

REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

Published 4 May 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
45		11		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

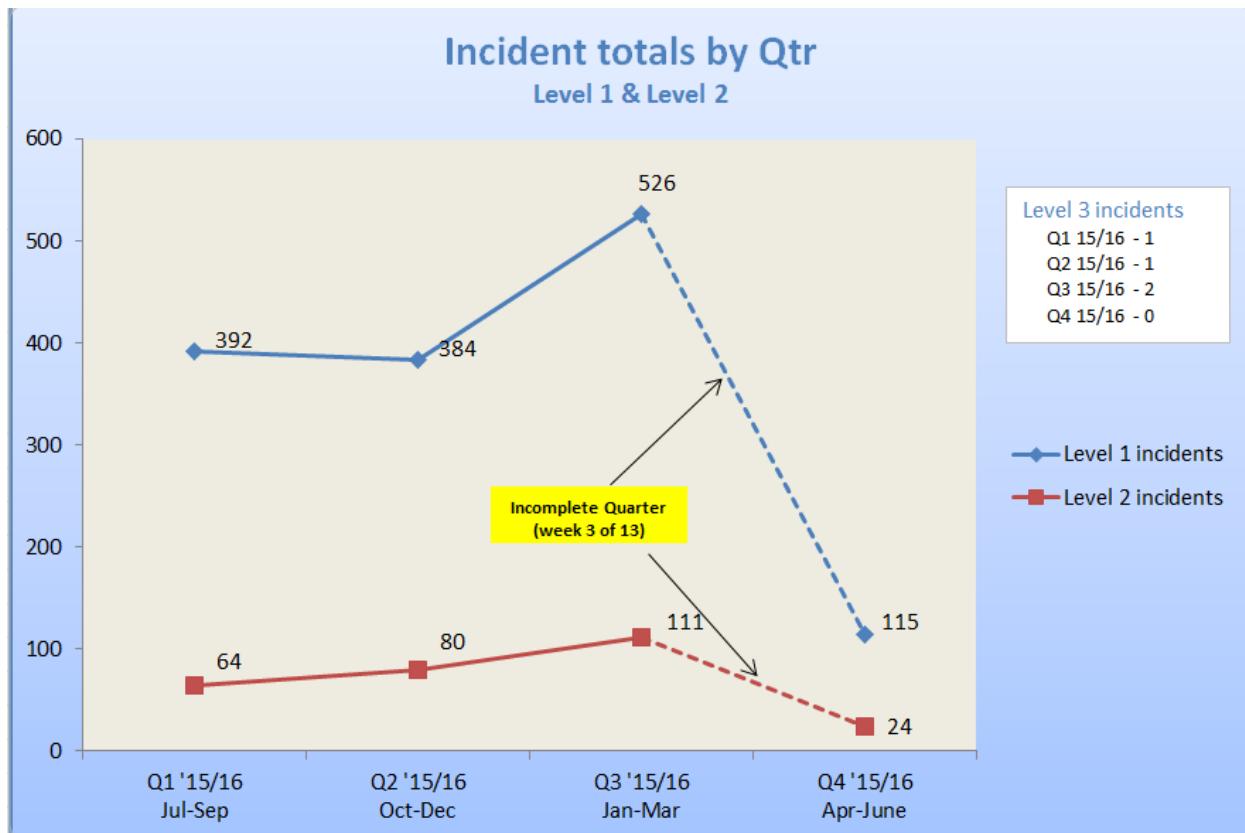
Note: While all incidents are investigated, generally only level 2 and 3 incidents are summarised below.

