File number:
2008/346
Deceased name:
Alan Richard Green

Form 20A

Version 2

Coroners Act 2003 (sections 45, 51 and 97(2))

Coroner's findings and notice of completion of coronial investigation

I have investigated the death of:

Name:

Alan Richard Green

Address:

31 Ninth Avenue, RAILWAY ESTATE QLD 4810 AUSTRALIA

Date of birth: 22/10/1966 Age: 41

Gender: ☒ Male ☐ Female

I find that:

This is how the person died (provide narrative of circumstances of death):

Background

MacMines Austasia was the holder of exploration lease EPC 987, the site of a coal exploration project known as Yarrowmere Project located on Hyde Park Station via Belyando Crossing about 175km north of Clermont. MacMines t engaged Conglomerate Project Management to co-ordinate exploration activities. The managing director, Mr Paul Joseph Dale assumed the role of Site Senior Executive responsible for the exploration activity including safety.

Mr Glenn Campbell was the owner of Campbell's Tippers and Water Trucks and was contracted to supply water to the exploration drills. This involved transporting water from an adjacent property known as EPC 926, also located on Hyde Park Station. Mr Campbell reported:

> *"I entered into a contract with Conglomerate Project Management to initially cart water on the Hyde Park exploration project. The contract was to supply water to the drill rigs on the site during daylight hours. Later on it changed the double shift supplying water to the rigs on a 24 hours basis. About 2 weeks ago I stopped my water trucks from operating on the site due to the conditions of the roads. I had a verbal agreement with CPM that they would maintain the roads for my trucks to operate on. This caused all drill rigs to be shut down as they cannot work without water. Eventually an agreement was made that I would provide some earthmoving equipment and another truck to work on maintaining the roads. Paul Fermi requested me to supply a Grader, Loader and another Tip Truck."*

At the time of the incident, Mr Campbell used two trucks carting water, his 1985 Model Econodyne Mack Truck fitted with a 16000 litre capacity water tank and the other was an International ACCO owned by CPM.

There were a number of drivers involved in the operation. Mr Alan Green had worked for Campbell for varying periods over 8-10 years, started at this site three weeks earlier and was the night shift operator of the Mack truck. Mr Richard Locke was the day shift operator of the Mack truck. And Mr Jeffrey Hunter was the night shift operator of the CPM truck. The driver operated 12 hour shifts from 6.30am to 6.30pm and 6.30pm to 6.30am.

Narrative:

On 24 September 2008 Mr Green returned to the work site after 3 day off work and started on the night shift. On 25 September Mr Campbell attended the work site and, amongst other things, checked the serviceability of the Mack truck including its hand brake. He found the truck was serviceable. In the afternoon, he returned to Townsville.

On 28 September Mr Locke was driving the Mack when it rolled back into an open water pit. Mr Locke started his return to camp to get help when met Mr Dale and reported the incident including the park brake failure. Mr Dale said he would have a look. Mr Locke returned to camp, got Mr Green on a loader and returned to pull out the truck. After removal from the water pit, Mr Locke testing the handbrake and it appeared to hold. Mr Locke couldn't exclude the possibility that the handbrake was not applied prior to the roll back and didn't take the investigation of difficulties with the handbrake any further.

At about 1pm on 29 September Mr Locke noticed deterioration in the effectiveness of the park brake. The truck started to creep back when the park brake was engaged, then grab. At about 4pm Mr Locke found the park brake was ineffective, forcing him to rely on stopping the engine and engaging gear whenever he had to get out. At about 5.30pm Mr Locke returned to camp and reported to Mr Dale that the park brake was failing to stop the truck. Mr Locke tells Mr Dale he will report problem to Mr Campbell. He reported to the Mines Investigators that he didn't get a satisfactory response from Mr Dale and decided to report the defect to Mr Campbell. Mr Locke then telephone Mr Campbell on the satellite telephone and reported the brake problem including the fact that he could hear air leaking under the truck. Mr Campbell told Mr Locke to park it, find out what's wrong and ring him back with list of parts so he can pick up and deliver the required parts tomorrow. There was a poor line of communication over the satellite phone. Mr Locke did not hear Mr Campbell say to 'park it'.

At about 6.30pm Mr Locke approaches Mr Green for assistance in trouble shooting the brakes but Mr Green responds to the effect that it was too dark and they'd do it first thing tomorrow. Mr Green takes the truck and starts his shift. Mr Locke he didn't argue with Mr Green about parking the truck, thinking he was better placed to make that decision.

