REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

12 October 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.

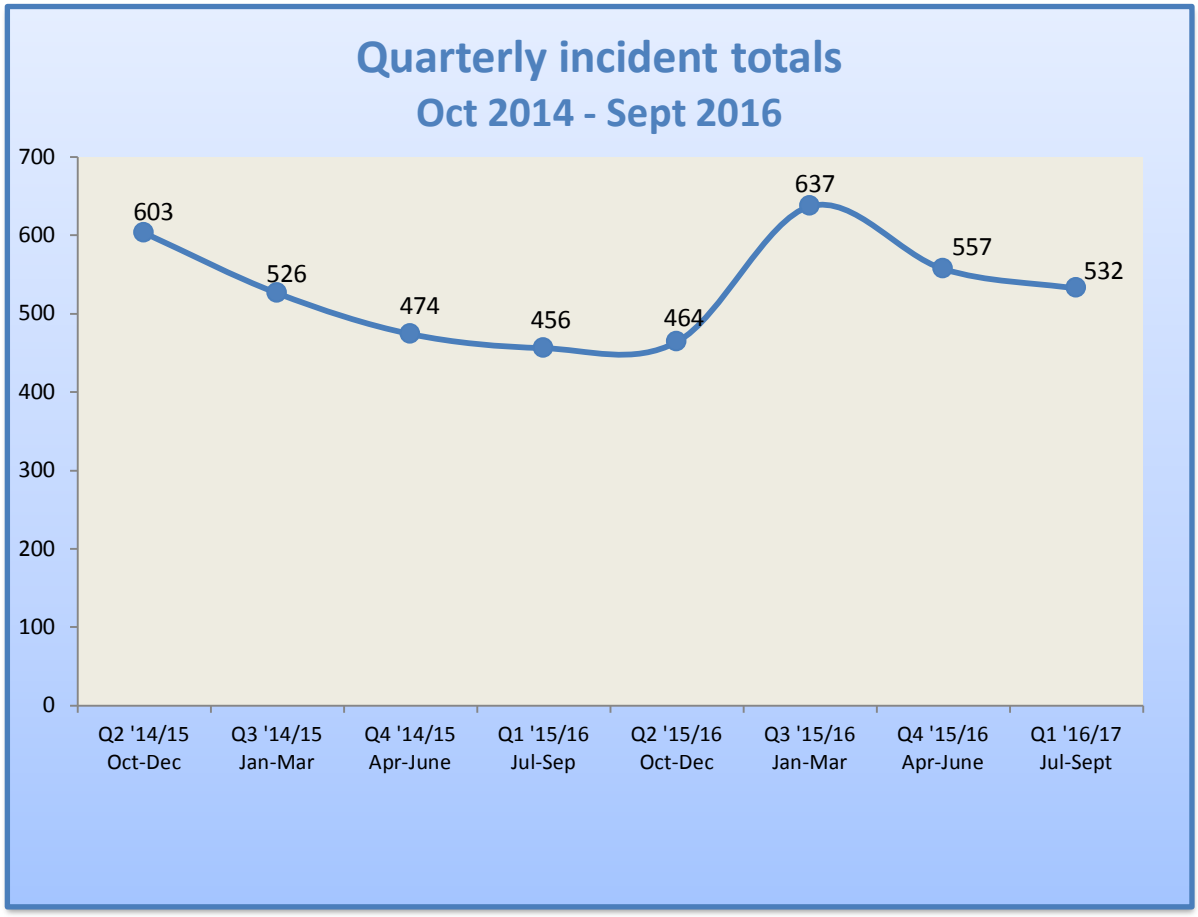
To report an incident call 1300 814 609 24 hours a day, 7 days a week

Reportable incidents total: 51 Summarised Incidents: 7

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
High Potential Incident SinNot 2016/00487	A fire on a conveyor burnt through the belt. No-one was in the vicinity at the time and there appears to be no major structural damage.	Mines should assess surface conveyors and assign regular inspection schedules based on risk. Defects noted in inspection reports should be acknowledged in the system and actions assigned.
High Potential Incident SinNot 2016/00482	Two large rocks (approx. size 2m x 1.5m) breached a berm and rolled into an active haul road. A haul truck tipped the material in an active dump which was tended by a track dozer. From the material dumped, two large rocks crossed over a rock drain and 5m high berm coming to rest in the active haul road below the dump. The rocks rolled approx. 5m into the road and did not make contact with any vehicles.	Dumping above any active working area is poor practice and should be avoided if possible. If it is not possible, the mine should implement additional controls to ensure no risk to those working below from those above. As a minimum, the controls should include more rigorous inspection regimes, increased supervision and improved barriers.
Dangerous Incident SinNot-2016/00480	A top belt slinger roller near the belt transfer has collapsed and hot material has dropped into the fines tray below and ignited the fines.	Mines should consider temperature monitoring of critical high speed rollers. Chutes designed to collect and transfer fines should be fitted with positive clearance systems.
Complaint SinNot-2016/00531	A complaint has been received that concerns raised regarding high levels of dust within a mine are not being addressed.	Mine operators are required by law to eliminate exposure to airborne dusts, so far as is reasonably practicable. Controls stipulated in the Work Health and Safety (Mines and Petroleum Sites) Regulation 2014 include:

Incident type	Summary	Comment to industry
		• implementing a principal hazard management plan for air quality or dust or other airborne contaminants • ensuring the exposure standards for respirable and inhalable dust are not exceeded • implementing a ventilation control plan to ensure effective ventilation • implementing air quality, monitoring and ventilation arrangements The management of airborne dust at mines will be the subject of targeted assessments. These assessments will focus on how mines prevent worker exposure to potentially harmful levels of respirable dust.
Dangerous Incident SinNot-2016/00524	Two workers had completed charging of a hydraulic accumulator with nitrogen gas from a G size cylinder. The regulator was opened and the nitrogen cylinder isolation valve turned off. The workers then started to remove the regulator from the cylinder. The regulator was ejected from the cylinder and the cylinder fell over. While continuing to discharge nitrogen from the cylinder, the cylinder bounced over the kick rail and wedged into a cable tray.	Mine operators should ensure robust safe work procedures are in place and personnel are competent and aware of hazards associated with the use of pressurised fluids. Gas cylinders should be appropriately restrained and pressure regulators, isolation valves and connections should be fit for purpose, maintained and kept as clean as possible to minimise contaminant ingress.
Dangerous Incident SinNot-2016/00506	A 250 tonne excavator was working on a 4 metre face, when the face slumped onto the excavator. Operator used boom to stabilise excavator and a dozer has pushed material up to further support machine.	Risk assessment and operating procedures should consider changing geology and weather events such that the bench can support the weight and movement of the excavator while top loading. Dimensions of bench mining should be specified that trigger movement of the excavator to stable ground if necessary.
Dangerous Incident SinNot-2016/00498	A contractor fitter was working on a Moxie water truck air conditioning unit. As he was recharging the unit the sight glass in the air-conditioning system blew out and fragments of glass hit the fitter in the face and chest area.	Mine operators should ensure that equipment is fit for purpose, subject to inspection, testing and maintenance and compliant with relevant standards and codes of practice where required. Workers must be competent and licenced where required.



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

Email: mine.safety@industry.nsw.gov.au:

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COAL (SOUTH)

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