

REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

22 March 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](#).

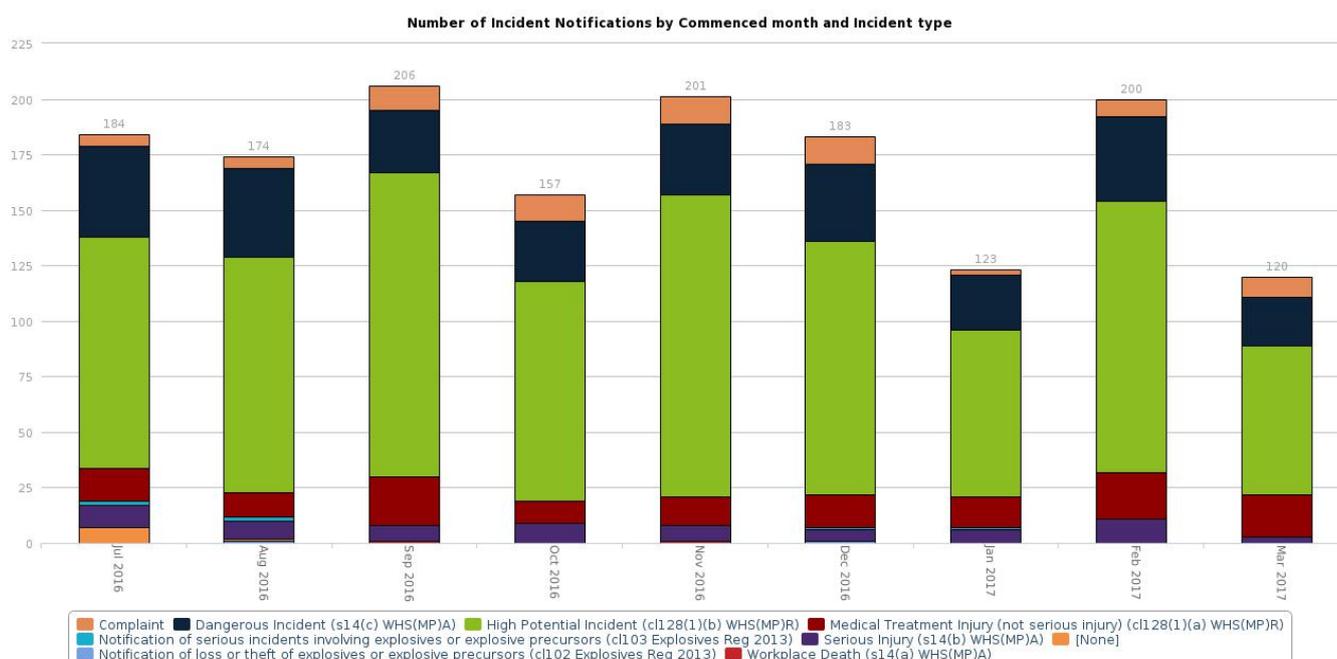
To report an incident call **1300 814 609** 24 hours a day, 7 days a week

Reportable incidents total: 43 Summarised incidents: 3

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 2017/00458	A rear dump truck was in normal operation while tipping a load at a tiphead, when the hoist cylinders failed allowing the body of the truck to fully extend and then free fall uncontrolled back to the truck chassis rails.	Mines should consider: <ul style="list-style-type: none"> fatigue/endurance life of hoisting cylinders and where possible carry out periodic non-destructive testing of structural areas hoisting cylinders can be overloaded or subject to shock loads, such as body top out, body kick out settings, reversing collisions with tray up replacement, repair and/or testing of hoisting cylinders in accordance with original equipment manufacturer recommendations communicating good dumping practices to truck drivers and reporting/stand down requirements such as when the body top is out.
Dangerous incident SInNot 2017/00421	An operator was using a hired pneumatic ratchet on a boat winch to tension recovery mesh in preparation for a longwall change out, when the swivel fitting on the air hose detached from the ratchet tool striking him in the left forearm. A similar incident occurred at the same mine on a previous longwall change out, and the incident investigation controls identified installing a swivel to prevent rotation of the air hose undoing the fitting into the ratchet tool.	Mines hiring powered tools should ensure: <ul style="list-style-type: none"> they are fit for purpose that any controls identified have been effectively implemented automated hose rupture detection air shut off valves are fitted when required.

Incident type	Summary	Comment to industry
Dangerous incident SInNot 2017/00419	<p>A fitter isolated a longwall powered roof support near the tailgate. In the process of preparing maintenance access the fitter pulled a hose bundle clear and the high set hose failed, spraying emulsion onto the floor that ricocheted hitting the fitter in the face. The fitter was uninjured.</p> <p>The support isolation did not isolate the high set hose, which is normally isolated at the dump sled in the maingate.</p> <p>The hose failed as it was worn through from rubbing on mounting bolts for the base lift cylinder. This rubbing had been identified on previous failures.</p>	<p>Mines should:</p> <ul style="list-style-type: none"> identify wear points for high pressure hydraulic hoses and implement effective controls, refer to Section 7 <i>Inspection, maintenance and repair</i> of MDG 41 Fluid power system safety ensure that pressurised fluid power systems can be effectively isolated and energy dissipated , refer to SB12-03 Fluid power isolation failures ensure workers are aware of, and trained in effective isolation and energy dissipation.



Recent incident publications

- SA17-02 [Fall from height risk](#)
- SB17-03 [Rocks breach catch bund](#)
- IIR17-03 [Coal workers' mixed dust pneumoconiosis](#)
- Investigation report [Fatality at Ridgeway Mine](#)

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

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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (March 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 Industry, Skills and Regional Development or the user's independent advisor.