation to fatal inquiries.

A directions hearing was held in relation to this inquiry, however, I am of the opinion that such directions hearing was not completely successful.

For such directions hearings of this nature to be successful in the future, it is imperative that all respective parties provide productive input.

This includes, but is not restricted to, the number and identity of witnesses to be called and the production of any documentation proposed to be tendered by a party at a reasonable time prior to the commencement of an inquiry.

It is the intention of this court to hold directions hearings at an early stage in relation to future inquiries.

I am extremely confident that such directions hearings if they are held on this basis can only expedite and improve the effectiveness of the inquiry Process as a whole, in the future.

I thank Mr Tate for his assistance during this inquiry. I also thank the reviewers for their participation and assistance during this Inquiry.

The inquiry is now closed.

14/08/1997

Last Updated 21 October 2007

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**Great state. Great opportunity.**