



REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

22 June 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	\longrightarrow	Level 3 incidents
53	7		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
13	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 317661382001	Park brake activation while the dozer was operating in reverse, without it being initiated by the operator, resulting in neck pain to operator following sudden stop of dozer.	Mine operators should consult the OEM whenever proposing changes to plant design, operating systems or procedures. Also, operators should apply change management which may include assessing risks, implementing additional controls. This must be done in consultation with workers.
2	Work Environment 317661409001	Unplanned entry of dozer onto site. The dozer came from a neighbouring property without the operator after the dozer rolled, ejecting the operator, then landed onto its tracks and kept moving uncontrolled.	Mines must have Safe Work Method Statements (SWMS) about operating plant on sloping ground. Plant operators should wear seat belts. Roll Over Protection Structures (ROPS) do work.
1	Electrical Energy 317661384001	A machine has struck an energised 11kV cable and damaged it. Damage not reported and found some time after it occurred.	All cabling should be positioned in roadways and shunts such that they will not be struck by vehicles and loads being transported. Effective management systems should be in place to manage load sizes and to audit cable positioning in transport roadways and shunts.

Level Incident type Summary

1 Mechanical Equip

317661367001

Operator of a haul truck entered the dump to tip the load. They saw a track dozer was tending the dump on the left hand side. This was the sixth load this operator had delivered to this dump. As the truck operator entered the dump the dozer operator told them, via the twoway, to go back to the start of the dump as the truck was too close. The truck operator said they did not hear the call on the two-way. The operator in the truck attempted to position the truck for dumping but lost sight of the dozer on their off side. The proximity detection alarm in the haul truck was alarming but the operator said they did not pay attention to the proximity alarm as it had sounded when on this dump in the past. The operator in the truck reversed towards the tip head and did not check the off side mirror where the dozer was positioned. The dozer operator called the operator in the truck the second time and told them to stop the truck when contact was made.

Comment to industry

Mine operators should ensure proximity devices (where installed) are operating as intended at all times when equipment is being operated. Testing and maintenance must be carried on a regular basis.

Positive communication procedures should be reviewed and communicated to all relevant workers, especially whenever operational changes take place and/or significant incidents occur.

Defect management systems should be implemented and workers need to be encouraged to report all defects when they occur.

1 Mechanical Equip

317661361001

While driving a light vehicle down the decline, the operator has lost brakes. He has then driven the light vehicle into the wall to slow the vehicle, which has driven up a windrow and rolled the vehicle onto its side. No injuries reported.

Investigation concluded that corrosion of the brake line caused the incident, by allowing the pressurised fluid to escape when the brake pedal was applied. Mine operators should review their planned and preventative maintenance schedules in order to ensure that a comprehensive inspection or replacement is conducted of all critical safety system components including, but not limited to, braking systems, according to OEM manuals and further adapted for the harsh mining environment. Vehicle operators should have access to FFP vehicle washing facilities in order to allow the vehicles to be cleaned underneath to prevent the build-up of mud and hence corrosion around these components.

2 Mechanical Equip

317661435001

A contract electrician was changing out batteries on a rear dump truck in the main workshop. Due to the weight of the batteries, a crane was used to lift them out of the battery boxes and over the top of hand rails. The body of the truck was down which did not allow a straight lift to occur. As the second battery was being lifted the hook of the lifting chain has caught on the "eye brow" of the truck body, bending the hook open and allowing the sling to slip out. At this stage the battery was at the height of the

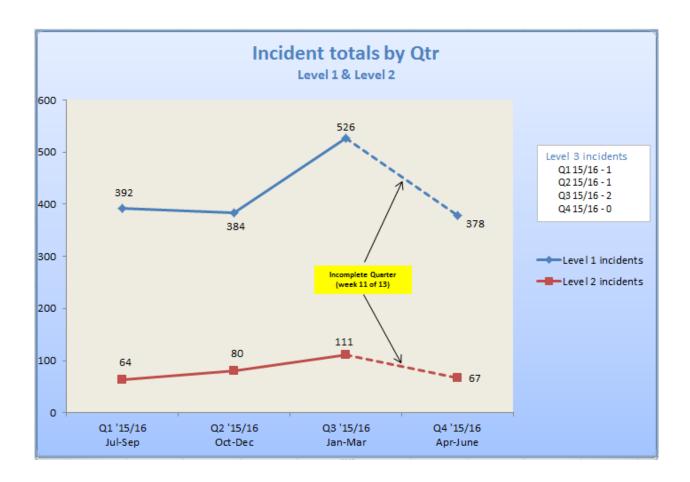
Mines are advised to consider providing assistance to operators whilst lifting heavy loads such that sufficient clearance is maintained around 'catch points'.

It should also be noted that 'no go zones' are to be identified and inadvertent access to these zones is maintained at all times during the lift.

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Level	Incident type	Summary	Comment to industry
		middle handrail and being guided by the electrician. The battery has then fallen onto a new battery waiting to be fitted on the deck, bounced through the handrail and fallen from the front of the truck onto the workshop floor below within the drop zone set up for the lift. The battery has ruptured and slid a small distance outside the drop zone.	
2	Complaint 317661421001	An electrical fire broke out at a quarry when a short circuit occurred in an extra low voltage circuit in a control panel.	Mines are advised to ensure that regular maintenance of electrical installations is carried out to reduce the risk of fire through short circuit. All control panels should be cleaned on a regular basis to ensure that contaminants do not build up inside.
2	2 Strata/Ground Control	A large fall of ground (15-20 tonne) fell from an underground development face.	Mine operators must ensure that workers are trained to observe and understand the
317661463001	317661463001	The fall occurred while the charge crew were scaling from within a charge up basket approx. 1.2m above the drive	geological and geotechnical characteristics of their work environment in order to assess prevailing and possible hazards.
	floor.	The mine operator should consider the	
		Approx. 150kg spilled into the basket causing non-life threatening injuries to the charger. The remaining rock spilled around the IT. The large face (~6.5H x ~5.5W) was not supported and was intersected by a dense pattern of multiple joints increasing the failure potential.	possible adverse effects of geological structures as they are known, and as they become known, and reduce risk ALARP at the initial planning stage and as an on-going monitoring and review process.
			Geotechnical controls should be both predictive and reactive.
			If a change/deterioration in the work environment occurs then the change needs to be risk assessed and appropriate ground control protocols implemented to ensure workers are not exposed to risk.
1	Electrical Energy	Ampcontrol Burnbrite socket non-compliance.	As part of their introduction to site process, managers of electrical engineering for
	Various events		underground coal mines should have a rigorous review process for documentation associated with the testing, repair and overhaul of explosion protected electrical equipment.
			Where it is identified that explosion protected electrical equipment in use in a hazardous zone does not comply with its Certificate of Conformity, mine operators should take the appropriate steps to address both the risks arising from this non-conformity, and the requirements to comply with the applicable clauses of the NSW WHS(M&P)R 2014.

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Recent incident publications

Туре	Identifier	Title	Date published
Information release	IIR16-04	Exposure to hazardous chemicals	21 June 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 <u>website</u>.

Further information

Should you wish to seek further information, please contact one of our offices:

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