Mr Campbell later attempted to call Mr Locke but didn't reach him. Mr Locke got a message to call Mr Campbell but he was unable to get through after several attempts.

A driller offsider, Mr Josh Scott, radioed Mr Green from his work ute asking for more water at his location. Mr Green reported that he was just filling up. About 40 minutes later at about 9.10pm, Mr Hunter arrives at a location known as the Bottom Gate and finds Mr Green upright at the rear of his truck with a torch in his hand. It was very dark and on closer examination, realised that Mr Green was pinned between the rear of his truck (right hand water spray baffle plate) and the closed steel gate. Mr Hunter jumped into the driver's seat of the truck, moved it forward and parked it in a table drain. He then called the camp for assistance. Mr Dale and others at the camp responded to the emergency. Mr Hunter conducted CPR until the others from the camp arrived on scene. However, it was apparent that Mr Green was unable to be revived.

An investigation into how Mr Green came to be pinned revealed that he had moved the truck forward through the open gate and exited to close the gate. On closing the gate, Mr Green was standing at the back of the truck when it moved backward on slightly sloping ground and pinned him to the gate.

Mechanical and other inspections and testing of the truck revealed, amongst other things, ineffective park and service brake system.

Autopsy confirmed that Mr Green died due to a severe crushing injury to the chest. His cause of death was certified as multiple injuries due to a motor vehicle accident.

An Inspector of Mines (Mechanical) Mark Moffat prepared a report to the Chief Inspector of Mines in which he identified the following contributing factors:

- Inadequate park brakes;
- Inadequate maintenance;
- A failure on the part of Mr Dale to take the truck out of operation;
- The decision of Mr Green to drive the truck with inadequate park brakes;
- No operational stop or tail lights at the rear of the truck;
- The absence of a Safety and Health Management System; and
- Poor communication via satellite phone.

The decision of Mr Green to drive the truck knowing the condition of the service brake, must be considered in light of the 'can do' culture that exists on work sites of this nature. This is a matter about which senior management on site is expected to exercise leadership. Mr Dale knew about the condition of the brakes and clearly should have exercised leadership in ensuring that the Mack truck was taken out of service until issues with the service brake were rectified.

The Mines Inspectorate identified a greater need to ensure those responsible for safety on sites, Senior Site Executives, understand their statutory obligations and how to satisfy them in a practical sense. It was recommended that the legislative requirements be considered about requiring a legislation exam for Site Senior Executives.

A further recommendation was that the Inspectorate advance and promotes the development and implementation of effective Safety Health and Management Systems for exploration activities.

The Inspectorate also responded with a statewide 'Brakes Blitz' in the form of a comprehensive audit of maintenance systems, aided with a hand held infra-red brake assessment tool which gives an immediate assessment of brake capability.

I am satisfied that the circumstances of this incident were fully investigated by the Mines Inspectorate and that lessons of an OHS nature were fully explored and disseminated.

I also note that MacMines and Mr Dale were prosecuted for breaches of Mining and Quarrying Safety and Health Act 1999 for,

amongst other things, failing to ensure the risks to persons including Mr Green from mining operations was at an acceptable level, in particular, allowing the Mack truck to operate with a defective park brake. MacMines was fined $75,000 and ordered to pay costs including investigation costs of $75,000. Mr Dale was fined $15,000 and ordered to pay investigation costs of $49,908.39.

Findings:
Alan Green died on 29 September 2008 at the Bottom Gate, Mine Access Road, Hyde Park Station due to multiple injuries due to a motor vehicle incident. His was crushed to death when he parked the truck he was driving at nighttime and went to close a gate behind the truck. The truck was parked on a slight slope with an unserviceable park brake. On closing the gate, the truck had rolled backwards and pinned him against the gate causing fatal injury. There were a number of opportunities for intervention within the system of work to prevent this incident. It was preventable.

This is when the person died:
29/09/2008

This is where the person died (where possible this must include whether the person died in Queensland):
Mine Access Road, Hyde Park Station, CHARTERS TOWERS QLD 4820 AUSTRALIA

This is what caused the person to die (this will usually be the medical cause of death):
multiple injuries due to motor vehicle accident

An inquest was not held in relation to this death.

☒ I authorise the investigating officer to dispose of any property obtained in connection with this investigation according to law.

OR

☐ I make the following directions in relation to the disposal of property obtained in connection with this investigation:

Name:
Kevin Priestly, Coroner

Signature:

Date:

Place:
CAIRNS