REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

Published 30 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
40	10	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
11	0

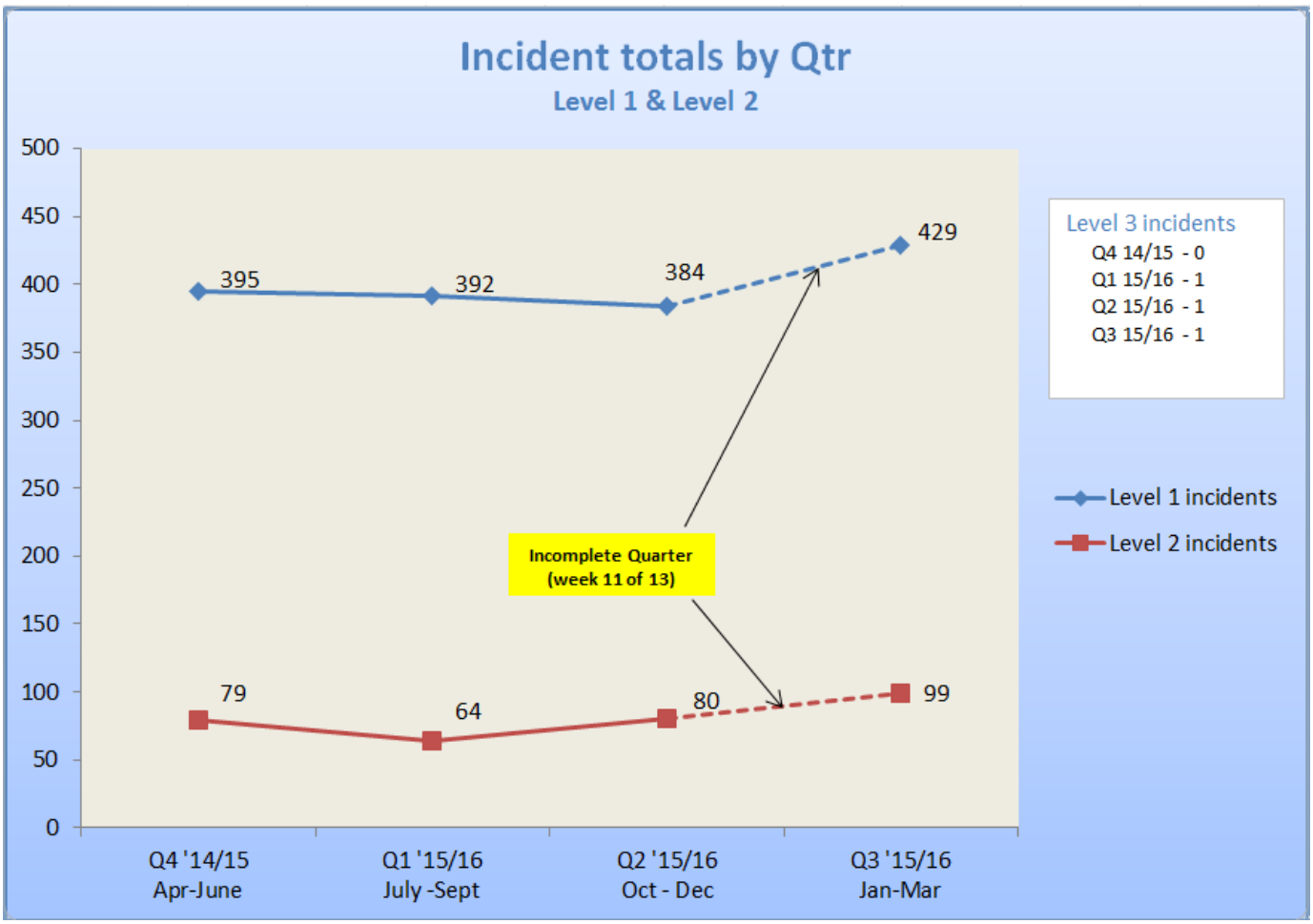
Reportable incidents overview

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

Level	Incident Type	Summary	Comment to industry
2	Work Environment 317659685001	On the completion of engine bay live test inspections an equipment inspector attempted to move position on the left hand track of a dozer. While transitioning his stance he has fallen onto the push arm landing on the ground outside of the machines footprint.	Mine operators should ensure workers are provided with safe access points whilst inspecting / working on equipment. In the event of a slip or fall, restraints and/or safety chains should also be considered.
2	Mechanical Equipment 317659613001	A fitter was attempting to rotate a crusher drum using a steel bar. The fitter had one leg (right) off the ground, positioned on the crusher, with the other (left) on the ground. As the crusher drum started to rotate, the fitter's weight went from being placed on the front leg (right) to the back leg (left). As the weight went onto the left leg the fitter felt his left knee give way, followed by pain. The fitter fell to the floor. The fitter was taken to hospital, where x-rays identified a dislocated and fractured (L) patella, and a fractured (L) distal tibia.	Safe systems of work should consider minimising a workers exposure to stored energy that could be potentially harmful to workers whilst carrying out a task. In consultation with original equipment manufacturers, it is recommended that mine operators review the use of engineering controls where practicable whilst carrying out work on equipment. This should include the use of suitable devices or tools.

Level	Incident Type	Summary	Comment to industry
2	Mechanical Equipment 317659635001	The cabin of a 30t articulated truck rolled over during reversing action to tip the load.	Plant must be driven at appropriate speed when manoeuvring in reverse on uneven ground.
2	Explosives 317659663001	A pyromex booster was found while digging the interburden to the coal seam. Some detonation cord had been noticed in the area prior to the booster being located.	Sites must maintain effective explosives management systems. These systems should include safe work procedures and signed off checklists that minimise the potential for misfires and / or unaccounted explosives devices.
2	Mechanical Equipment 317659687001	A fitter suffered a crush injury to his little and ring fingers resulting in fractures and stitches while he was reinstalling a diesel particulate filter on a bogger. The filter slipped on its sling and struck the fingers against the frame of the machine. He was taken to hospital where he underwent surgery.	The use of fit-for-purpose lifting lugs on small heavy items is recommended where practicable. When lifting without lugs, rigging / slinging work should be conducted by competent workers holding appropriate high risk work licences.
2	Mechanical Equipment 317659661001	A loader slipped sideways pushing through bund and tip ramp.	Wash-down water around plant must be appropriately drained away so as not to cause damage to road and ramp infrastructure.
