REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

01 June 2016

Note: While the majority of incidents are reported and recorded within a week of the event, some are notified outside this time period. The incidents in this report therefore have not necessarily occurred in a one week period. All newly recorded incidents, whatever the incident date, are reviewed by the Chief Inspector and senior staff each week and summarised in this report. For more comprehensive statistical data refer to our Annual Performance Measures Reports.

Reportable incidents total

Level 1 incidents	Level 2 incidents	Level 3 incidents
31	7	0

Note: Incidents are categorised as Level 1, 2 or 3 according to the seriousness of the incident, with 3 being the most serious.

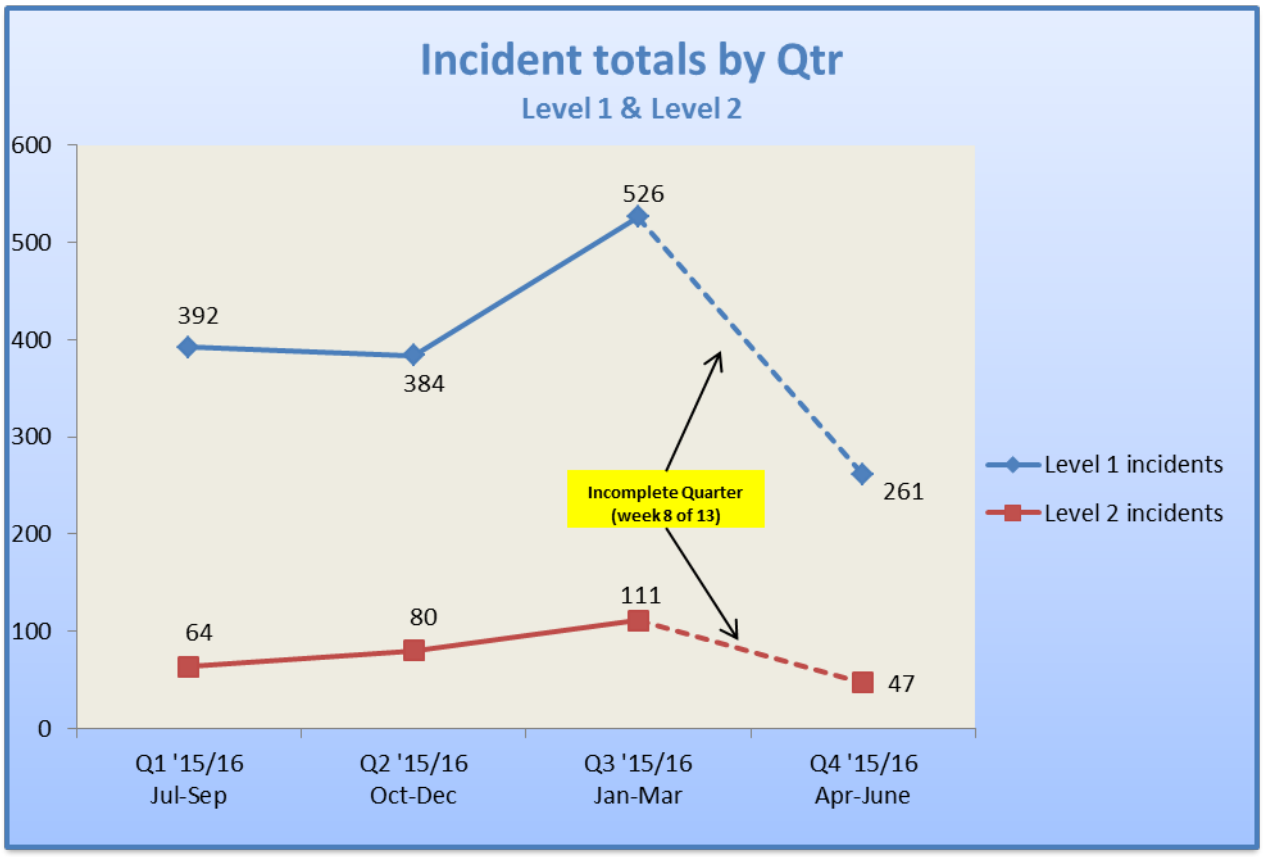
Injuries	Fatalities
8	0

Reportable incidents overview

Note: While all incidents are investigated, generally only level 2 and 3 incidents are summarised below.

