

REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

Published 16 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
41		19		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
15	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 317659174001	Cable fell from the roof roller and struck employee on the head and neck.	Ensure cable management considers the potential for cables to fall of roof rollers taking into consideration all cable handling activities.
3	Work Environment 317659147001	While driving a load haul dump vehicle the driver came into contact with a broken W strap roof support.	<p>Mine operators need to ensure that all plant or machinery at a mine site is inspected prior to going into service. The inspection should verify that the overall dimensions are within tolerances for driving machines or towing plant through the mine without colliding with roof or infrastructure.</p> <p>The inspection process should include authorisation from relevant management personnel.</p> <p>An Investigation Information Release will be published to provide more detailed information to industry. It will be available from: www.resourcesandenergy.nsw.gov.au/miners-and-explorers/safety-and-health/incidents</p>
2	Work Environment 317659212001	Complaint about safety and planning matters at a small quarry.	Mine operators should provide adequate warning signage, and dispose of redundant

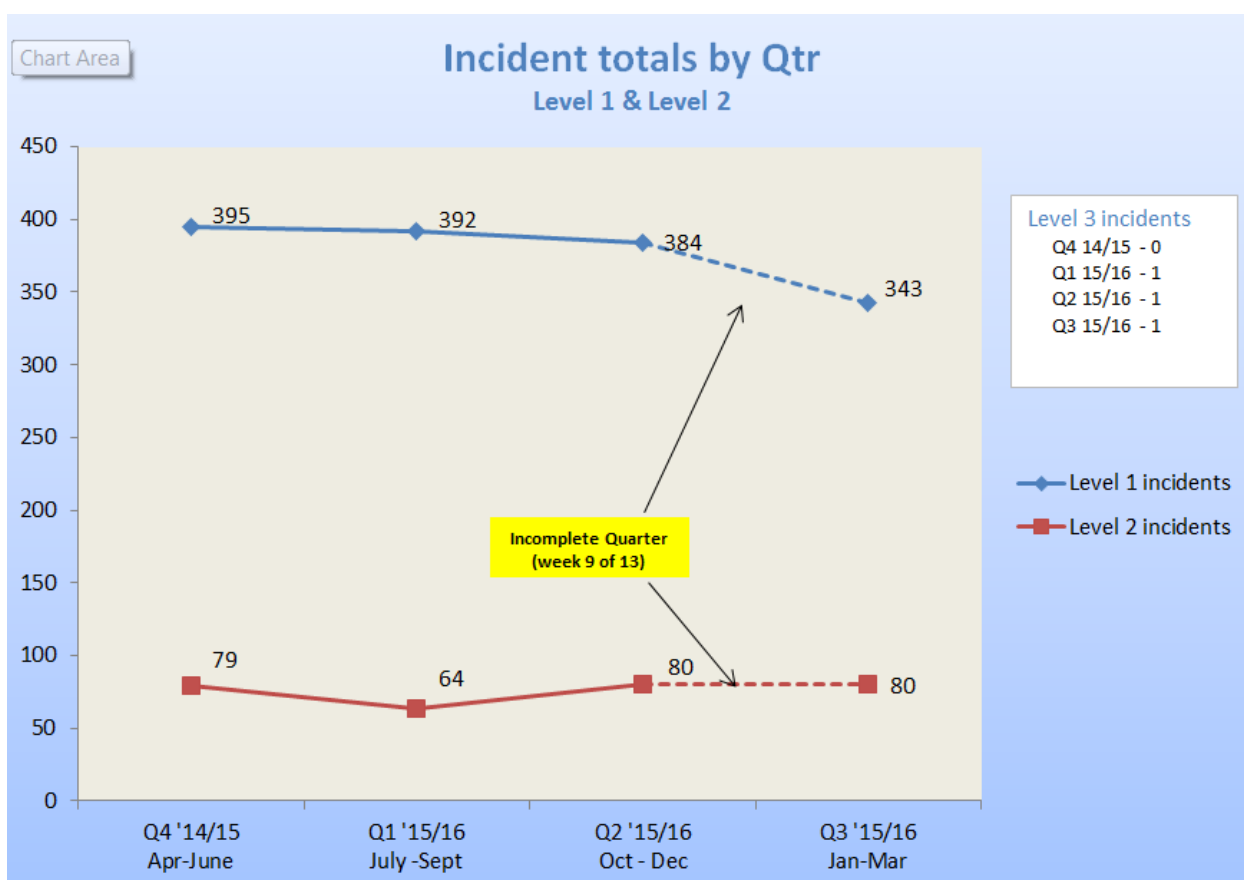
Level	Incident type	Summary	Comment to industry
			plant items.
2	Mechanical Equipment 317659184001	Worker's arm jammed in conveyor lifting device. The device was able to be raised beyond full extend allowing the drive spindle to disengage from the screw block and the unit to collapse.	The supplier of the device has issued a safety alert to its customers. Mines should comply with recommendations of the safety alert.
2	Mechanical Equipment 317659162001	A contract operator was using a mini excavator and tip truck to remove build-up from under a conveyor. The conveyor and associated stacker was isolated. The reclaimer on the adjacent stockpile was auto-relocated, in the process of relocating the reclaimer made contact with the tip truck.	Mine operators should consider implementing a contractor work permit system such that contractor supervision, impact of work activity and interaction with other operations at a workplace are identified, communicated and understood prior to commencing work.
2	Electrical Energy 317659143001	Arc fault on drift conveyor motor on start up after maintenance activities.	Where wound rotor motors are used, mines should: <ul style="list-style-type: none"> • review brush gear/slip ring maintenance frequency and cleaning methods, i.e. vacuuming, blowing, washing with solvents to effectively remove carbon and copper dusts and other residues. • perform thorough inspections post maintenance of the SR enclosure prior to repowering. • explore arc venting options for the slip ring enclosure with the motor OEM.
2	Explosives 317659125001	400gm Booster was noticed missing during shottfiring.	Have rigorous systems to safeguard and account for all explosives products and accessories. These systems should be regularly audited.
2	Electrical Energy 317659208001	66kV power CT catastrophically failed in a surface substation of an underground mine. The CT was an oil filled hairpin style. The explosion resulted in debris being ejected in a 360 degree radius with a significant quantity of the shattered ceramic material landing up to 50m away in a car park where people were present.	Where mines have high voltage switchyards, they should: <ul style="list-style-type: none"> • review maintenance strategies for oil filled ceramic/porcelain CTs. • review suitability of hairpin style CTs against other designs • review fencing and barriers in the switchyard to minimise injury or damage in the event of catastrophic failure of switchyard components. • minimise exposure of persons by limiting number and duration of activities where personnel are required to access the switchyard, or work in proximity to the yard.

