

REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

21 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: 55 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 |
|---|---|--|
| Serious incident SInNot 2016/00992 | An excavator dug into loaded shot while double benching. It was reported that a 10 m exclusion zone was in place at the time (witches hats and red flashing lights). The excavator operator realised there was a problem when he saw one of the red flashing lights in the dig face. | Mine operators should review the adequacy of their arrangements for delineating exclusion zones, particularly considering the visibility of the zones to the operators of mobile mining equipment in the vicinity. |
| Dangerous incident SInNot 2016/00983 | A collision occurred between a light vehicle and a LHD. The LHD was driving down a ramp in second gear carrying a set of AFC pans. The machine was taking up a significant amount of the available road width. The person driving the light vehicle tried to pass the LHD and assumed the LHD operator had seen his vehicle and would stop, but the LV driver had restricted visibility. The vehicles collided resulting in the light vehicle being damaged. The driver was sent to hospital as a precaution. | Mine operators should consider segregation of light and heavy vehicles as an effective control measure. Refer to investigation report into the fatal collision at Ravensworth open cut mine in 2013. |
| High potential incident SInNot 2016/00974 | There was a fall of rock down a bench face close to where there was an operator working on a portable screen plant. | Mine operators should consider the use of appropriate benches and bunding as an effective control measure to contain the potential risk to operators of rock falls from slopes and high walls. |

| Incident type | Summary | Comment to industry |
|---|--|--|
| Dangerous incident SInNot 2016/00976 | <p>A winder cage with several people on board hit something when leaving an underground level plat. No injuries occurred but the cage received minor damage. A fault with the retractable plat where the cage was loaded required that the plat be retracted manually. The plat was retracted manually while the cage was still engaged with the plat and just as the cage was starting to go up the shaft. This caused the cage to swing and strike the shaft wall and the next level plat.</p> | <p>Mine operators should ensure that only trained and competent people operate equipment associated with shaft winding systems including manually operated functions.</p> <p>Where manual controls of winder functions can bypass/override automatic controls or the functions that are controlled by a winder driver, the access to these controls should be restricted by hard barriers or interlocking.</p> <p>The mine should have clearly documented procedures for the operation of winding systems including manually operated functions that may be required for maintenance and repairs.</p> |
| High potential incident SInNot 2016/00970 | <p>An operator in an underground metalliferous mine was using a Jumbo drill rig to drill a development face when flames came out of two drill holes. The flames came out for several minutes and then went out. The flames were from an ignition of gas from the geology, released via the drilling. The operator backed the drill rig away and out to the decline edge. The operator was not injured or affected by the flames and the drill rig was not damaged. The operator had a gas detector that did not alarm before or after the flames appeared.</p> | <p>Mine operators should be aware of areas where gas has the potential to release from ground strata. The hazards associated with unintended release of gas must be assessed and appropriate controls must be implemented.</p> <p>Controls in a metalliferous mine may include but are not limited to:</p> <ul style="list-style-type: none"> • establishing formal exclusion zones • regular gas monitoring of areas where gas may potentially accumulate • procedures for workers to access and work in areas where gas may be released or accumulate. <p>Mine operators should consider the need to probe drill for gas accumulations using appropriate drilling techniques.</p> |



Recent incident publications

Principal hazard management plans guide

Mine Safety has published the Principal hazard management plans guide. It includes guidance on what's required to manage principal hazards and sources of information on particular hazards.

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

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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.