

Coal Mining Safety and Health Act 1999

FINAL REPORT THE CHIEF INSPECTOR OF COAL MINES

Investigation into the nature and cause of the fatal injury

To s.73 Irrelevant info

BMA Blackwater Mine

February 20, 2009 On

Investigating Officers District Inspector of Mines – Mike Walker (Lead Investigator)

Deputy Chief Inspector Coal Mines – Doug White

Inspector of Mines – John Sleigh

Inspector of Mines (Mechanical) Bruce McKinnon Principal Investigation Officer, Andrew Broadfoot

Date 9 July 2009

File Reference 1714

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Nature and Cause report into fatality to s.73 Irrelevar at Blackwater on 20 February, 2009

1 SUMMARY

A fatal accident occurred to s.73 Irrelevant in, a contract employee at BMA open cut coal mine at approximately 11 am on 20 February 2009. The autopsy certificate states that the cause of death was "head injury" with the further comment "crushed head with disruptive fracture of the skull floor and disruption of the brain."

Mr s.73 Irrele a radio technician employed by Nixon's Communications, was driving a Mitsubishi Triton utility north towards the main administration complex on the main haul road and ran into the rear of an empty "Towhaul" heavy vehicle travelling in the same direction. The Towhaul unit is a large, low loader, weighing about 200 tonnes, which is used to move heavy equipment such as dozers and excavators around the mine.

The deceased's vehicle hit a tow hook on the rear of the heavy vehicle. The impact was with the roof of the light vehicle, immediately in line with Mr. S.73 Irrelev head. Damage sustained to the vehicle and the location of the damage relevant to the position of the driver indicates that it is likely that death would have been instantaneous.

The environmental and road conditions did not appear to contribute to the incident. The incident occurred on a straight, 25 metre wide haul road, with a gradual grade. It was a sunny day, but the position of the sun did not appear to affect visibility at the location of the incident. A re-enactment under controlled conditions at the same time on the following day did not generate excessive dust.

Checks revealed that the deceased had not participated in any radio or mobile phone communications around the time of the incident, so a distraction of that nature was ruled out.

Both vehicles were examined after the incident. Examination of the utility found that three of the four tyres were on the limit of acceptability for road use. It is unlikely that this was a factor in the incident as no signs of excessive braking or swerving prior to impact were found at or near the accident site.

The deceased s.73 Irrelevant information						
s.73 Irrelevant information						
s.73 Irrelevant information	In the opinion of the Occupational Physician, it					
seems possible that a combination	n of these factors could have caused Mr. s.73 Irrele to					
fall asleep while driving.						
Mr. s.73 Irrelevant information						

Nature and Cause report into fatality to s.73 Irrelevan at Blackwater on 20 February, 2009

2 FATALLY INJURED PERSON

Name	s.73 Irrelevant information
Address	
Date of Birth	
Next of kin	

3 MINE DETAILS

Name BMA Blackwater Open Cut Coal Mine

Address Private Mail Bag, Blackwater, Qld., 4717

Principal Holder B M Alliance Coal Operations Pty Ltd

Operator BM Alliance Coal Operations Pty Ltd

ABN 67096412752

SSE s.73 Irrelevant information

4 NOTIFICATION OF INCIDENT

The SSE s.73 Irrelevant informatic contacted Central Region Manager Safety & Health, s.73 Irrelevanated 11.15 am, approximately 15 minutes after the incident. He had already left a message on Deputy Chief Inspector Doug White's message bank. Details of the incident were confirmed by the Deputy Chief Inspector at 11:50 by return call.

Mr s.73 Irrelevant in advised that there had been a possibly fatal light vehicle roll-over.

Mr s.73 Irrelevant i confirmed that Mr. s.73 Irrel had died in the accident shortly afterwards.

At the time of the initial reports it was not known that the light vehicle had collided with the Towhaul.

The police were called and officers from Blackwater station responded.

A report of the mine's investigation into the accident, under section 201 of the Coal Mining Safety and Health Act, 1999, was provided on 20 March 2009. It is included as Appendix V, "SSE report"

5 INSPECTORATE RESPONSE

An investigation team comprising District Inspector of Mines, Mike Walker (Lead Investigator), Deputy Chief Inspector of Coal Mines Doug White, Inspector of Mines John Sleigh, Inspector of Mines (Mechanical) Bruce McKinnon and Senior Investigation Officer Andrew Broadfoot travelled to the mine.