Level	Incident type	Summary	Comment to industry
2	Work Environment 317659226001	An allegation of bullying received from a current worker (operator) at a mine. The worker alleges being bullied by three supervisors and managers.	The Division of Resources and Energy publishes information on bullying in the workplace on the following webpage: http://www.resourcesandenergy.nsw.gov.au/miners-and-explorers/safety-and-health/topics/bullying-in-the-workplace . Safe Work Australia also publishes guides to preventing and responding to workplace bullying and a worker's guide to dealing with bullying. http://www.safeworkaustralia.gov.au .
2	Strata Ground Control 317659294001	Dozer levelling coal on product stockpile. Dozer tilted to the left when travelling over suspected void on stockpile.	Stockpile control valve monitoring systems should include audible and visual alarms to <ol style="list-style-type: none"> 1. Detect unintended movement of valves from the closed position. 2. Detect coal loading onto a conveyor without coal valves being selected to open.
2	Work Environment 317659222001	A single 100 mm diameter rock fell a vertical distance of approx. 15 m onto a lower bench from rill material used to construct an open pit haul ramp windrow. The final position of the rock was 1 metre short of a person who was dipping production holes. No injuries.	Conduct detailed inspections and monitoring of high walls and associated windrows/ bunds to identify and eliminate potential rock fall hazards. Regular reviews of haul road and windrow construction is essential to assess compliance to design criteria. Consider potential rock falls when working adjacent to and below high walls. Controls such as modified work practices, stand-off distances, retention berms or physical protective barriers will mitigate or eliminate the risk.
2	Mechanical Equipment 317659273001	The work basket of an underground utility vehicle made contact with a parked broken down light vehicle when it moved from a parked position and attempted to drive past it in an underground metal mine. Minimal damage.	Dedicated parking areas should be identified and utilised whenever possible. Broken down vehicles parked outside designated parking areas should be clearly identified by reflective tape, warning triangles or some form of lighting. Before moving a parked vehicle, inspect, and be fully aware of, their surroundings and any potential hazards.
2	Mechanical Equipment 317659238001	Workers waiting at an underground shaft plat heard an object fall down the shaft. The plat doors at the surface are operated by pneumatic cylinders mounted in trunnion brackets. The bolts securing a trunnion bracket failed (evidence indicates failure over a period of time) and the bracket fell down the shaft. No damage in the shaft.	All moving components of a shaft system should be included in the planned inspection / maintenance system. Consider the installation of retaining / locating mechanisms that eliminate the risk of critical components falling down a shaft should they fail.

