

REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

26 April 2017

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. For more comprehensive statistical data refer to our [Annual Performance Measures Reports](#).

To report an incident call 1300 814 609 24 hours a day, 7 days a week

Reportable incidents total: 29 Summarised incidents: 6

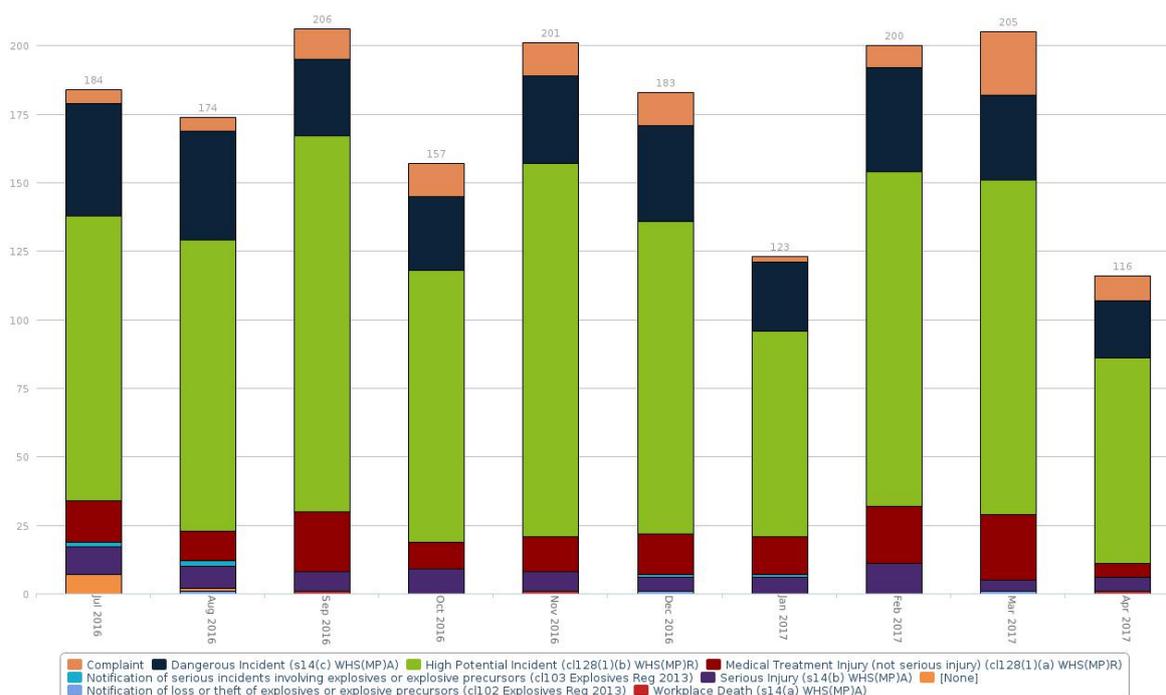
Summarised incidents – incidents of note for which operators should consider the comments provided and determine if action needs to be taken.

Incident type	Summary	Comment to industry
High potential incident SInNot 2017/00668	<p>Two transport vehicles collided while travelling in opposite directions at the bottom of the drift in an underground coal mine. There were no injuries reported.</p> <p>Traffic lights in the mine were functional, however, the two drivers failed to observe that other traffic was in the area.</p>	<p>Mine operators should:</p> <ul style="list-style-type: none"> remind all vehicle drivers of the site traffic rules and that they must be followed periodically monitor traffic rule compliance at the site through unplanned task observation. <p>When site traffic rules have not been followed, mine operators should investigate why and review those rules as appropriate.</p>
Dangerous incident SInNot 2017/00660	<p>A dump truck driver was approaching a crushing pad area while another truck was reversing into the tip off area. The dump truck operator stopped the truck to wait. When it was clear, the driver proceeded slowly until he was 10m away from the other truck. When he applied the brakes, they were unresponsive. The operator attempted to use the truck's retarder but it also did not work. The truck rolled into the 2m high berm (artificial ridge). This activated the truck's emergency stop.</p> <p>The operator found that a failure of the service brake chamber caused the incident.</p>	<p>Operators of mobile plant must be trained in emergency braking procedures, including how to apply the emergency (or secondary) brakes.</p> <p>Braking systems should be inspected, tested and maintained in accordance with the original equipment manufacturer's information. Braking systems on mobile plant must be maintained by competent people. These people must have a thorough understanding of the braking systems on the mobile plant that they are maintaining.</p> <p>For information on braking systems' integrity, refer to:</p> <ul style="list-style-type: none"> SA11-10 Park-brake malfunction leads to crush injuries SA11-07 Transport service brake failure SB10-03 Mobile plant - safety critical systems SB09-05 Failure of mobile equipment braking systems and procedures