5.1 On site briefing

District Inspector Walker arrived at the mine at 3.40 pm and was briefed by the mine's Incident Management Team led by SSE s.73 Irrelevant information

The nature of the incident was clarified as a collision, not a roll-over incident as initially assumed. Photos taken by the mine's Safety Manager showed extensive damage to the light vehicle and marks on the rear of the low loader as a result of the collision. The low loader driver had not been aware of the collision and continued to his destination. The light vehicle was found by a Grader driver travelling in the opposite direction, within minutes of the accident.

Inspector John Sleigh arrived at the mine at 4.25 pm. A police investigator and photographer from the Rockhampton Forensic Crash Unit arrived at the same time. Inspectors Walker and Sleigh, the police and mine management travelled to the incident site, arriving at 5.05 pm.

Deputy Chief Inspector White and Inspector of Mines (Mechanical) McKinnon arrived at the mine at 5.05 pm. Senior Investigation Officer Broadfoot met the team in Blackwater later that night.

On arriving at the scene at approximately 6 pm, Deputy Chief Inspector White spoke with the Queensland Police Service investigating officer and requested further measurements and photographs. The Deputy Chief Inspector also discussed jurisdiction and agreed that the damaged vehicle be removed to secure storage in the police pound in Blackwater. After the additional measurements and photographs were taken the site was officially handed over to the Mines Inspectorate at 8 pm.

Due to failing natural light it was decided to return to the administration area and take stock of the preceding events to that point.

The investigating team left site at 8.15 pm and travelled to Blackwater.

The investigation team returned to the mine on Saturday 21 and Sunday 22 February.

5.2 Interviews

A list of people who were interviewed is attached in section 9 on page 20 of this report. Audio recordings were made of 7 of these interviews. These are included on an audio CD as Appendix II, "Recorded interviews – audio CD."

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The interviews were conducted by Mike Walker as the lead investigator. The presence of legal representatives and the Industry Safety and Health Representative, s.73 Irrelevar was at the discretion of the interviewee.

s.73 Irrelevant information

discussed the incident and s.73 Irrelevant information

with Deputy Chief Inspector White and the department's Occupational Physician, Dr.

David Smith, s.73 Irrelevant information

Dr.

Smith prepared a report, based on this interview and follow up with appropriate medical practitioners. The report is summarised in section 7.4.1, Occupational Physician's report on page 16 and included as Appendix IV Statement and summary of medical evidence.

6 INVESTIGATION OF SCENE

The local police officers had already taken control of the scene. The site was marked by witches' hats and a mine employee had been assigned to record the names and functions of those entering the site. The mine's rescue and ambulance teams were also near the scene, waiting to be mobilised.



The inspectors acknowledged the expertise of the police in what was essentially a road accident on a mine site. A cooperative approach between the police and the inspectorate enabled the inspectors to gather information and request photographs or measurements be taken by the police officers.

The deceased was still in the vehicle when the inspectors arrived. The windscreen was covered with a blanket for sensitivity reasons.

The Towhaul was at the Ramp 50 crib hut, where the driver had stopped after the incident, but before he became aware of it. The Towhaul was not moved from that position until a re-enactment was staged on the following day. The site of the Towhaul was secured by mineworkers to the satisfaction of the inspectors.

6.1 The scene

The incident happened on a straight haul road. A Mitsubishi Triton single cab utility with a covered canopy/toolbox was standing on the roadway in a "normal" driving location in left hand lane of road, approximately 4 metres from the left hand safety berm.



The cab roof was severely crushed downward on the driver's side. The deceased was in the cabin when the inspectors arrived. The air bags had not deployed.

The vehicle number plate was 293 JPB. The mine site identification was NXNO6. The canopy was labelled "Nixon's Communications and Tait Electronics." The canopy had "gull wing" doors. The passenger side door canopy door was open. A few items were strewn around on the roadway.

There was a distinct concave indentation approx 300 mm diameter in the passenger side front mudguard. There were black rubber marks on the guard.

The vehicle had a top mounted orange beacon and a light vehicle warning flag.

