

REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

2 March 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
39	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
5	0

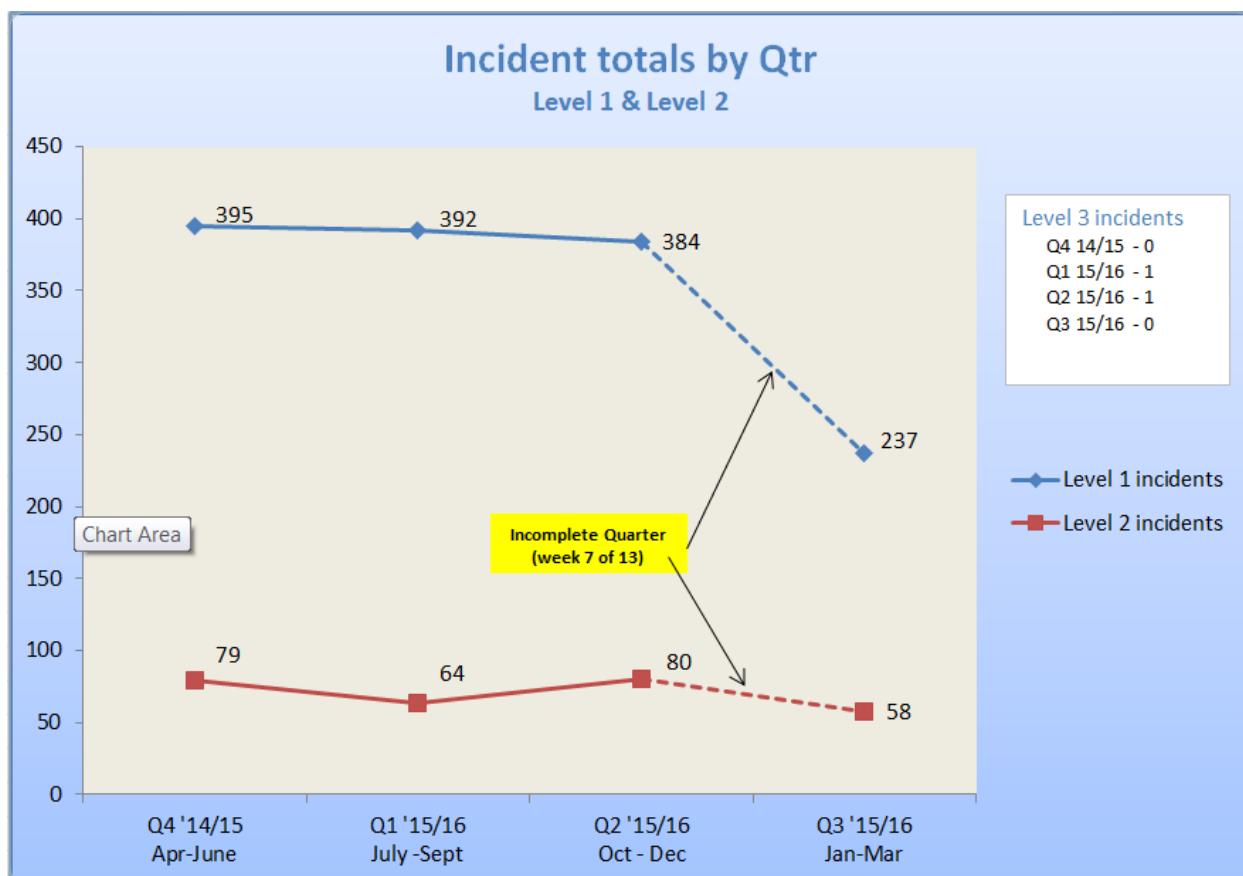
Reportable incidents overview

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

Level	Incident type	Summary	Comment to industry
2	Mechanical equipment 317658890001	A work-over crew were engaged in pulling tubing out of a hole. When the driller applied the draw works brake to stop hoisting, a critical pillow block in the brake linkage system failed and the brake was released. The travelling block and elevators descended until arrested by the tubing tong, with the travelling blocks then leaning over and resting on the V-Door. The crew evacuated the work floor safely. The driller did not hit the emergency shut-down device (ESD) which would have engaged the draw works brake and stopped descent of the travelling blocks.	Where pillow blocks are critical components of a draw works brake linkage system, or any other system critical to the safe operation of a rig, they should be considered in routine quarterly NDT inspections. Driller's awareness in respect of emergency responses should be reviewed, in particular, the use of ESD.
2	Strata ground control 317658337001	A worker working on a rock filled stope floor was preparing to bore a rib pillar with a jumbo - to enlarge a breakthrough and create a tip head to fill the adjacent stope. On hearing rocks rilling in the adjacent stope he withdrew and turned off the water hose spraying onto the rock fill.	The risk of destabilising the fill in the stope had been recognised and addressed via a Tele-Remote Risk Assessment (TRRA) which was not implemented. Multiple formal controls should apply at each step of any mining process (i.e. mine planning through to drill/blast/muck/fill).

