

Mine Safety

REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

Publication Date: 2 December 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	\longrightarrow	Level 2 incidents	Level 3 incidents
46		5	0

Note: Incidents are categorised as Level 1, 2 or 3 according to the seriousness of the incident, with 3 being the most serious.

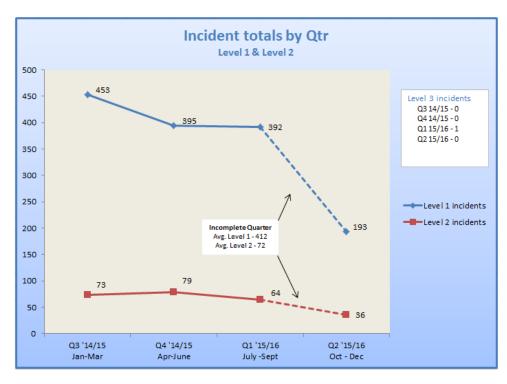
Injuries	Fatalities
13	0

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 317657042001	After checking the fluid levels on an Eimco, a mine worker suffered a serious injury when he fell while alighting from the top rear of the machine. As the mine worker alighted he placed a foot on the tow hitch pin. The hitch pin pivoted underfoot causing the mine worker to fall to the ground.	Mine operators and equipment manufacturers should ensure that mobile plant is designed so as to allow mine workers to maintain three points of contact while alighting from the plant.
		The rear of the Eimco was fitted with two grab handles positioned on the top part of the machine. It was not possible to retain a grip on these grab handles whilst placing a foot on the ground.	
2 Gas 317657060001		Methane (CH4) concentrations exceeded 2.5% in various areas of the underground mine, due to a loss of total ventilation for approximately 11 hours and a partial loss of ventilation for approximately a further 5 hours.	Mines should ensure that their documented procedures adequately control the risks associated with repowering operations after extended power outages, caused by events which are outside of the control of the operator.
		An extreme storm event caused an external failure of power to the site and the loss of an 11kV aerial on site.	

Level	Incident type	Summary	Comment to Industry
2	Strata/Ground Control 317657070001	A roof fall was found during a pre-shift inspection by a mining official. The fall occurred in a part of the mine that had access restricted to only inspections. The mine has organised for a full geotechnical inspection of the area and has employed additional labour to carry out remedial work.	Mines should assess the appropriate frequency of geotechnical inspections in older areas of the mine that have little or no strata monitoring in place and consider installing monitoring in those areas.
2	Strata/Ground Control 317657054001	Dozer pushing clay material over a multi-level high wall, with catch benches, to seal old underground workings. The dozer was pushing a large rock over the high wall, lost traction and was unable to reverse. The dozer operator decided to run down the rill to the catch bench. However, the dozer got caught by a protruding rock ledge stranding the dozer at a precarious angle. The operator was able to exit the dozer safely.	Mines should review their procedures and training associated with pushing material over high walls and consider the use of spotters when in high risk situations.
Control of material from th large open cut min high wall. The operator move from the high wall notified. Soon afte 1000t of material f across three bence Mining activities w was evacuated. Th and a detailed inve		An excavator operator dislodged a wedge of material from the high wall face in a large open cut mine while scaling the high wall. The operator moved the excavator away from the high wall and the supervisor was notified. Soon afterwards an estimated 1000t of material fell from a wedge failure across three benches. Mining activities were stopped and the pit was evacuated. The area was barricaded and a detailed investigation commenced. The wedge structure had not been identified prior to the failure.	Operators are reminded of the importance of conducting detailed and comprehensive geotechnical mapping, inspections, monitoring and modelling of high walls. Also, implementing an effective Ground Control Management Plan and associated safe work procedures that include immediate withdrawal from the area should a fall of ground be suspected.



Recent Publications	No. published	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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