The tyres showed signs of wear. A later police inspection¹ noted:

Tyres: All four tyres were inflated and of a satisfactory tread depth however, all tread sections were chipped and scuffed across their entire tread widths consistent with continual operation on non sealed roads. The left rear tyre was in a potentially dangerous condition due to a section of the tread being stripped away exposing the tyres' inner construction layers to the elements.

¹ Report of Mechanical Inspection Of A Motor Vehicle, Inspection Number 216/2009, Queensland Police, Vehicle Inspection Unit, Fleet Management Branch. Report by A. A. McDonald. 18 March 2009.

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A mobile phone was found in the vehicle and was taken by police. An s.73 Irrelevant information was on the passenger seat. An s.73 Irrelevant information on the vehicle's dash.

Items on the floor on the passenger side included a helmet, isolation locks and keys and a vehicle defect report book.

After the police had photographed the scene and arranged for measurements to be taken by the mine surveyor, they allowed the mine rescue and ambulance teams to extricate the body from the cabin, using cutting implements.

The body was transported from the scene by mine ambulance at approximately 6 pm on 20 February. The vehicle was taken to a secure police location in Blackwater for security until mechanical tests could be conducted.

6.2 The Roadway

The grade near the point of impact was 4.5% downhill in the direction of travel. The road was between 25 and 28 metres wide.



The point of impact was approximately 280 m from a crest in the road to the rear (south). The road to the north (direction of travel) was straight for approximately 2.4 km, then curved to the right. The average grade over the full distance from the crest to the curve was 1.5%.

There were some tyre marks on the road, however they were consistent and even in nature and did not indicate skidding or sudden correction.

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About 6 to 7 metres immediately behind light vehicle there was a zone, about 400 mm wide, with no tyre marks and covered in a thin layer of gravely material which may have been dried mud dislodged from wheel arches at the time of impact. From this gravely zone to the vehicle, fragments of broken glass are evident — the density of fragments increasing toward the vehicle.

Beyond this zone there were distinct tyre marks for both wheels extending south for a further 6 to 7 metres. They curve slightly to the right in the 1 metre or so before the gravely zone.



These marks continue to the south (up the grade), but as "normal" tyre marks for a further 80 metres. Starting from the furthest point from the LV (near top of crest) this 80 m of tyre marks indicate a gradual "drifting" off line to the left in the direction of travel - perhaps 1 metre in total. In that distance there appears to be two partial corrections about equally spaced.

The mine ambulance and rescue teams had erected a shade awning near the location so that they were available if needed.

A water cart following the light vehicle at the time of the incident was parked up about 100 metres behind the incident site. This had been arranged by radio when the incident was discovered.

No vehicles had passed the incident site in either direction from the time of the incident until the light vehicle was removed.

Mine ambulance and rescue vehicles had travelled to the site, however had kept to the other side of the road, so they would not disturb the scene.

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6.3 Environmental Conditions

The incident happened at approximately 10.50 am on a dry, sunny day. There was a light westerly breeze.

The environment at about the same time on the next day is shown in this photo. Weather conditions on both days were reported to be similar.



FURTHER INVESTIGATION

7.1 **Preliminary tests on Towhaul**

The Towhaul was secured at Ramp 50 crib hut after the driver was advised of the incident.



A visual inspection showed marks that were consistent with a collision with a light vehicle from behind.



To enable a controlled re-enactment under similar environmental conditions a mechanical inspection of the Towhaul was carried out by the John Holland trainer / assessor, s.73 Irrelevant and supervised by Inspector of Mines (Mechanical) McKinnon. The inspection included a visual walk around inspection, steering and static and dynamic brake tests. Mr. McKinnon approved the use of the Towhaul in the reenactment.

7.2 Re-enactment

After the mechanical tests Mr. s.73 Irrel was asked to drive the Towhaul to the crest on the South side of the incident site and then travel at the maximum speed that could be achieved while operating the vehicle correctly.

The objective was to confirm the maximum speed that the vehicle was capable of in the vicinity of the collision and the nature of the dust raised by the vehicle at maximum speed. This maximum speed had been estimated at 30 km per hour.

The re-enactment was carried out at 11.40 am on the day following the incident. The weather conditions on both days were similar – sunny, dry and a light westerly wind.

