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

# SAFETY ALERT

# MINER KILLED IN UNDERGROUND SHAFT (Updated Alert)

#### **INCIDENT:**

An employee was travelling in a man-riding cage, operated by a winder driver, when his head was caught between a cage component and the shaft platform at one of the levels underground. The employee died as a result of his injuries.

## **CIRCUMSTANCES**

The cage involved in the incident was a double deck man-riding cage with two doors on each cage. One door is fixed and the other is a sliding door. When the sliding door is fully open both doors can be opened back into the cage. Across the front of the cage is a drop bar that is normally used when material is hoisted, but is closed when hoisting people.

The employee was alone, travelling up the shaft from one level to another in the top deck of the cage. The cage stopped slightly above the level it was going to as the winder driver had not received a stop signal. Two employees waiting at the level went to the cage, opened the platform gate and discovered the employee lying on the platform.

### INVESTIGATION

From the investigation it was concluded that the sliding door had been left open or had been opened by the employee during travel. The drop bar was down. The employee had put his head outside the cage into the shaft and was crushed between the drop bar and the shaft platform.

### **RECOMMENDATIONS**

- All mining companies with shaft mine access review their employee shaft transport risk assessment in light of this accident.
- Particular attention should be directed to the interlocking of cage doors during travelling.
- Review safe work procedures in light of this accident.
- All personnel who use the cages are trained, assessed and authorised before they use the cages.

Report No: SA 04 18 Comet ID 24492000001 Date: 16 September, 2004 Prepared by: Bob Johnson Phone (08) 6572 1899



R Regan
DIRECTOR MINE SAFETY OPERATIONS

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