Level	Incident type	Summary	Comment to industry
2	Fall 317660962001	A worker slipped on some conduit and fell across an open floor-space inspection hatch when taking photos of a new electrical installation.	Mines should review their Contractor Management Plans and SWP's with particular attention to supervision, risk management and maintaining housekeeping standards. Open hatches should be clearly identified and have barriers in place to prevent falls.
2	Loss of control 317660980001	A service truck lost control on a ramp and collided with the windrow. The ramp had been watered earlier and there were skid marks indicating a loss of traction.	Mines should review vehicle operations on roads and ramps with a focus on safe driving during and after inclement weather and road watering operations. Heavy and light vehicle operators need to be aware of changing road conditions and rules that apply.
2	Unplanned movement 31766090001	An MBF bolter was being used to drill 8m PUR holes on a longwall face. The bolter was anchored to the pan line by a U-shaped bracket that fitted over the spill tray of the AFC. During drilling the drill string bowed and lifted the U bracket off the pan line allowing the bolter to extend into the chock line.	Mines should ensure that any such anchor bracket is designed to provide restraint in all directions that force may be applied. In this case, a restraint against vertical movement was added.

Level	Incident type	Summary	Comment to industry
2	Unplanned movement 317660982001	A worker had his finger crushed between the base of a roof bolt and the top of a drill rig dolly while installing monorail hanging brackets. A drill rig on a continuous miner was being used to do the job when the documented process nominated another method.	Mines should consider alternative methods for installing ancillary items on to roof bolts other than the CM drill rig. Drill rigs should only be used for the design function. Any variation of use of drill rigs should follow change management procedures.
1	Fall of pipe 317661063001	A supply pipe fell from supports onto a walkway below. Failure of a rotating flange on an 82.5 degree bend that caused the pipe to move as the fluid released under pressure. The movement overloaded the pipe support brackets allowing the pipe to fall.	Mines should regularly inspect the integrity of all pipe mounting brackets/ hanging supports. When designing infrastructure involving piping/ brackets/fastenings, consideration must be given to the total weight of the pipe and the contents being suspended.
2	Unplanned Movement 317661020001	A serious near miss incident occurred when an equipment operator was grazed by the front wheel of a Cat 785 dump truck while he was on the ground conducting pre-start checks on the vehicle. Another operator had incorrectly assumed he was allocated this same truck and after completing his pre-start checks had entered the cabin and drove the truck away from the Go-Line without realising another operator was inspecting the same truck.	The mine operator must ensure, so far as is reasonably practicable, the workplace or means of entering or exiting the workplace are without risk to the health and safety of persons. The mine operator must also ensure the provision and maintenance of safe systems of work and ensure adequate instruction, training and supervision is provided to protect all persons from risks to their health and safety. Management have a duty to identify hazards and implement risk control measures to minimise the risk to the health and safety of workers. Examples of risk controls are: appropriate segregation distances between trucks, delineated walkways, formally allocated trucks, sequencing of truck/operator despatching.
2	Work environment 317661042001	A worker was found dazed and disoriented on the ground next to a shuttle car. The apparent (but not yet confirmed) cause of the incident was that he was struck by a plate that had been ejected from an 8m tendon support. The helmet of the injured person had a split brim and the cap lamp holder had been sheared off.	In areas where there is a large roof displacement consider the need for an inspection of the tendon bolt plates in the area, looking for signs of the barrel/wedge arrangement pulling through the plate. Consider developing a support or restraint (suitable for the force of release of the plate) for those plates at risk of failure.
2	Collision 317661057001	Collision between FEL980H and 7408 articulated dump truck. Failure to provide positive communication within the 10 20 30 zone of operation.	Operators should be reminded of the importance to inspect workplaces to ensure suitability of safe standoff distances between operating plant. Review site traffic management plans and ensure that controls are being followed by operators.



Recent incident publications

No recent incident publications.

You can find all our incident related publications (i.e. safety alerts, safety bulletins, incident information releases, weekly incident summaries and investigation reports) on our website.

Further information

Should you wish to seek further information, please contact one of our offices:

COAL (NORTH) and EAST METEX

Maitland

NSW Department of Industry
Mineral Resources
516 High Street, Maitland NSW 2320
(PO Box 344, Hunter Region MC
NSW 2310)
T 1300 736 122 or 02 4931 6666
F 02 4931 6790
E mine.safety@industry.nsw.gov.au

COAL (SOUTH)

Wollongong

NSW Department of Industry
State Government Offices
Level 3, Block F, 84 Crown Street,
Wollongong NSW 2500
(PO Box 674, Wollongong NSW 2520)
T 02 4222 8333
F 02 4226 3851

WEST METEX

Orange

NSW Department of Industry
161 Kite Street, Orange NSW 2800
(Locked Bag 21, Orange NSW 2800)
T 02 6360 5333
F 02 6360 5363
After hours – emergency only 02 6360 5343