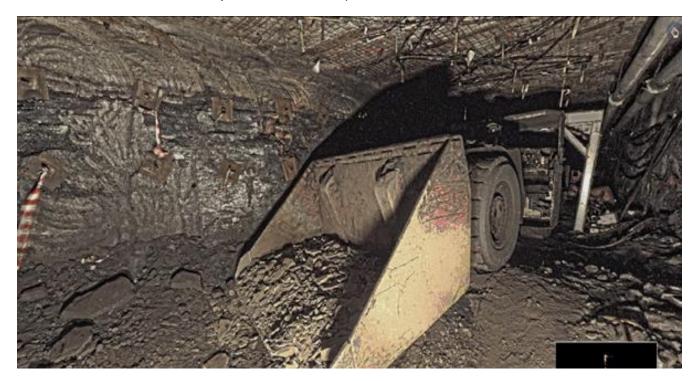


Coal Mine Worker struck by Load Haul Dump

Mines safety alert no. 370

What happened?

A Coal Mine Worker (CMW) was seriously injured when he was struck by an Eimco Load Haul Dump (LHD) bucket. As the Eimco articulated it momentarily pinned him between the side of the bucket and the rib. This resulted in crush injuries due to the impact from the Eimco bucket.



Equipment: Eimco LHD ED7

Hazard: Vehicle / Collision with a person

Cause: CMW working in close proximity to an operating LHD

Comments:

The investigation determined that it is very possible that the Eimco reached the end of its articulation ability as it impacted the injured person. If this was the case the CMW could have been much more seriously injured, potentially fatally, if the CMW or LHD had been in a slightly different position at the time of the impact.

A small crew of CMWs were mucking out a fall of roof after initial support work had been completed. The injured worker was acting as a spotter, within a restricted zone, for the Eimco operator who was removing debris from the fall area with the machine.

The investigation has identified that the CMW was standing in a Restricted Access Zone and believed that with communication protocols in place that he was in a safe position.

Authorised by the Chief Inspector of Coal Mines | Peter Newman Further information contact: Laurie Crisp | Inspector of Mines |

Place alert on noticeboards and ensure relevant people in your organisation receive a copy. See more safety alerts and bulletins at https://www.dnrme.qld.gov.au And the hazard database at https://www.business.gld.gov.au/industry/mining/safety-health/miningsafety-health/mining-hazards/hazards





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A previous safety alert (#161) was issued in 2007 relating to a fatality where persons were in restricted areas with moving equipment in underground operations. The alert recommended;

- All underground coal mines review the safety management system relating to the operation of face production equipment, specifically no go zones, to ensure that risk to all personnel in the face area is at an acceptable level.
- That all underground coal mines conduct refresher training of underground employees in the correct operation of "No Go Zones".

In this particular context, "No Go Zones", related to development equipment. In the findings from the Coroner's Inquest the Coroner referred to CMWs not being in a "No Go Zone" but in a Restricted Zone. There are similarities in this incident that should be addressed by Operators of Underground Coal Mines.

Recommendations:

- Inform all Coal Mine Workers via this safety alert of the circumstances of the incident
- Underground mines should review their safety and health management system with regard to "No Go Zones" around LHD machines. This review should ensure that Coal Mine Workers are not placed in a position where they may be impacted by LHD equipment.
- Mines should review their safety and health management system with regard to risk control.
 This review should ensure that Job Hazard Risk Management documents for high-risk activities
 are reviewed by responsible persons other than those who completed them prior to the risk
 management controls being used.