Incident type	Summary	Comment to industry
Serious injury SInNot 2017/00653	<p>A fitter was working on an automatic processing filter and called out to a colleague to lower a hydraulic cylinder on the filter. The cylinder dropped onto the fitter, crushing his foot. The mine identified that the filter was locked out during the maintenance procedure. However, the maintenance remote control was not locked out.</p> <p>At the time of giving the all clear to move the hydraulic cylinder, the worker did not believe he was located at a high-risk position.</p>	<ul style="list-style-type: none"> • SA06-12 Maintenance of safety critical systems - braking, steering & warning systems • SA05-10 Fatal truck accident at quarry. <p>This incident raises two safety issues. These are failure to:</p> <ul style="list-style-type: none"> • lock out the remote control, and • identify that the fitter's foot was in a hazardous position. <p>Mine operators should communicate to workers that:</p> <ul style="list-style-type: none"> • they must not put any part of their body underneath unsecured suspended loads • effective isolation means: <ol style="list-style-type: none"> 1. isolate the energy source 2. lock the isolation method 3. dissipate any stored energy 4. verify effective isolation is achieved. <p>Refer SB12-03 Fluid power isolation failures and the mechanical engineering control plan code of practice. Mine operators should provide appropriate maintenance access systems.</p>
High potential incident SInNot 2017/00645	<p>An underground mine experienced what may have been a significant seismic event or earthquake. There were 60 people working underground at the time. All workers were evacuated. The mine suffered some damage.</p> <p>All mining operations have been stopped while detailed investigations are undertaken by the regulator. The investigations will determine the likelihood of another similar event and to assess the damage to the mine.</p>	<p>The investigation has not yet determined if the event was caused by natural means or by mining. Until the regulator has completed the investigation, mine operators are reminded of the following:</p> <ul style="list-style-type: none"> • operators have obligations under clause 44B of the Work Health and Safety (Mines and Petroleum Sites) Regulation, in particular sub-clause (2)(c): <p style="margin-left: 20px;">“Mine operators must ensure that, as far as is reasonably possible, the design of the mine mitigates the damage arising from the sudden release of energy from the build-up of mining induced stress.”</p> • in general, mine operators are reminded that the process of identifying potential emergencies must be comprehensive. The process should consider low frequency and high consequence events. These events may arise from factors external to the mining activities (for example, natural disaster-type events). The effects of these events should form part of the considerations within the mine's principal mining hazard and emergency management plans. Refer to the NSW code of practice for emergency planning at mines for more

Incident type	Summary	Comment to industry information.
Dangerous incident SInNot 2017/00641	<p>A grader driver was maintaining a haul road at a quarry. While he was changing direction, the grader made contact with a tipper truck.</p> <p>The mine determined that the driver of the tipper truck did not allow enough distance when travelling behind the grader. All haul road transport was stopped by the mine to investigate the incident. The mine engaged its workers in a tool box talk to reconfirm the safety issue of keeping minimum distances between vehicles.</p>	<p>All mines should review signage and visual indicators on any vehicle that frequently stops or changes direction on haul roads. The risks related to frequently stopping vehicles should be assessed and controls implemented through the principal hazard management plan (PHMP) for roads or other vehicle operating areas.</p>
Dangerous incident SInNot 2017/00638	<p>A tyre fitter contractor was using a forklift to place a heavy machinery tyre vertically on top of a second tyre. The heavy machinery tyre weighed approximately 600kgs. The fitter placed his body between the tyres to insert a piece of wood. The forklift did not have its hand brake on and the forklift moved back and the tyre descended onto the fitter. The fitter was trapped for a few minutes until he was rescued.</p>	<p>Workers should not undertake any work underneath unsecured suspended loads.</p> <p>All energy that has potential to move a suspended load needs to be isolated and locked out.</p> <p>Mines should reinforce the need to complete pre-task hazard assessments when tasks or environments change.</p>

Number of incidents, by commencement month and incident type



Recent incident publications

SA17-03 Pneumatic air tool fitting fails

You can find all our incident related publications (that is, safety alerts, safety bulletins, incident information releases, weekly incident summaries and investigation reports) on our [website](#).

Further information

Email mine.safety@industry.nsw.gov.au or contact one of our offices:

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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (April 2017). However, because of advances in knowledge, users are reminded of the need to ensure that information upon which they rely is up to date and to check currency of the information with the appropriate officer of the NSW Department of Planning and Environment or the user's independent advisor.