Now incorporating Department of Mineral Resources
ABN 51 734 124 190-003

SAFETY ALERT

UNPLANNED MOVEMENT OF MATERIALS POD RESULTS IN SERIOUS INJURIES

INCIDENT

A production worker in a Continuous Miner development panel sustained serious upper body injuries, seven fractured ribs, a fractured scapula and sternum when he was crushed against the rib by a full materials pod.

CIRCUMSTANCES

The production employee was assisting to position a full materials pod, suspended from a jib on a 913 Eimco, onto the left-hand side of the continuous miner. The inbye end of the pod was located into the stops at the front of the miner. The location of the outbye end of the pod required the accurate locating of a pin on the miner to insert into a socket in the pod. The employee was at the outbye end when a sudden movement of the pod to the rib side crushed him against the rib.

INVESTIGATION

The right hand suspension chain, looking inbye had dislodged from the jib. This put all the weight onto the left-hand suspension chain.

Due to the nature of locating the pod to the miner it appeared to be common practice for employees to view the locating of the pin into the hole by moving to the rear of the continuous miner.

The driver's vision was partially blocked by ventilation ducting suspended on the same side of the roadway.

The manufacturer's manual for material pod handling had not been readily communicated to all employees

Due to the restricted work area and vision of the driver, communication between himself and the person giving him guidance was by hand signals, which varied among employees.

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RECOMMENDATIONS

- 1. Mine management employing a materials handling system review and regularly reinforce its risk assessment to identify the hazards and communicate the same to the workforce.
- 2. Determine "No Go Zones" in restricted areas and reinforce on a regular basis to the workforce.
- 3. Ensure the attachments associated with jib suspension and materials handling are such that they are captive at both ends to prevent them from becoming disengaged before the process is completed.
- 4. Review communication between vehicle drivers and those assisting, adopt a common approach and communicate this to the workforce.

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