REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

14 December 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. For more comprehensive statistical data refer to our Annual Performance Measures Reports.

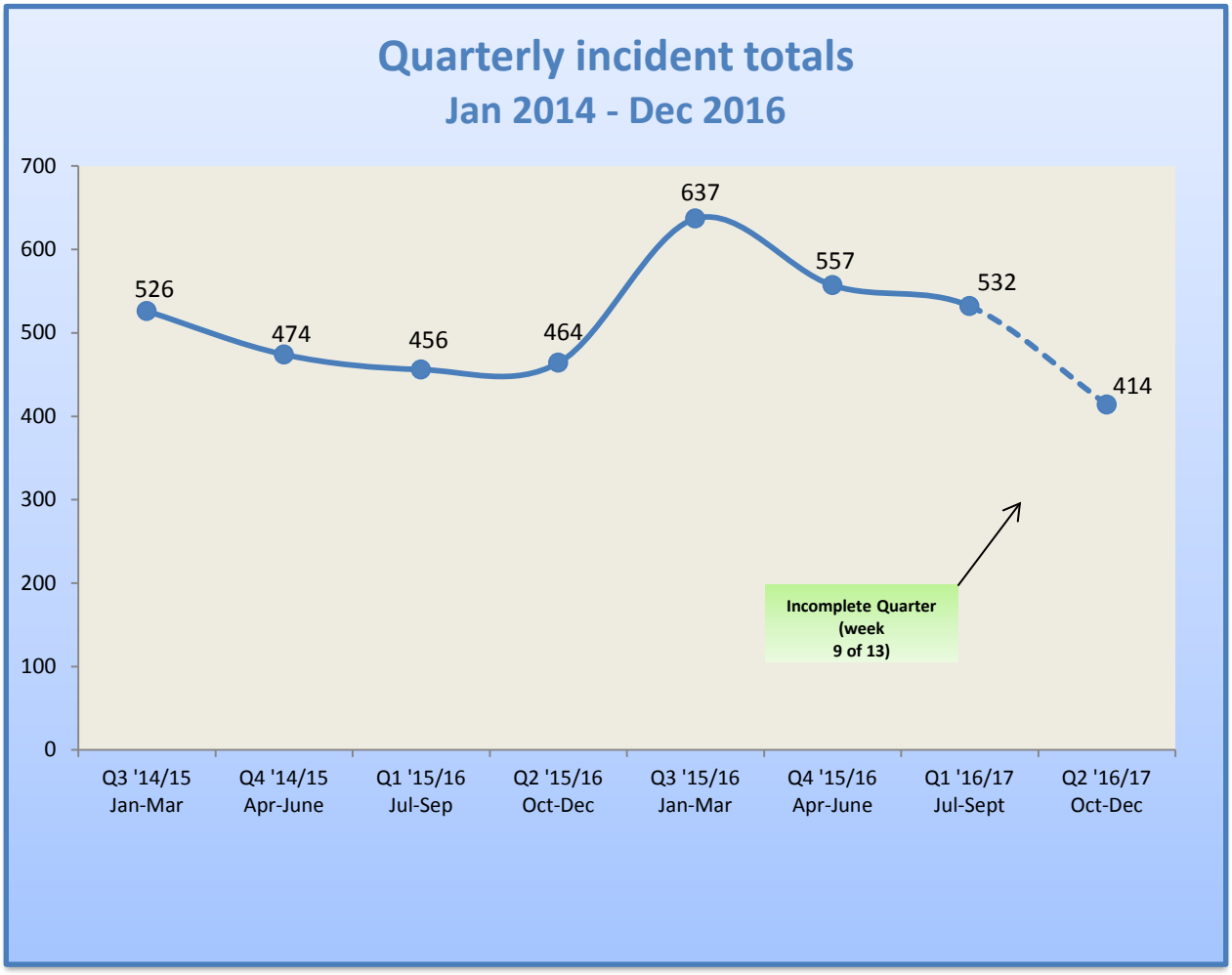
To report an incident call 1300 814 609 24 hours a day, 7 days a week

Reportable incidents total: 50 Summarised incidents: 5

Summarised incidents – incidents of note for which operators should consider the comments provided and determine if action needs to be taken.