There had been no treatment of the road in the intervening period. There had been no rain in the period. The dust generated in the re-enactment could be safely assumed to be at least as great as it had been at the time of the accident.

The re-enactment was witnessed by the investigation team from the inspectorate, the Industry Safety and Health Representatives and mine officials. The re-enactment was videoed by Senior Investigation Officer Broadfoot, using a hand-held portable camera provided by the mine.

A copy of the video is included as Appendix IX, "Video of re-enactment."

7.2.1 Maximum speed of Towhaul

The Towhaul operator at the time of the incident, Mr. s.73 Irrelevant info had stated that the gearing of the Towhaul vehicle would limit its speed to about 27 km/hr on the gradient in question.

The machine was operated for the re-enactment by another John Holland operator, Mr. s.73 Irrelevant Mr. s.73 Irrelevant Mr. s.73 Irrelevant has often operated the machine, and is a trainer / assessor. He was accompanied in the vehicle by Mr. s.73 Irrelevant informatio a John Holland supervisor. In a recorded interview after the test, Mr. s.73 Irrel advised that he had reached a maximum speed of 33 km/hr approaching the incident site and had applied the retarder because the engine revs had reached 1900 rpm. Failure to retard would have led to alarms sounding and if these were ignored, progressive engine damage.

The application of the retarder did not result in a significant or sudden slowing that would affect a following vehicle. It was gradual, controlled braking.

Mr s.73 Irrelevant in, the driver at the time of the incident watched the re-enactment and confirmed that it was basically how he would drive, but perhaps the engine was revving a bit harder.

7.2.2 Dust raised by Towhaul

In the opinion of the inspectors, the amount of dust raised would not affect visibility on the road at the time of the accident.



Mr s.73 | red | had advised that, in his opinion, the dust was not significant on the previous day. He advised that on a scale of 1 to 10 with 10 being the worst dust on a normal haul road at the mine, the rating would have been 6 at the top of the crest, gradually reducing to 4 at the bottom of the slope.

7.3 Mechanical Inspections

7.3.1 The Towhauler

Inspector of Mines (Mechanical) McKinnon conducted an examination of the Towhaul² and reached these conclusions:

- Examination of mechanical componentry on TH 01 revealed that only minor faults e.g. small oil leaks etc. were present on the vehicle.
- Dynamic and static brake testing has shown that the brakes performed as expected and within specification for the vehicles application.
- Operator feedback suggested that the truck performed normally during all facets of testing and use during the re-enactment

² Truck Examination Report BMCK BWater TH01.doc conducted 21 and 22 February 2009.

A copy of Inspector McKinnon's report is included as Appendix X, "Truck Examination Report BMCK BWater TH01."

7.3.2 The Light Vehicle

A Mechanical inspection of the light vehicle was conducted by Inspection Officer (Mechanical) Mick McWilliam³. This inspection included collaboration in a mechanical inspection conducted by Mr. A. A. McDonald of the Queensland Police Vehicle Inspection Unit⁴.

A copy of Officer McDonald's report is included as Appendix XI, "Report of Mechanical Inspection of A Motor Vehicle, Inspection Number 216/2009"

Mr McWilliam's observations concur with Mr. McDonalds's findings:

This vehicle was in an unsatisfactory mechanical condition due to the condition of the right rear brake assembly, however this defect was not serious enough to significantly reduce the brakes operating efficiency. No other mechanical defects were evident at the time of my inspection which could have been contributory to the cause of the incident. The left rear tyre was found to be in a potentially dangerous situation.

The vehicle carried a permit sticker for operation at BMA mines (issued October 2008) and Curragh Mine (issued November 2008).

A defect log book was found in the cabin of the vehicle. Pages from the Log book are included as Appendix XII, "Vehicle log book."

Entries in the book going back to 18 December 2008 refer to defective tyres.

