REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

03 August 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.

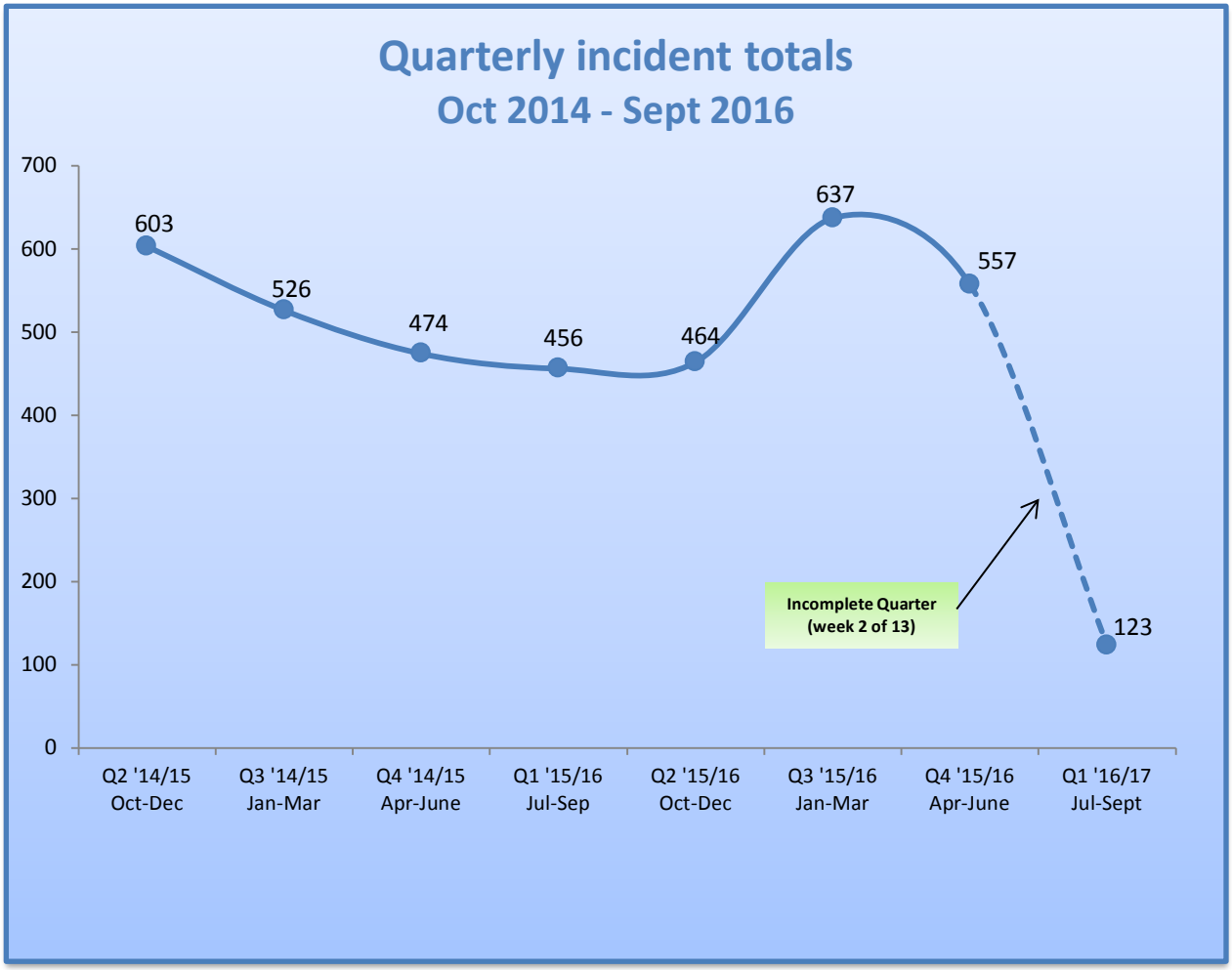
To report an incident call 1300 814 609 24 hours a day, 7 days a week