2	Strata Ground Control 317659669001	A slip of material (approx. 10,000 bcm) from the wall of an open cut mine. This occurred in an area of previously identified poor/weak ground conditions. The area was being monitored and no people were working in the open cut at the time of failure.	An effective ground control management plan was in place that included regular inspections and monitoring of bench walls. Mines should ensure geotechnical information and associated controls such as modified work practices, stand-off distances, retention berms or physical protective barriers are effectively communicated to and implemented by operators.
2	Mechanical Equipment 317659599001	A fire on a dump truck retard braking system – collapse of resistor grids resulted in electrical insulation burning.	Maintenance inspections of retard braking resistors should include the inspection for integrity of resistor mountings and the resistors themselves. Development of appropriate inspection frequencies should be in consultation with the original equipment manufacturer and include consideration of a change out/overhaul programme with intervals to ensure safety from failure of retardation system and fire.
2	Electrical Energy 317659701001	A low voltage electric shock occurred following the placement of 1000l oil cubes against 240V outlets. A battery charger unit lead was squashed by the metal frame of the cube.	When a change in work practices takes place, sites must make an assessment of risks and implement controls to manage any additional hazard or risk to workers health and safety.

Level	Incident Type	Summary	Comment to industry
2	Mechanical Equipment 317659712001	A operator parked a light vehicle and went to get a dozer to prepare a pad. When returning with the dozer he struck the light vehicle and pushed it around 5 metres.	Mines should ensure compliance with light vehicle/heavy vehicle stand-off distances and light vehicle parking rules.
2	Strata Ground Control 317659190001	Approximately 5 tonnes of rock and shotcrete fell onto, and around, the boom of a cable-bolting machine when it commenced grouting 12 cable holes that had been drilled the previous shift. This incident occurred in an underground metalliferous mine in the main decline. The fallen material included steel mesh and resin grouted rock bolts that had been installed when the decline was first developed some 2 years previously. No injuries and minimal damage. The investigation revealed incomplete encapsulation of bolts and a time delay in cable bolt installation after the need for installation of cables was identified.	Mines should ensure that pull test results are analysed and effective action plans are implemented to immediately address any unexpected results. Ground control management plans at underground metalliferous mines may be reviewed with reference to MEX-009 – 'Mine ground control management plan audit tool' which is available on the Department's website at www.resourcesandenergy.nsw.gov.au/miners-and-explorers/safety-and-health/publications/tools



Recent incident publications

Type	Identifier	Title	Date published
Incident information release	IIR16-01	Severe head laceration from damaged roof support	23 March 2016

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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