4 December 2008 Tyres fair. Need rotating
18 Dec 2008 Tyre are worn. Need replacing next service
11 January 2009 Tyres need replacing soon, will advise.
1 February 2009 Tyres are bald
6 February 2009 Tyres need replacing

Other entries in the log book include:

11 January 2009 Vacuum sensor broken
 1 February 2009 Vacuum sensor needs repair under warranty
 6 February 2009 Vacuum sensor needs repair, Clutch slips under load

7.3.3 Radio and phone communications

Mr. s.73 Irrele had a mobile phone in the vehicle and a suitable hands free cradle. Telephone records were obtained by the investigating police. The last call was to Ms. s.73 Irrelevant information in the company's Rockhampton office about 1 hour before the collision. The call was about his next assignment and had been terminated normally.

A review of the recorded radio traffic in the hour preceding the collision showed that Mr. s.73 | rrele had not used the radio in that time.

A distraction caused by a radio or phone call has been ruled out.

³ *Mechanical Inspection Report* prepared by Mick McWilliam, conducted at the QPS holding compound, Blackwater, 11 March 2009

⁴ Report of Mechanical Inspection Of A Motor Vehicle, Inspection Number 216/2009, Queensland Police, Vehicle Inspection Unit, Fleet Management Branch. Report by A. A. McDonald. 18 March 2009.

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Mr. s.73 Irrel had a laptop computer, which was in the rear section of the utility. A distraction from that source is also ruled out.

7.4 MEDICAL REPORTS



An autopsy was conducted and samples taken for a toxicology analysis.

7.4.1 Occupational Physician's report

Dr. Smith reviewed available health information and contacted Mr. s.73 Irrelet s treating doctors. His report is included as Appendix IV, "Statement and summary of medical evidence."

Dr. Smith's conclusion was:



that a combination of factors could well have caused him to fall asleep while driving.

7.4.2 Autopsy Certificate

An Autopsy Certificate was issued by Dr. A Olumbe on 24 February 2009. It is included as Appendix VII, "Autopsy Certificate."

The cause of death is described as "head injury" with the further comment "crushed head with disruptive fracture of the skull floor and disruption of the brain."

A blood sample was taken at the time of the autopsy.

7.4.3 Toxicology Report

The Coroner provided a Toxicology Certificate which indicated s.73 Irrelevant information in the blood sample taken from the deceased during the autopsy. A copy of the report is included as Appendix VIII "Toxicology report."

The department's Occupational Physician, Dr. David Smith, considered the toxicology report and found:



Dr. Smith's complete report is included as Appendix IV, "Statement and summary of medical evidence."

8 SEQUENCE OF EVENTS - 20 February 2009

	<u>, </u>			
8.15 am	S.73 Irrelevant John Holland Dozer driver was last person to see Mr. S.73 Irrele drove Mr S.73 to the crib room so that Mr S.73 Irrele could install a hands free radio in Mr. S.73 s assigned dozer.			
At about 10 am – but before collision	communication North Rockhampton spoke to Mr. s.73 Irrele about another job assignment to be carried out when he had finished at Blackwater. He had estimated that he would be finished at the mine at about 12.30 pm.			
At about 1040	OCE s.73 Irrelevant info passed the tow haul at Turngoods Hardstand, near White Hill, after Ramp 56.			
At about 10.45	s.73 Irrelevant in arrived at the Ramp 50 crib hut in a light vehicle. As he pulled up, he saw the grader leaving. Shortly after he heard the emergency call on the radio.			
At about 10.58 am	Collision occurred 200 metres south of Ramp 54			
11 am	Emergency call from s.73 Irrelevant inform grader driver who was first on scene. (Time determined from time stamped recording of mine radio channels.)			
11.02 am	Ambulance and Emergency vehicle responding. (Radio stamped time)			
11.03 am	s.73 Irrelevant infarrived at scene in light vehicle (Radio stamped time)			
11.06 am	Water Cart 19 at site (first following vehicle) (Radio stamped time)			
11.07 am	Emergency response vehicles at scene. (Radio stamped time)			
11.15 am	SSHR s.73 Irrelevant info received call from mineworker. Headed to mine.			
11.15 am	SSE s.73 Irrelevant information notified Department of possible fatality			
11.15 am	OCE s.73 Irrelevant inforarrived at the accident scene.			
11.30 am	SSHR s.73 Irrelevant info arrived at the mine.			
11.35 am	SSHR s.73 Irrelevant info was advised by s.73 Irrelevant info (BMA official) that the incident had occurred.			
11.35 am	SSHR s.73 Irrelevant info arrived at the scene.			
12.30 pm	Blackwater Police arrived at accident scene (according to OCE s.73 Irrelevant info).			