Reportable incidents total: 41 Summarised Incidents: 8

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 2016/0096	Uncontrolled release of pressurised substance (hydraulic oil) whilst a person was installing a rib bolt off the LHS of a Sandvic bolter miner. The oil sprayed the operator on the back of his right knee and under his right arm. The hose was sheathed and the oil deflected off an electric motor and cabling prior to spraying the operator.	Mine operators are reminded to review hydraulic hose maintenance management systems at regular intervals and/or when an incident occurs that places workers at risk. Inspections should consider checking for hose wear points and the removal of a build-up of fines that could potentially cause premature damage or wear.
Medical Treatment Injury SinNot 2016/0090	An operator drove an LHD under ventilation ducting near an auxiliary fan and dislodged it. He attempted to repair it alone with the fan still in operation when the ducting dislodged further resulting in his being sucked into the edge of the ducting. This resulted in lacerations to the LHS of his face.	Identifying hazards in the workplace prior to commencing work is a fundamental step towards minimising the risk of injury. Mine operators are reminded that workers should conduct a pre-work assessment for each task that is undertaken. Also, routine tasks such as replacing ventilation tubes should have a safe work procedure in place.
Dangerous Incident SinNot 2016/089	Fire on conveyor drive head underground. Fires were extinguished with a fire extinguisher but reignited. Water was then used to extinguish the fire and cool the area. Co2 monitor	To minimise the likelihood of catastrophic component failure on conveyor belt systems, maintenance procedures should include routine temperature monitoring and routine vibration

Incident type	Summary	Comment to industry
	detected 20ppm CO.	analysis.
Dangerous Incident SinNot2016/0087	930E Truck travelling at low speed down ramp lost control and rear slid to almost 90 degrees to direction of travel. Ramp had just been watered. Truck did not strike any objects or windrows.	Strip watering techniques should always be applied to ramps/ grades to increase traction and reduce the potential for loss of traction. Consideration should also be given to current weather conditions prior to watering.
High Potential Incident SinNot 2016/0121	When conducting a daily inspection on the Longwall tailgate motor, the electrician discovered a gap in the banana plate greater than 0.5mm.	To ensure design standards are maintained, mine operators should review maintenance procedures and consider including verification inspections and/or audits. When checking Ex enclosure gaps as part of daily inspections and post maintenance, the feeler gauge used should be less than the max allowable gap for the enclosure.
Dangerous Incident SinNot 2016/0113	Contact was made between an LHD bucket and an underground 11KV HT cable, tripping the electrical protection back to the surface. The LHD machine was stowing material in a cut-through that had variable heights (approx. 2.4m back to 2.1 metres at the roadway). The bucket was left up as the LHD reversed under the smaller roof height. The cables were installed in compliance with the mine cable management plan.	The aim of well setup and coordinated network electrical protection is to trip at the first system in-line closest to the damage on any HT cable. Risks require management when stowing material in cut-throughs where HT cables are run and there is the possibility of machine contact. Consider controls such as cable re-routing, additional mechanical protection and/or isolation. Mines should also consider the implementation of a formalised stowage procedure and permit system.
High Potential Incident SinNot 2016000/082	Person illegally gained entry to the mine site through a gate on the public highway by cutting the lock or chain. Electrical equipment was interfered with.	Mines should review site security, take reasonable steps to prevent unlawful entry and put in place controls to protect unwanted access to equipment.
Serious Injury SinNot 2016/0106	Claim holder reports that the mullock dump is too steep and too high. His truck lost power on the slope and began to roll back. He jumped from the cabin landed heavily and fractured his femur.	Operators responsible for mining trucks need to ensure that they are fit for purpose and properly maintained. Overloading of trucks is to be avoided and gradients are to be within acceptable limits for loaded trucks.



Recent incident publications

No recent incident notifications.

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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