Level	Incident type	Summary	Comment to industry
2	WORK ENVIRONMENT 317660444001	A section of spiral wound steel ducting, which formed part of a dust extraction system underground, fell from its supports to a designated vehicle/pedestrian thoroughfare below. No one was in the vicinity at the time.	A regular, planned and effective inspection regime should be implemented for pipes and ducting to ensure structural integrity is maintained. The frequency should take into account the material or fluid conveyed, the environment and the potential for corrosion.
2	MECHANICAL EQUIPMENT 317660391001	While conducting a weekly maintenance inspection LHD did not shutdown during the Low Water Cut Out Test. Pneumatic safety circuit air pressure was set high enough that the run solenoid did not shut down machine as expected.	Mines should consider lockable or tamper-indicator devices on valves that are integral to safety circuits or systems.
2	OTHER (COMPLAINT) 317660377001	Complaint from a neighbour regarding access to the site by the general public including children, and other matters.	Mine should restrict access to the site by the general public. Mines should use fit-for-purpose equipment.
2	WORK ENVIRONMENT 317660440001	During the rib bolting cycle an operator activated the gripper jaws and the timber jack extended. Root cause was an out of adjustment counterbalance valve. The	Mines should have a formal commissioning procedure. The commissioning procedure should take into account torque settings and

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		rib bolter was replaced the previous shift and had been sitting on the store shelf for nine months	pressure settings.
2	MECHANICAL EQUIPMENT 317660406001	Operator stopped a personnel transport in roadway, did not apply park brake and alighted from the machine. When the machine door was open the door interlock with the park brake did not activate. After approximately 60 seconds, the machine rolled forward 2 - 3 meters. No person was injured.	Mines should require safe parking practices without reliance on door interlock brake application. Safe parking behaviours should be reinforced through training and supervision.
2	MECHANICAL EQUIPMENT 317660452001	A crusher operator was attempting to remove a section of vent bag from a moving crusher feeder conveyor when his thumb became entangled in a length of rope attached to the vent bag. His thumb was broken when the vent bag fell from the feeder conveyor.	The controls identified in the risk assessment for removing waste material from a crusher feeder conveyor must include application of the hierarchy of controls such that operating procedures eliminate the need for manual handling – particularly while the belt is moving.
2	ELECTRICAL ENERGY 317660420001	Fire detected in the cabin of a delivery truck by a person operating a nearby crane. No personnel were in the truck at the time, and the engine was not running. A small portable fridge and a flashing light were both connected to the vehicle cigarette lighter outlet fitted to the centre console.	In addition to normal reporting requirements, incidents that highlight potential safety issues with the design/manufacture of road registered vehicles should also be reported to the vehicle OEM and to the Australian government Department of Infrastructure and Regional Development. For additional information, refer to https://infrastructure.gov.au/vehicles/reporting/index.aspx
2	MECHANICAL EQUIPMENT 317660404001	During the removal of roof support process as part of the Longwall recovery a 4th year apprentice fitter has been splashed with a small amount of oil, some of which has gone into his eyes. The chock in this case was fully isolated and decayed, isolation permits were completed and verified.	Mines should review hydraulic circuits for the potential of entrapped fluid and update procedures were this occurs.
2	MECHANICAL EQUIPMENT 317660504001	A light vehicle was being driven down a ramp and was driving on a freshly watered section of the ramp. As the operator felt the vehicle drift out he accelerated to keep the vehicle in control. The vehicle suddenly gripped and spun in the opposite direction turning over onto the passenger side of the vehicle.	The maximum travelling speed of trucks and other vehicles should be established for each site, taking into account the vehicle load, roadway gradient and surface conditions. Additionally, mines should ensure that road watering procedures include leaving dry areas for increased traction on ramps.
2	MECHANICAL EQUIPMENT 317660466001	A low speed collision with high potential occurred between a LHD and personnel transport. Lack of communication, failure to comply with the underground	Mines should review their transport management plans and specific vehicular procedures in high traffic areas (such as longwall recovery) to ensure shunting and all