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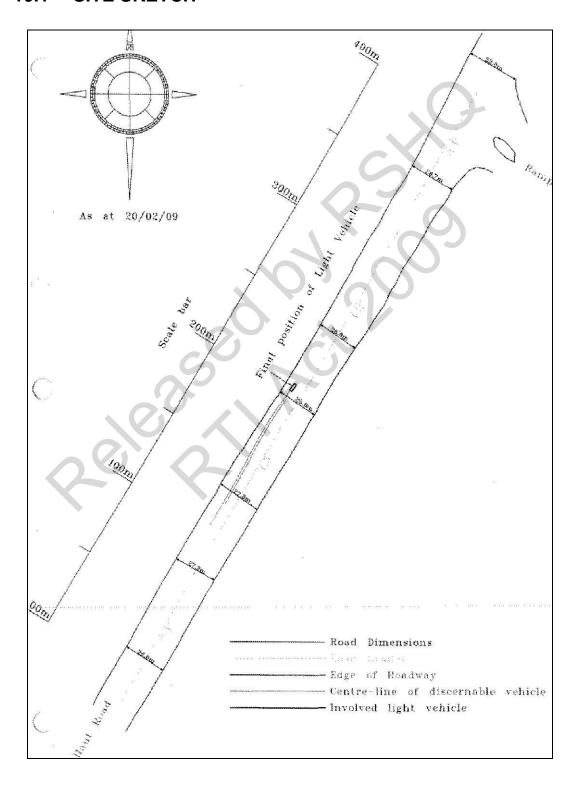
3.40 pm	District Inspector Mike Walker arrived at mine	
4.25 pm Rockhampton Police arrived at mine		
4.25 pm Inspector John Sleigh arrived at mine		
5.05 pm	Police, inspectors and mine officials arrived at scene	
5.05 pm	Deputy Chief Inspector Doug White and Inspector of Mines (Mechanical) Bruce McKinnon arrived at mine administration area.	
6 pm	Deceased released from car,	
7.20 pm	Vehicle moved from scene	
8.00 pm	Scene handed over to Department of Mines and Energy.	

9 PERSONS PROVIDING STATEMENTS TO THE **MINES INSPECTORATE**

Name	Position	Role	Interviewed	Recorded?		
s.73 Irrelevant informa	Grader operator	First on scene	6 pm, 20 Feb 2009	No		
s.73 Irrelevant infor	Dozer utility driver, John Holland	Second on scene	1 pm 21 Feb 2009	Yes		
s.73 Irrelevant info	Towhaul" low loader operator	Driver of Towhaul	2 pm, 21 Feb 2009	Yes		
s.73 Irrelevant inform	SSHR	At site within 30 minutes and took photos	21 Feb 2009	Yes		
s.73 Irrelevant information	Water truck operator, John Holland	First vehicle on scene following same direction	4.35 pm 21 Feb 2009	Yes		
s.73 Irrelevant informa	OCE, Allegra Mining Services	On duty.	5.10 pm 21 Feb 2009	Yes		
s.73 Irrelevan	Operator, John Holland	Last person who had face to face contact with Mr. s.73 Irrele	10 am 22 Feb 2009	Yes		
Andy Talbot	Ambulance Officer QRS	Responded to incident	12.43 pm 25 Feb 2009	No		
s.73 Irrelevant	Blackwater mines rescue captain	Responded to incident	11 am 4 Mar 2009	No		
s.73 Irrelevant inform	Work coordinator, Nixon's Communications, Rockhampton Office	Last person to speak to Mr s.73 Irreleby phone.	23 Feb 2009	No		
s.73 Irrelevant informa	s.73 Irreleva		28 Feb 2009	No		

10 ATTACHMENTS:

SITE SKETCH 10.1



10.2 MINE RECORD ENTRY



Safety & Health, Mines Inspectorate Rockhampton Office

P.O. Box 548, ROCKHAMPTON QLD 4700 Phone: (07) 4938 4187, Fax: (07) 4938 4331

Mine/Quarry Name	File #	Operator	Activity Type	Region	Activity Date
Blackwater Mine	1714	B M Alliance Coal Operations Pty Ltd	Investigation	Central	20/02/2009

RIPS Elements:

Vision: Our Industries Free of Safety and Health Incidents

Mine Record Entry

This report forms part of the Mine Record under s68 of the Coal Mining Safety and Health Act 1999. It must be placed in the Mine Record and displayed on Safety Notice Boards.

