Dale GADSBY

Findings and Recommendations

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

The *Coal Mining Act 1925* -

Findings and recommendations of reviewers and mining warden following an inquiry into fatal injuries received by Dale Gadsby at Blackwater Open Cut mine on 4 may 1997 Warden's Court of Queensland Emerald 2-3 december 1997.

Before: Mr A J Chilcott, esquire mining warden

Reviewers:

- Mr John Patrick Brady
- Mr Russell David Muller
- Mr Derek Leigh Hammet
- Mr Raymond Norman Bird

To assist:

Ms Margaret Maloney, barrister instructed by crown solicitors office for inspectorate

Appearances:

- Mr A S Mellick, barrister instructed by Messrs Rees R and Sydney Jones, solicitors for next of kin
- Ms M Gibney, solicitor of Allen Allen & Hemsley for BHP Coal and Graham Smith (mine manager)
- Mr M Best, Construction, Forestry, Mining and Energy Union (CFMEU)
- Mr P H Lees, Australian Manufacturing Workers Union (AMWU)

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:

- Michael Paul Walker (inspector of mines)
- Thomas Graeme Sullivan
- Graham Hedley Smith (mine manager)
- Evan Graeme Biles
- Robert Peter Williams
- Paul Van der Klooster (witness in hospital - discharged)
- Francis Geoffrey Paull
- Lyle Booker
- Craig Ian Caton
- James Ronald Wirth
- Darryl Ross Wockner

Schedule "B" List of Exhibits

No of Exhibit	Nature of Exhibit	Tendered by
1	Post-Mortem Examination Report - Form 10	Ms M Maloney
2	Post-Mortem Examination Certificate - Form E	"
3	State Analyst Certificate - 24 June 1997	"
4	State Analyst Certificate - 21 October 1997	"
5	Life Extinct Certificate	"
6	Police Report	"
7	Original Report - Inspector of Mines	"
Exhibit A for Ident	Three (3) Colour Photographs - (Large)	Ms M Gibney
8	Folder of Documents - BHP Australia Coal Limited	"
9	BHP Blackwater Open Cut Mine - Record Book Entry	Mr M Best
10	Three (3) Colour Photographs - (Large) formerly Exhibit A for identification	Ms M Gibney
11	Overtaking Heavy Equipment - (Overhead)	"

12	Original Statement - Professor Christie	"
13	Medical Certificate - Paul Van der Klooster	Ms M Maloney
14	Letter of Appointment - Craig Caton (dated 9 May 1995)	Ms Gibney

Schedule "C" Findings:

We find -

Name of deceased: Dale Gadsby

Date of fatal injury: 4 may 1997

Place of accident: Blackwater

Nature of accident:

Shortly after 12-30 pm on sunday 4 may 1997 Mr Dale Gadsby received fatal injuries when the light vehicle, a toyota cruiser trayback utility, unit number TKP5746, which he was driving collided with and was subsequently crushed by an articulated Euclid 90,000 litre water truck, unit number TKD1300, and trailer 749-1300 being operated by Mr Thomas Graham Sullivan. The passenger in the toyota, Mr Evan Graeme Biles sustained minor injuries.

Immediately prior to the accident, Mr Gadsby accompanied by Mr Biles as the sole passenger in the light vehicle was travelling south along the haul road from the BHP Blackwater mine industrial complex.

At a point about one kilometre south and adjacent to a building known as the large parts warehouse, the light vehicle approached the Euclid water truck which was watering the haul road to the south.

The evidence of Mr Biles and Mr Sullivan indicates that the water truck moved to the left side of the haul road, before turning right into the stockpile entrance prior to the collision occurring.

Mr Gadsby attempted to pass the water truck by moving to the right hand side of the haul road.

When the toyota vehicle was adjacent to the water truck and past the water sprays, Mr Biles observed that the water truck was turning to the right.

From the evidence submitted, it would appear that Mr Gadsby attempted to take evasive action by moving further to the right and applying the brakes in a controlled manner. The toyota subsequently impacted with the right hand side of the water truck primemover and the truck's trailer went over the front section of the toyota.

Cause of death:

From the medical certificate tendered:-

1. (a) Crushed brain

Cause of accident:

From the evidence given to this Inquiry it would appear that the inter-departmental communication between the coal haulage and the maintenance departments on this particular day was inadequate.

As a result of this Mr Biles was unaware that the Ramp 2 west stockpile area was in use and therefore unaware of this mining activity.

Both the light and the heavy vehicles were fitted with two way radio communication albeit on different channels, however, Mr Sullivan stated that no attempt was made by the occupants of the toyota to advise him of the intention to overtake.

It would seem from the evidence that Mr Biles and possibly Mr Gadsby did not realise or know that the water truck was turning into the stockpile area, until just prior to the collision.

Contributing factors may include:-

- A failure to observe the turning indicator on the water truck.
- Visibility obscured by the spray from the water truck.

Mr Sullivan, the water truck operator, did not realise or know that the toyota land cruiser was attempting to pass on the right hand side.

Contributing factors may include:-

- Poor visibility from the operator cabin.
- Water spray.
- No communication with the toyota.

From the evidence presented, although cannabis was detected in Mr Gadsby's urine, we are unable to find whether or not this contributed to the accident.

Although signs were erected, we are not satisfied that the location of these signs clearly defined the entrance and exit of the Ramp 2 west stockpile area.

Schedule "D" Recommendations:

The recommendations of the reviewers are as follows:

1. An effective communication system that ensures that all persons performing duties within the active work areas of the mine are advised of the nature, extent and location of normal mining activities.
    1. (b) This communication system shall contain elements that ensure that all persons are advised of and have sufficient knowledge to identify any abnormal activity.
2. All persons must comply with the safe work procedures, special rules and the manager's schemes for the Blackwater mine.
3. Proactive action should be taken to develop and implement an effective drug and alcohol testing program.

Schedule "E" Report of the Warden:

The reviewers and myself wish to acknowledge the pro-active action which has been taken by BHP subsequent to the occurrence of this fatality.

We also acknowledge that it is the legal responsibility of managers, supervisors, foremen, open cut examiners and mine officials to ensure that all employees are provided with a safe place of work.

However, we also acknowledge that if Acts, schemes, policies and procedures are put into place to ensure the safe place of work then, all employees have a personal responsibility to be fully committed, understand and comply with such processes as a whole.

We commend the inspectorate for the standard of their report. Indeed, we consider the report to be of a high standard. Further, we found the re-enactment video tape to be of great benefit in understanding the incident.

I thank Ms Maloney for her assistance during this inquiry.

I also thank the reviewers and my clerk for their time 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.

03/12/1997

Last Updated 21 October 2007