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		<p>On return he saw that the rock fill had slumped beneath the jumbo.</p> <p>During filling of the stope the rock fill had flowed through a window/void into the adjacent empty stope. This created a rill that blocked the window/void and contained the rock fill within the filled stope.</p> <p>Further ore was fired in the empty stope and removed by tele-remote loading which disturbed the rock rill from the adjacent stope and exposed the window/void between the stopes.</p> <p>The application of water appears to have mobilised the fill at the exposed window/void, leading to the slump in the stope.</p>	<p>Controls should be such that a failure at any one point will trigger a reaction e.g. loader operator (& supervisor) refuses to load out without a valid TRRA. This means employees must be empowered to stop the job when a system failure is detected.</p> <p>In this case the problem was exacerbated by failures in communication and a relaxed safety culture at the mine meaning procedures were not rigidly enforced or adhered to.</p>
2	Mechanical equipment 317658806001	<p>A worker was in the basket of an elevating work platform at the brow of an open stope. He was checking up-holes prior to charging.</p> <p>A 'hang-up' of broken ore material in the stope rilled (slumped down). The material ran over/through the top of the drawpoint safety bund but did not come into contact with the basket or a second worker, who was standing behind a pre-determined 5m safety demarcation line.</p>	<p>Risk controls where work is conducted in proximity to a drawpoint brow (particularly beyond a safety demarcation line) should include bund design that specifically considers the stope geometry, drawpoint dimensions and the practicality of constructing the bund.</p> <p>Purpose built bund construction equipment may be required to achieve design bund height.</p>
2	Mechanical equipment 317658842001	<p>The operator of a rear dump truck lost control as the truck was being driven down a ramp, this resulted in the truck sliding approximately 80m impacting the left hand side embankment of the ramp. Excessive truck speed on the ramp in conjunction with a wet, slippery road surface, may have contributed to the incident.</p>	<p>The maximum travelling speed of trucks and other vehicles should be established for each site, taking into account the vehicle load, roadway gradient and surface conditions. Additionally, information should provide operators with steps to be taken to recover control of the vehicle in the event of loss of traction.</p>
2	Electrical energy 317658812001	<p>A newly completed cable joint in a PVC junction box caught fire shortly after commissioning.</p>	<p>The electrical engineering control plan for a mine must provide for visual inspections of electrical installations to be undertaken as per Chapter 8 (clause 8.2) of AS/NZS 3000 prior to a circuit being energised for the first time. As part of these inspections, connections must be checked as correct and secure.</p>
2	Work environment 317658870001	<p>An electrical fault in the surface 11kv power correction building caused a small fire. A hot joint on a contactor appears to have been the cause.</p>	<p>Maintenance and inspection systems for electrical plant and installations need to include checks that verify the integrity of circuit connections at frequencies that are appropriate to the type of equipment and to the duty cycles for that equipment.</p> <p>Installation and modification works undertaken</p>

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2	Electrical energy 317658876001	<p>A operator reported an electric shock through his hands when touching the frame of a continuous miner with one hand & rib mesh with the other hand. Production activities were occurring at the time.</p> <p>A cutter motor cable was found to be damaged.</p>	<p>by contract organisations must be reviewed by the mine to ensure that works undertaken attain the standards required by the mine's management systems.</p> <p>Inspection and maintenance procedures must include the routine inspection of machine (motor) cables as well as enclosures, to identify issues such as build-up of fines or other debris that may cause damage.</p> <p>Failure to adequately inform personnel of modifications to electrical plant had led to practices of resetting power following protection trips, without effective testing.</p> <p>Procedures for restoration of power following a protection trip must include methods that are to be followed by all personnel to identify the cause of the trip prior to restoring power.</p>



Recent incident publications

No recent incident related 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:

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