Site Safety & Health Reps Consulted: s.73 Irrelevant information

On 20/02/09 a team of four Inspectors attended the mine to commence investigation into a fatal accident and were joined by a fifth on 21/2/09. They travelled from various parts of the state arriving at different times. The team comprised District Inspector of Mines, Mike Walker (Lead Investigator), Deputy Chief Inspector of Mines Doug White, Inspector of Mines John Sleigh, Inspector of Mines (Mechanical) Bruce McKinnon and Senior Investigation Officer Andrew Broadfoot.

INCIDENT SUMMARY:

At approximately 11 am on 20 February 2009 a Nixon's Communications employee, Mr s.73 lf was driving his Mitsubishi Triton utility north towards the main admin complex on the main haul road in the vicinity of Ramp 54 and ran into the rear of an empty, John Holland owned "Towhaul" low loader travelling in the same direction. The size of the low loader is such that the driver was unaware of the collision and continued on to his destination.

INVESTIGATION:

After being briefed by the IMT, that included viewing photographs just to hand, the accident site was inspected and observations made.

It should be noted at the outset that the accident was very much a "traffic accident" in nature and on arrival at the scene the police were busy with their investigations including the taking of photo's by the forensic photographer. Two police officers from the Blackwater station were also at the scene (and had been for some time). Their expertise in these matters is acknowledged and their investigation activities took precedence but did not inhibit Inspectorate activities.

Activities on Saturday 21/2/09 included:-

- A more detailed examination of the low loader and photo's
- A partial accident re-enactment was conducted in which the Tow haul low loader involved in the accident was driven down the haul road through the accident site. This was at a

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similar time to when the accident occurred and was in similar environmental conditions. It was now 24 hours longer since the road was watered and so would represent drier and potentially more dusty conditions than at the time of the accident. The driver was instructed to drive at the maximum speed that could be achieved while operating the vehicle correctly. The objective was to confirm two factors:-

- The nature of the dust raised by the vehicle at maximum speed.
- 2. Information provided by the Tow haul operator as to the speed of the vehicle in that situation.

The test demonstrated that the dust raised by the Towhaul low loader at that location was minimal and was unlikely to have been a contributing factor in the accident and that the vehicle would have been travelling at approx. 30 kph. The test was photographed and recorded by video camera.

- The low loader undertook a dynamic brake test (empty) a loaded test to be done later
- Travelling from South to North over the crest of the hill and towards the accident site at
 approx. the same time of day as the accident. This was to examine the significance of the
 crest with respect to visibility, the general visibility and the possible effect of the sun.
- A number of formal statements were taken from witnesses
- · A document search was conducted
- Various liaison meetings

NOTE: The accident site was formally released following the re-enactment activities.

Activities on Sunday 22/2/09 included:-

- Taking further formal statements
- Continued acquisition of documents
- Various liaison meetings

There will be further follow up activities before the investigation is concluded.

It was apparant that Blackwater mines rescue and ambulance squad conducted themselves in a thoroughly professional manner

Thanks are extended to mine management for their cooperation and hospitality.

Mike Walker Inspector of Mines Central Region John Sleigh

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11 LIST OF APPENDICES

Appendix I Photographs taken at scene

Appendix II Recorded interviews – audio CD and transcripts

Appendix III Other witness statements

Appendix IV Statement and summary of medical evidence

Appendix V SSE report

Appendix VI Section 4 Medicals – 2007, 2008

Appendix VII Autopsy Certificate

Appendix VIII Toxicology report

Appendix IX Video of re-enactment

Appendix X Truck Examination Report BMCK BWater TH01

Appendix XI Report of Mechanical Inspection of A Motor Vehicle,

Inspection Number 216/2009

Appendix XII Vehicle log book

Appendix XIII Plan view of movements

Appendix XIV Training records – s.73 Irrelevant infor











