

REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

Published 13 April 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
21		7		1

Note: Incidents are categorised as Level 1, 2 or 3 according to the seriousness of the incident, with 3 being the most serious.

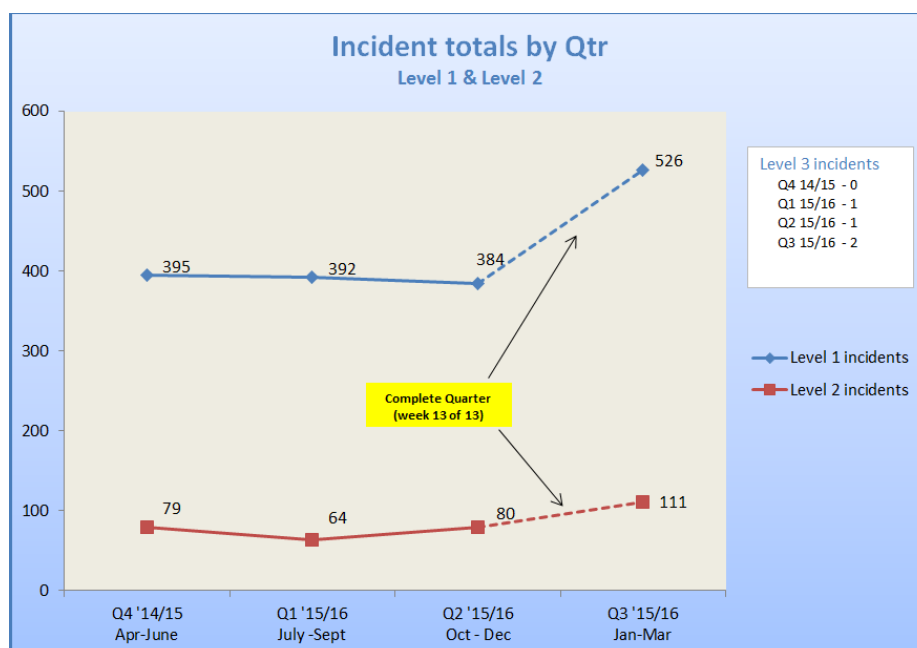
Injuries	Fatalities
6	0

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
3	Mechanical Equipment 317660010001	Loader made contact with light vehicle. Light vehicle operator failed to follow set positive communication rules regarding approaching heavy vehicle.	Refer to Incident Information Release IIR16-02 on our website .
2	Work Environment 317659990001	During the process of fitting a continuous miner an operator was required to access the top of the miner to turn a water tap off. The water hose was hanging high on a hanger instead of the standard position on the floor. When climbing down from the machine he misplaced his foot resulting in a strain injury to his left knee.	Position isolation valves, including water taps so they are accessible from ground level. Where this is not possible, items at height should be accessed from safe work platforms, ladders or purpose designed alternatives.
2	Strata/ Ground Control 317660000001	Conveyor belt system damaged. The delamination of roof strata consisting of 800mm of coal and 1 metre of claystone had fallen around the conveyor belt structure. The roof bolts in the area remained anchored into the conglomerate roof.	Mine operators need to consider the possibility of localised strata failure in all parts of the mine accessible to workers. Particularly older areas of the mine where deterioration of support systems is likely to occur.

Level	Incident Type	Summary	Comment to industry
2	Mechanical Equipment 317659996001	A man transport vehicle lost control when the driver's side rear tyre rolled off the rim. This caused the man transport to impact the coal rib as the vehicle was travelling around a 90 degree left hand turn.	The mine identified running air filled tyres assists in mitigating vibration injuries to passengers. When running air filled tyres mines should check compatibility between tyres and rims and have maintenance systems to check tyre condition.
2	Mechanical Equipment 317660049001	Hi-set hose failed on roof support. Hose failed due to age and fatigue.	Hose integrity is the single control measure for the prevention of an escape of pressurised fluid into the work area. Mines should have effective hose management systems to ensure hose integrity. This should include consideration to the recommendations in Section 7 of MDG 41 <i>Guideline for Fluid Power System Safety at Mines</i> .
2	Work Environment 317659967001	The tub of an articulated dump truck rolled onto its side while tipping when a rear wheel travelled up a previously dumped load. No injury and minor damage to truck tub.	To prevent truck rollovers while tipping, tipping areas need to be level. Operators should conduct regular inspections and supervision to monitor active tipping areas such that rough or uneven ground and potentially hazardous tipping positions are identified and eliminated.
2	Hazardous Materials 317660026001	A hydraulic tensioning device was incorrectly positioned allowing the spindle on the swivel joint to take the load and failing. The release of pressurised oil contacted the equipment and splashed back onto the fitter. No injuries resulted.	High pressure hydraulic tensioning devices should be inspected prior to use and personnel should be competent in their operation especially in relation to correct positioning of the reaction arm.



Recent incident publications

Type	Identifier	Title	Date published
Incident information release	IIR16-02	Collision between front-end loader and light vehicle	14 April 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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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (April 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.