

## REPORTABLE INCIDENTS | WHS MINES LEGISLATION

# Weekly incident summary

Published 17 February 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	→	Level 3 incidents
42		10		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

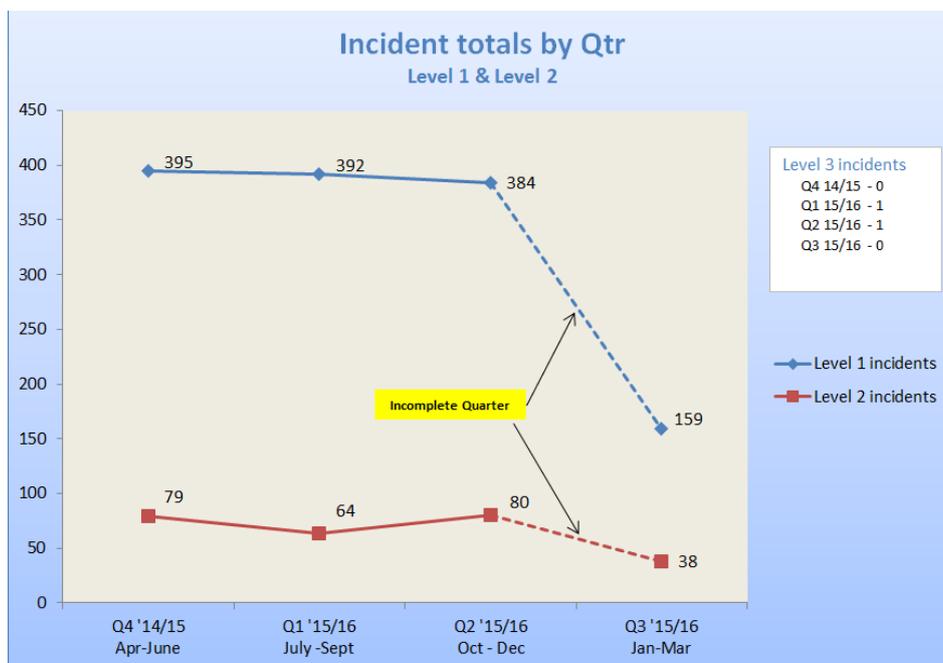
### Reportable incidents overview

Note: While all incidents are investigated, generally only level 2 and 3 incidents are summarised below.

Level	Incident type	Summary	Comment to industry
2	Strata/Ground Control 317658511001	Failure of strata support system resulting in a fall from height of bolt hardware - Bending moment on beam sufficient to cause tab failure and tensile/shear failure of roof bolts and cables pinning the beam.	Mines should consider risk of strata forces causing sudden shearing of bolts, allowing support hardware to fall where people may be present. Control measures such as propping/slinging steels should be considered where the risk may be present.
2	Mechanical Equip 317658519001	Haul truck reversed through the windrow at the dump. The operator reversed at an angle to the windrow, the windrow was not constructed to the design height and was constructed of poor quality material.	Operators should review dumping procedures and consider providing instruction such that: <ol style="list-style-type: none"> <li>Dumps are maintained in a straight line with windrows being constructed of predominantly dry, competent material to a specified height.</li> <li>Drivers are to reverse into the dump at a safe speed with the truck perpendicular to the tip face. The windrow must not be relied upon to stop the truck.</li> <li>Regular inspections are carried out to monitor active dumps and ensure that correct dump standards are maintained.</li> </ol>

Level	Incident type	Summary	Comment to industry
2	Work Environment 317658475001	Electric shock in mechanical surface workshop while adjusting operating crane chains.	Mines with overhead cranes must undertake regular maintenance on the earthing systems of the crane to ensure earthing remains effective, particularly where the crane uses sliding brushgear. Mines should also consider 30mA RCD's were practical.
2	Elect Energy 317658517001	An instrument transformer (VT) exploded approximately 20 minutes after being energised during initial commissioning. The VT was installed on a 22 kV pole top circuit recloser and as a result of the failure distributed ceramic pieces of VT insulator up to 20 metres from the pole.	The mine's commissioning procedures must include checks that verify electrical equipment is suitably rated and correctly installed for the proposed installation, and original equipment manufacturer support documentation is available to confirm the equipment ratings and installation. When a contractor is engaged for electrical work, the mine's commissioning procedures must also apply to the work performed by the contractor.
2	Work Environment 317658535001	A tradesman was using the workshop overhead crane to move electro-hydraulic rig idler. It appears as though the track idler fell, the tradesman tried to catch it which resulted in his finger being caught between the idler and a bracket.	Risk management processes for such tasks should include consideration of ergonomics in relation to crane control pendant position, selection of chain/sling appropriate to task and body position in relation to suspended load.
2	Mechanical Equip 317658505001	During the course of maintenance activities the owner of a quarry has fallen off a mobile screen to the ground where he has sustained a broken collar bone, fractured ribs and a punctured lung.	Mines must develop and implement procedures for working alone and working at heights.
2	Mechanical Equip 317658529001	During a planned maintenance task on an overhead monorail, the operator was moving the trolley on the beam manually using the chain while standing on a walkway behind some guard railing. Without warning the trolley fell from the beam onto some pipework below and came to rest near the operator.	Lifting apparatus, including monorail trolleys should be inspected by competent personnel on a regular basis in accordance with an appropriate standard and/or original equipment manufacturer instructions and should always be inspected prior to use in a lifting capacity.
2	Mechanical Equip 317658595001	A loss of load in the men and materials drift - failed load retention chain.	In this case the mine had a documented standard for load retention specific to this task that was not followed. Mines should consider human factors in task design, need for refresher training on rigging/dogging standards and importance of supervision/task observation programs.
2	Mechanical Equip 317658579001	An operator fell while getting down from an articulated dump truck that was positioned on a low loader trailer, suffering a serious head injury as a result.	Plant operators should descend vehicle ladderways by facing towards the ladder and using the three points of contact.

Level	Incident type	Summary	Comment to industry
2	Mechanical Equip 317658581001	While operating the left hand side drill rig the hydraulic oil supply to the rotation unit on the drill rig failed. Hose burst protection was in place and the failed hose released hydraulic oil that was defused (at lower pressure) before making contact with an operator of the drill rig.	Consider hose burst protection for hoses in high risk areas where physical guards are not possible. Refer to <a href="#">MDG 41 – Fluid power system safety</a> for more information.



## Recent incident publications

**No recent incident publications.**

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 [website](#).

## Further information

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

### COAL (NORTH) and EAST METEX

#### Maitland

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Mineral Resources  
516 High Street, Maitland NSW 2320  
(PO Box 344, Hunter Region MC  
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T 1300 736 122 or 02 4931 6666  
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E [mine.safety@industry.nsw.gov.au](mailto:mine.safety@industry.nsw.gov.au)

### COAL (SOUTH)

#### Wollongong

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Level 3, Block F, 84 Crown Street,  
Wollongong NSW 2500  
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### WEST METEX

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