

Government of Western Australia Department of Mines, Industry Regulation and Safety

Safety and Health Snapshot

for the Western Australian minerals sector

Amputations, fractures and crushing (AFC) injuries

ssued November 2019



6% were bauxite and alumina

May 14 - Apr 15

May 15-Apr 16

Fractures

May 16 - Apr 17

Amputations

May 17 - Apr 18

Crushings

May 18 - Apr 19

50

Some recent incidents



Crush injuries 02/05/18

A worker at an open pit received a crush injury to his finger. He was sourcing ground engaging tools (GET) for a bulldozer at the supply warehouse goods storage and pick up yard and had placed them on a forklift tyne. The GET rolled onto his hand and his finger was pinched between the GET and the forklift tyne. The worker was treated at the medical centre before being flown to hospital in Perth for surgery.

Spotlight on Mines Safety Significant Incident Report No. 241

Underground worker crushed between integrated tool carrier (IT) work basket and roof of excavation (backs)

7 June 2016



Contributory causes

- Lack of effective communication between personnel.
- The injured person was new to the task and was undergoing training.
- Tilting of the work basket was not included in the training documentation.
- The operator directing the work basket was not aware of the position of the offsider when the direction was given to tilt the work basket.
- The operating procedure did not identify the potential for a crush hazard while conducting work from the basket.



- Crush injuries 22/08/18

A driller working on a diamond drill rig at an underground mine attempted to manually feel a break in the core sample. When he handled the drill rods, the chuck moved up the rod and trapped his hand between the chuck jaws and the water swivel. The driller managed to free his hand by releasing and moving the chuck mechanism. First aid was given and a supervisor informed. After receiving initial attention at a regional nursing post, he was flown to hospital in Perth for further treatment, which included amputation of two fingers.

Spotlight on Mines Safety Significant Incident Report No. 242

Tyre fitter's fingers crushed while operating hydraulic bead breaker 14 June 2016





Contributory causes

- The equipment design does not encourage the correct positioning of hands nor restrict access to moving parts.
- There is no guarding to prevent inadvertent contact with moving parts nor labelling on the equipment to warn of the nip or crush point.
- Work instructions did not outline the controls for all hazards associated with the task.

Safe work practices

All personnel need to remain vigilant and ensure that they do not enter any area or place themselves in a position where an AFC injury could occur. The following safe work practices are recommended to reduce the incidence, frequency and consequence of AFC injuries.



Identify all potential AFC hazards, assess the risk of injury and implement sufficient effective safety controls in line with the hierarchy of control.



Eliminate the need for personnel to undertake any task where AFC hazards are present.



Introduce automation, tooling and load shifting equipment to reduce the need for any hands on tasks.



Install guarding for all equipment moving parts and pinchpoint hazards.



Improve the selection of working at height equipment (e.g. EWPs and underground baskets) to ensure it is fit for purpose, has height limiting sensors and is fitted with physical barriers.



Provide safe access and egress and handrails on all walkways, fixed plant and mobile equipment.



Establish stop points in work tasks to ensure management and supervision are present to implement effective prevention strategies.



Train personnel to identify the key AFC hazard categories and apply the correct hierarchy of controls.



Implement an effective ergonomic program for the management of all hazardous manual tasks.