

REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

19 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

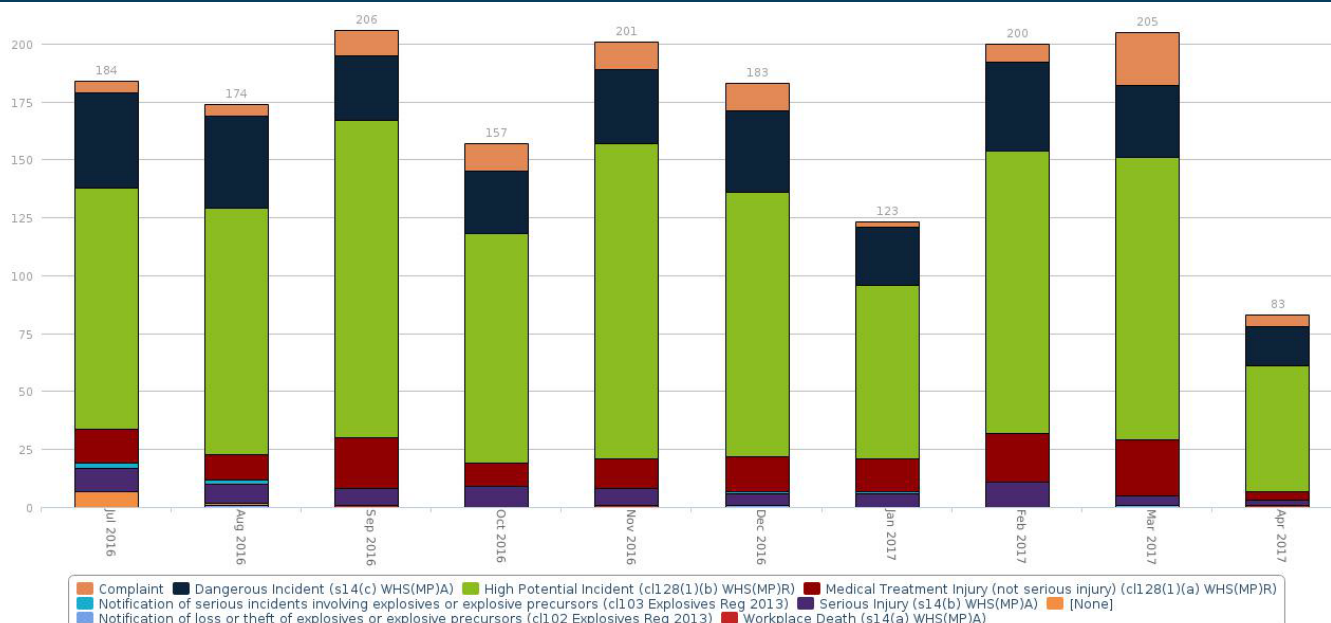
Reportable incidents total: 41 Summarised incidents: 5

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
Dangerous incident SInNot 2017/00636	Several workers were finishing working on a chute. The chute incorporated a solid structural door on hinges. When one of the workers opened the door, the hinges broke and the door fell off. The impact caused the worker to fall backwards. An investigation into the incident found that the door hinges were not built according to the original design. The investigation found the hinges were insufficient to hold the load of the door.	Structures need to be installed according to the designer's specifications, unless a qualified structural engineer has signed off on an alternative design.
Serious injury SInNot 2017/00623	While cleaning a conveyor, a worker pushed a hole through one of the conveyor guards. This caused his finger to be amputated. The guarding had been modified on the site to assist with the process of cleaning the tail roller.	Operators are reminded of the minimum standards for conveyor guards, contained in: <ul style="list-style-type: none"> AS/NZS 4024.3610 Safety of machinery - Conveyors - General requirements AS/NZS 4024.3611 Safety of machinery - Conveyors - Belt conveyors for bulk materials handling AS/NZS 4024.3612 Safety of machinery - Conveyors - Chain conveyors and unit handling conveyors. <p>These documents set the requirements for guard maintainability. They are incorporated in the Mechanical engineering control plan code of practice.</p> <p>Only a competent person should carry out</p>

Incident type	Summary	Comment to industry
High potential incident SInNot 2017/00615	<p>A maintenance worker was preparing to remove the lid from an A-frame reclaimer luff drive gearbox. As he undid the final bolts, the worker heard the gearing moving inside the box.</p> <p>The shaft had lifted and the gears had come out of their mesh. The rope drum attached to the output of the gearbox unspooled about 2 metres of rope. The bridle on the boom lowered about 1 metre to rest on the bucket. The worker was not injured.</p>	<p>changes to conveyor guards, taking these standards into consideration.</p> <p>Mine operators need to develop isolation procedures that identify all stored energies. The procedure must be developed using hierarchy of control methods to mitigate these risks.</p> <p>Plant should be maintained according to the original equipment manufacturer's specifications.</p> <p>Guidance on stored energy in conveyor systems (including stacker/reclaimers) is provided in appendix B of AS/NZS 4024.3610 Safety of machinery - Conveyors - General requirements.</p>
Dangerous incident SInNot 2017/00602	<p>A fire started on a grader while the engine bay was being refuelled. The fire was extinguished with a nearby water hose. It appears the filler cap became dislodged and fuel sprayed under pressure during the refuelling process.</p>	<p>Mine operators should review their engineering control plans with regard to risks associated with fuel management. This review should consider the recommendations in SB15-03 Fires ignite while refuelling mobile plant with quick-fill fuel system. Operators should also refer to SA15-05 Fire destroys water truck.</p>
Dangerous incident SInNot 2017/00601	<p>Two operators were working off the Malibu (platform) extending monorail when a beam dropped from the roof. As it dropped, it hit one of the operators on the right side of his body. Injuries included a cut above the ear and numerous abrasions.</p>	<p>Mines should develop detailed commissioning and decommissioning procedures for the installation of monorail, including pre-use checks, before installation. These procedures should be developed through a risk assessment process with reference to the original equipment manufacturer's standards.</p>

Number of incident notifications, by commencement month and incident type



Recent incident publications

SA17-04 [Pneumatic air tool fitting fails](#)

SB17-03 [Rocks breach catch bund](#)

Investigation report: [Fatality at Ridgeway Mine on 6 September 2015](#)

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

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