

REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

8 February 2017

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](#).

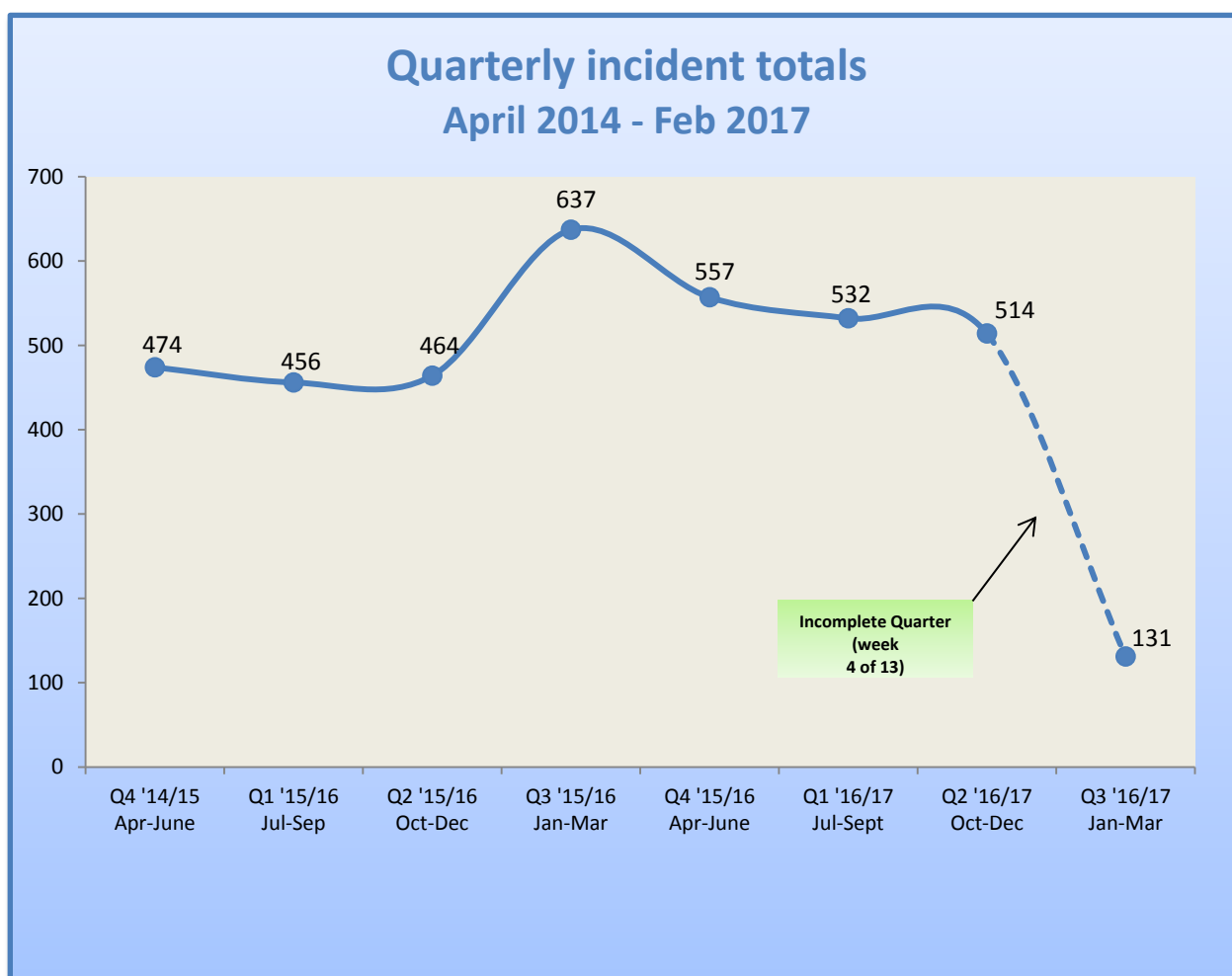
To report an incident call **1300 814 609** 24 hours a day, 7 days a week

Reportable incidents total: 39 Summarised incidents: 4

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 2017/00160	A shaft winder was in automatic mode bringing 12 people to the surface. It tripped out at 3.6 m below the surface due to the plat not being extended (i.e. not engaged into the cage plat guides). The winder was then placed in manual control to raise the cage out of the mine sufficiently to reset the winder position encoder. Once the position encoder was reset, it was then intended to then extend the plats and return the cage to the docking platform to enable the men to disembark. The cage subsequently hit the plat while being raised manually as the plat had in fact partially extended.	Winder controls should not enable movement of the cage while the plat is either not fully engaged, or not fully retracted for the appropriate mode/stage of the operation.
Dangerous incident SInNot 2017/00159	As a shaft cage was returning to the surface empty after dropping off a mine worker, the winder suddenly tripped and stopped the cage partway to the surface. When the cage was later brought to the surface, it was found that the cage sliding door had come open during transit causing the winder to trip.	Maintenance of the winding system, including the cage, must be undertaken in accordance with the manufacturer's recommendations, or if no manufacturer recommendations, as required by a competent person familiar with the winding system (refer to WHS clause 213).
Complaint SInNot 2017/00143	The department has received a complaint relating to the reporting of several safety defects and practices on a NSW quarry site.	It is the quarry operator's responsibility as the person conducting a business or undertaking (PCBU) under the <i>WHS Act</i> to ensure the protection of workers and others against harm. A PCBU must ensure, in so far as is reasonably practicable, that persons are not put at risk as a result of the conduct of their operations.

Incident type	Summary	Comment to industry
Dangerous incident SInNot 2017/00141	On night shift, the driver of a DT771 dump truck was reversing into the work area of an excavator when it struck the D10 dozer that was cleaning up the area. No workers were injured.	Investigation of this incident should highlight to mine operators that traffic management plans should include: <ul style="list-style-type: none"> • Positive communications process at the mine for all vehicle interactions • Lighting requirements for night shift operations • Allocation of who controls the loading/work area • Fatigue management • Adequate supervision arrangements to verify controls are being maintained



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

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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (February 2017). 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.