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2	Mechanical Equipment 317659182001	<p>The operator of a front-end loader travelling up the main decline of an underground metalliferous mine spotted a truck travelling down the decline. The loader was then driven into a nearby drive to allow the truck to pass and contacted a parked light vehicle. The light vehicle was pushed into a parked telehandler and a fitter had to move quickly to avoid injury.</p> <p>The loader turned into the drive without visual or radio confirmation that it was clear to do so. The dedicated decline radio channel was not being used by the loader operator at the time. No injuries. Significant damage to the light vehicle.</p>	<p>Consideration should be given to adopting a vehicle proximity system.</p> <p>Before driving 'blindly' into a drive or crosscut operators should pass by the junction to enable a visual check for other vehicles.</p> <p>Review parking procedures to ensure effective visibility of vehicles through use of dedicated parking areas and vehicle mounted and portable warning lights.</p> <p>Established radio protocols in main vehicle travel ways must be strictly enforced.</p>
2	Work Environment 317659262001	<p>A contract ecologist was monitoring bulldozer tree clearing operations from behind the work front at a distance of 50 m. While standing in an understory cleared zone, a tree branch fell to the ground in close proximity. It appears that the branch may have been impacted by other trees being cleared as part of the understory clearing works.</p>	<p>Tree clearing procedures at mining operations should include provision for conducting an inspection for unstable trees or parts of trees that have the potential to harm people or damage plant or equipment prior to allowing entry to personnel.</p>
1	Electrical Energy numerous	<p>Four incidents of damage to cap lamp cords were reported. These resulted from cords being damaged in vehicle doors, caught on broken mesh or snagged on equipment.</p>	<p>Mines should reinforce the following in relation to cap lamps:</p> <ul style="list-style-type: none"> • pre-use inspection for damage/defect. • awareness on exiting machines, including cords being caught on seats and being shut in doors resulting in cut leads. • awareness when working around rib mesh, bolts and other snagging hazards. • awareness when working around rotating machinery such as secondary support bolters. • wearing the cap lamp and battery so as to minimise excess looping at the rear. <p>Mines should consider having leads shortened to a more manageable length.</p>
	Court Judgement	<p>Judgment was delivered by the Court of Criminal Appeal on 11 March 2016 in relation to cross appeals from a judgment of the District Court in a recent mine safety prosecution. The Prosecutor was successful in the appeal. The original prosecution related to an incident on 23 April 2010 in which an employee of a Singleton mine was seriously injured after allegedly being struck in the head</p>	

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with fly rock and crushed by machinery. The defendant was convicted at first instance under s 8 of the *Occupational Health and Safety Act 2000*, and sentenced to a penalty of \$50,000 and ordered to pay 20% of the Prosecutor's costs. On appeal, the court ordered that a penalty of \$100,000 be imposed, and that the defendant pay 50% of the Prosecutor's costs. The court also awarded the Prosecutor costs of the appeal.



Recent incident publications

Type	Identifier	Title	Date published
SB	SB16-01	(http://www.resourcesandenergy.nsw.gov.au/__data/assets/pdf_file/0003/598134/SB16-01-Bolting-rig-injuries.pdf)	15 Mar 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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