Safety Alert

Date: July 2025

Supporting video: www.youtube.com/watch?v=wW-8PqoC9Xs

Worker seriously injured after being trapped in ventilation doors

This safety alert provides safety advice for the NSW mining industry.

Incident

A serious incident occurred during a planned major ventilation change involving a set of double machine doors, on 13 June at a mine in the Wollongong region. One worker suffered significant injuries after becoming trapped between the doors, highlighting the risks associated with uncontrolled movement of ventilation infrastructure under pressure.

Figure 1: The double doors at an underground mine site

Safety Alert SA25-03

Circumstances

During a planned ventilation change at an underground coal mine, workers were tasked with opening a set of double machine doors to redirect airflow. Due to significant pressure on the doors, mechanical assistance using a load haul dump (LHD) and man basket was required to open the inbye doors on the belt-road side.

The first (outbye) set of doors were opened and secured. Workers were in the process of opening the second set of doors. The right-hand door was opened by chaining the door to the man cage of an LHD and reversing the machine backwards to break the seal. The left-hand door was opened and appeared to be chained to the rib. While the team was in the process of unchaining the right-hand door from the LHD, the left-hand door unexpectedly became unsecured and closed rapidly, trapping a worker between the 2 doors.

The trapped worker remained pinned for up to 2 minutes before being freed by a colleague using improvised methods, including prying and repositioning the LHD to reapply force. The injured worker suffered serious injuries as a result of the uncontrolled door movement.

Key factors

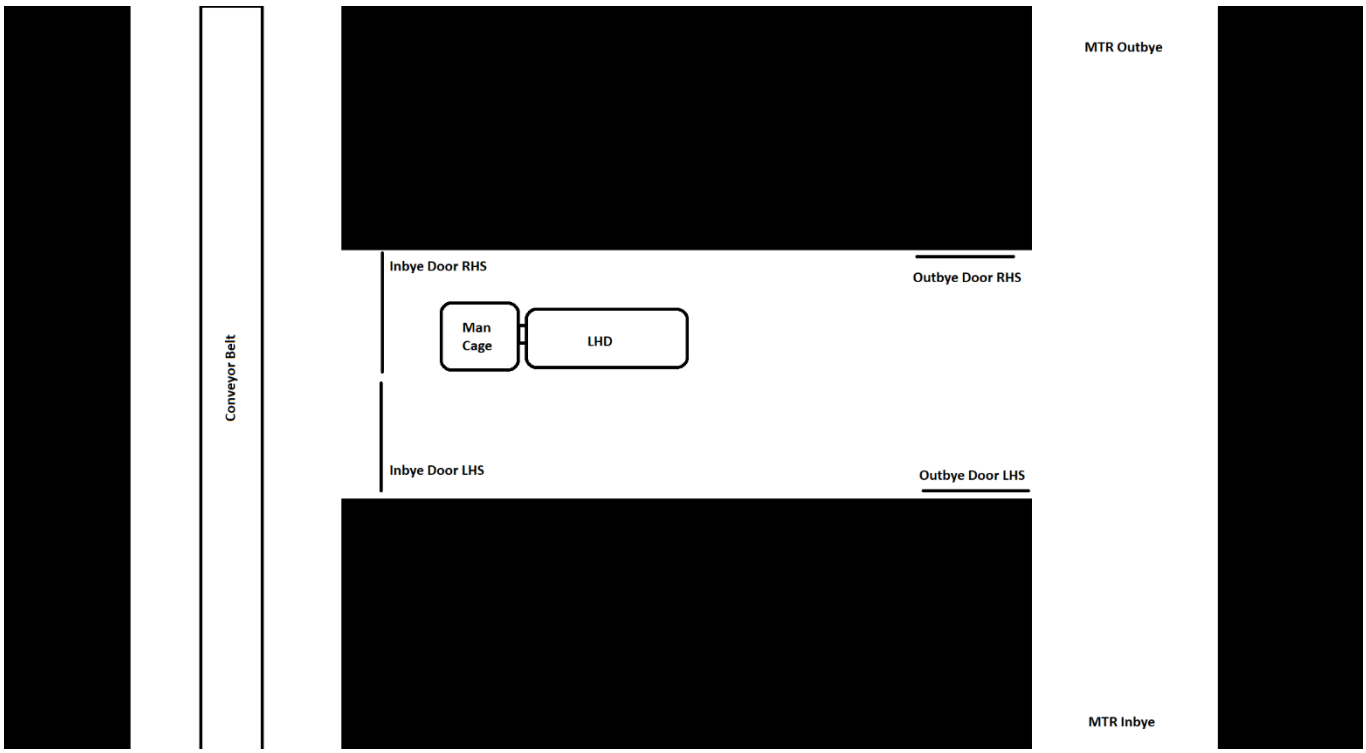
- No formal procedure existed for safely opening and securing double doors in instances when both doors were required to be open at once.
- No clearly defined exclusion zones or controls were in place to prevent workers from entering hazardous line-of-fire positions during the task.
- The method used to secure the left-hand door was improvised and not confirmed to be effective or stable.
- The pressure acting on the doors was not fully accounted for in the task planning or risk assessment. It should be noted the risk also existed when closing the doors.

Recommendations

All mine operators should:

- Develop formal, documented procedures for securing double doors in instances where both doors are required to be open at once.
- Identify and control line-of-fire hazards associated with high-pressure ventilation infrastructure through defined exclusion zones and task sequencing.
- Ensure door restraints and securing methods are engineered, fit-for-purpose, and verified before work begins.
- Train relevant personnel in using any mechanical aids, securing devices, and safe work practices for handling high-pressure ventilation systems.
- Include hold points in procedures to verify critical controls are in place before progressing through each stage of the task.

Figure 2: Diagram showing layout of incident site



Note: Please ensure all relevant people in your organisation receive a copy of this safety alert and are informed of its content and recommendations. This safety alert should be processed in a systematic manner through the mine's information and communication process. It should also be placed on the mine's common area, such as your notice board where appropriate.

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