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		transport management plan (reversing into cut through) and a high level of machine interaction in a confined area were contributing factors. No persons were injured.	communications between vehicle drivers are controlled in a safe manner.
2	MECHANICAL EQUIPMENT 317660478001	Uncontrolled release of fluid under pressure event from a CM mounted drill rig head plate. Incorrect length of head plate bolts fitted allowing head plate to come loose from limber jack. The rig was recently fitted after overhaul.	Mines should confirm with repair / overhaul workshops Quality Assurance Systems for work completed. In this case that correct length bolts are fitted.
2	MECHANICAL EQUIPMENT 317660517001	A dump truck lost control while travelling empty down the ramp. The tray made contact with the tray of fully loaded truck traveling up the ramp. Minor damage and no injuries. Although previously assessed as competent on this particular model of truck, the operator had not driven it for some time and was not fully familiar with its operation.	Equipment operators should undergo regular equipment re-familiarisation training and competency assessment before they operate different vehicles or different model of vehicles that they have not operated for some time.
2	WORK ENVIRONMENT 317659988001	A jacking shaft that was driving a coal screen exciter failed. The shaft whipped around and smashed the covering guard. The shaft and half of the covering guard then fell to the walkway below. No persons were present in the area. The root cause of failure was determined to be that the flange bolts were not to correct torque. This meant that the flanges of the jacking shaft were not evenly pulled together which allowed for ingress of dirt, together the effect was to create excessive torque which resulted in a failure of the jacking shaft.	Mines should examine jacking shaft flange bolt holes for imprint of the bolts threads in the flange bolt holes to determine if the bolts were loose (if found loose have the jacking shaft tested for cracking). Mines should examine the jacking shaft flange faces are mated properly and that they are secure. If they have not been pulled up square there will be ingress of dirt (if found not to be mated properly then have the jacking shaft crack tested).
1	EXPLOSIVES 317660075001	A misfire occurred when an overburden blast was initiated. The first surface delay on the control row failed, resulting in only the first echelon initiating (of 25 echelons). The new echelon face was then surveyed and it was found that one blast hole (on the new echelon face) had insufficient burden to be fired safely. A decision was then made to fire the remaining 24 echelons without this blast hole connected, resulting in a known misfire.	Sites must implement and maintain effective explosives management systems that include the safe transport and storage of explosives components. OEM's are reminded to regularly review the effectiveness quality control measures during the manufacture of explosives and associated equipment.
2	MECHANICAL EQUIP 317660130001	A rubber tyre dozer (RTD) requested clearance to drive behind a haul truck (HT), to clean up rock spillage in the	Mines should ensure that positive communication procedures are implemented and maintained at all times. These procedures

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		work area. The RTD operator called the HT for clearance on the wrong two-way channel, the HT operator did not hear the request. The RTD proceeded to clean-up behind the HT without positive communication from the truck. The truck operator began to reverse not realising the RTD was behind them, minor contact was made between the HT and the RTD. Position six tyre of the HT contacted the secondary access ladder of the RTD at slow speed. No injuries as a result of the collision.	should include the requirement for the incoming operator to be acknowledged by other operators prior to entering the work area. Additionally, verification of correct radio channel usage for all vehicles would be prudent for each worker prior to operating vehicles or plant in the working areas of the mine.



Recent incident publications

Type	Identifier	Title	Date published
Safety alert	SA-16-02	Defects found in self rescuers	29 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:

COAL (NORTH) and EAST METEX	COAL (SOUTH)	WEST METEX
Maitland	Wollongong	Orange
NSW Department of Industry Mineral Resources 516 High Street, Maitland NSW 2320 (PO Box 344, Hunter Region MC NSW 2310) T 1300 736 122 or 02 4931 6666 F 02 4931 6790 E mine.safety@industry.nsw.gov.au	NSW Department of Industry State Government Offices Level 3, Block F, 84 Crown Street, Wollongong NSW 2500 (PO Box 674, Wollongong NSW 2520) T 02 4222 8333 F 02 4226 3851	NSW Department of Industry 161 Kite Street, Orange NSW 2800 (Locked Bag 21, Orange NSW 2800) T 02 6360 5333 F 02 6360 5363 After hours – emergency only 02 6360 5343

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