Incident type	Summary	Comment to industry
Dangerous incident SInNot 2016/00933	A tradesman was using a 5" cutting disk, to cut a section of a when a piece of the disk broke off and struck him, embedding a piece of the cutting disc in his chest.	Before using cutting disks, mines should: • Consider various work methods and equipment so the safest is selected including PPE. Train operators in the use of cutting disks including: o awareness of the disc may kick back, and o the steel work that is being cut jamming the cutting disc. e.g. from the steel bending as the steel is being cut. o two-handed operation of cutting disc. • Check the work area is secure and stable, • Check equipment is inspected, in good order, has a handle and fit for task to be performed, • Check cutting discs are not worn down beyond their limits, • Confirm steel work is cut being square.
Dangerous incident SInNot 2016/00923	Some small rocks fell from a batter face in a metalliferous open pit mine and travelled down about 30 metres onto the main haulage ramp, landing approximately 5 metres from the highwall. No equipment or workers were in the vicinity when the rocks fell. Upon inspection it was noted that other rocks had also dislodged and became caught on a catch berm.	Mine operators should ensure that all highwalls are regularly inspected and monitored for potential areas of instability/poor ground conditions. Inspections should include detailed geotechnical assessment. Safe work procedures should be implemented when working in proximity to high walls. Audits should be conducted to ensure that procedures for working near highwalls are effectively implemented.

Incident type	Summary	Comment to industry
Serious injury SInNot 2016/00917	A worker collapsed and lost consciousness after exiting a confined space work area. The cause of lost consciousness for the worker is still to be determined.	Mine operators are reminded of their obligations working in confined spaces, refer to http://www.safework.nsw.gov.au/health-and-safety/safety-topics-a-z/confined-spaces Confined space work should comply with the NSW confined space code of practice, refer to http://www.safework.nsw.gov.au/__data/assets/pdf_file/0015/50073/confined-spaces-code-of-practice-3558.pdf
Dangerous incident SInNot 2016/00913	An articulated water truck skidded a distance of about 4 m in the direction of travel on a wet down ramp. It was reported that when the brakes were applied the wheels locked. The truck came to rest without contact with any other structure or berm. Nobody was injured and no equipment was damaged.	There have been several instances of vehicles skidding due to wet road conditions reported to Mine Safety recently. Mines should remind truck operator of: • Driving to the road conditions and slowing down on wet roads, • Using the retarder when travelling down ramps, • Selecting the correct gear when descending. Mine operators should also consider road wetness as a potential hazard in their PMHP for roads and other operating areas.
Dangerous incident SInNot 2016/00910	Timber was placed under a longwall chock pontoon. When finished and resetting chock, a worker used a chain block to lift services out of the way but broke a hydraulic hose. Fluid hit the chock leg and deflected onto worker's helmet. The worker was cleared of injury by the company's on call doctor. The investigation found the chain block was being used to support the Maingate cable and hose bretby become entangled around the hi-set isolation valve.	Mines need to consider: • The routing of pressurised hoses and other services, such as to minimise the potential of damage and/or entanglement, • Locating lifting equipment such as to minimise potential of damage and/or entanglement with hoses and/or cables services, • Locating, positioning and orientating isolation valves so as to minimises any potential of damage and/or entanglement.



Recent incident publications

SA16-09 Non-compliant stone dust supplied to underground coal mine

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

Email: mine.safety@industry.nsw.gov.au:

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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (December 2016). However, because of advances in knowledge, users are reminded of the need to ensure that information upon which they rely is up to date and to check currency of the information with the appropriate officer of the NSW Department of Industry, Skills and Regional Development or the user's independent advisor.