

Mine Safety

REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

Publication Date: 18 November 2015

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	
28	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.

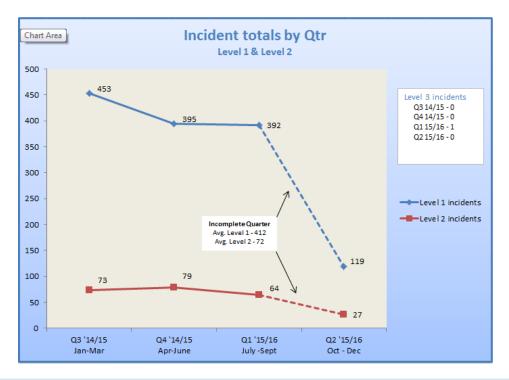
Injuries	Fatalities
11	0

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	Mech Equip 317656493001	Rigid dump truck operator reported that a truck had shut down and the fire suppression system fitted to the truck had deployed automatically. The main positive battery cable from the isolator to the starter motor has rubbed through on a clamp attached to the radiator. The fire suppression activation tube was also secured to the radiator housing with a clamp that had no insulation.	Cable/tubing routing and insulation should be assessed and installed according to best practice. Refer to MDG 15 Mobile and transportable equipment and AS/NZS 4871-6:2013 Electrical equipment for mines and quarries – Diesel powered machinery and ancillary equipment.
		As a result, the battery voltage travelled through the path of the steel braid in the activation tube creating significant heat. This caused the fire suppression detection tube to fail and triggered the fire suppression system to deploy.	
2	Hazardous Materials 317656630001	Uncontrolled escape of CO ₂ gas from the fire protection system.	The fire system was inadvertently activated and gas was released into the atmosphere due to a gas line fitting not being secured correctly. All personnel were able to exit the area.

Level	Incident type	Summary	Comment to Industry
2	Work Environment 317656558001	Operator installing cable bolts underground had cement grout sprayed in their eyes when the connection between the grout pump line and the cable fitter tube burst apart. Inadequate eye protection was worn (glasses rather than goggles).	Connection between grout pump line and cable fitter tube burst apart. Establish pre-emptive maintenance on high risk components rather than 'run to failure'. PPE standards should be enforced.
2	Work Environment 317656590001	Employee suffered laceration on a surface drill rig due to hand placement being incorrect.	Engineering changes to steel table to reduce risk of hand in wrong position.
2	Electrical Energy 317656505001	A live HT cable was struck by a bucket (duck's bill) attached to a load haul dump (LHD).	Tight (narrow) location for the operation of the LHD with the duck's bill. LHD operator was not aware that machine was in such close proximity to the cable.
2	Mech Equip 317656594001	Collision occurred between an excavator and a dozer while operating in close proximity to one another.	Procedures for controlling the risk of collisions not complied with. Miscommunication between operators. Proximity devices in use, though may have failed.
2	Mech Equip 317656512001	While operating a water truck, the operator saw a truck approaching and reversed back. As the road had no barrier (bunding) the truck rolled approximately 5-6m over an embankment.	Haul roads should have bunding installed along their entire length. The mine 'Roads or other vehicle operating areas' plan should address vehicles passing. Trucks must have a seat restraint fitted and it must be worn. Where a risk exists, trucks must have operator protective structures, so far as is reasonably practicable.
2	Mech Equip 317656552001	Uncontrolled escape of pressurised hydraulic oil on apprentices whilst working on an excavator track tensioner accumulator. Excavator was isolated using main isolator valve. It was assumed the circuit was de-energised.	Mines need to check isolation procedures of track tensioner systems. Provide correct procedures and drawings to people working on hydraulic systems. Provide appropriate supervision of apprentices.
2	Mech Equip 317656652001	Loader made contact with an 11kV cable in an underground mine.	Sub-standard cable installation, poor signage, no physical protection, and limited appreciation of required installation and protection standard for electrical cables.



Recent Publications	No.	Link	
E-alert	0	http://www.resourcesandenergy.nsw.gov.au/miners-and-explorers/safety-and-health/incidents/e-alert	
Safety Alert	0	www.resourcesandenergy.nsw.gov.au/miners-and-explorers/safety-and-health/incidents/safety-alerts	
Safety Bulletin	0	www.resourcesandenergy.nsw.gov.au/miners-and-explorers/safety-and-health/incidents/safety-bulletins	
Information Release	0	www.resourcesandenergy.nsw.gov.au/miners-and-explorers/safety-and-health/incidents/incident-updates	
Investigation Report	0	http://www.resourcesandenergy.nsw.gov.au/miners-and-explorers/safety-and-health/incidents/investigation-reports	
Gazette Notices	0	www.resourcesandenergy.nsw.gov.au/miners-and-explorers/safety-and-health/legislation/gazettals	

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