REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

1 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

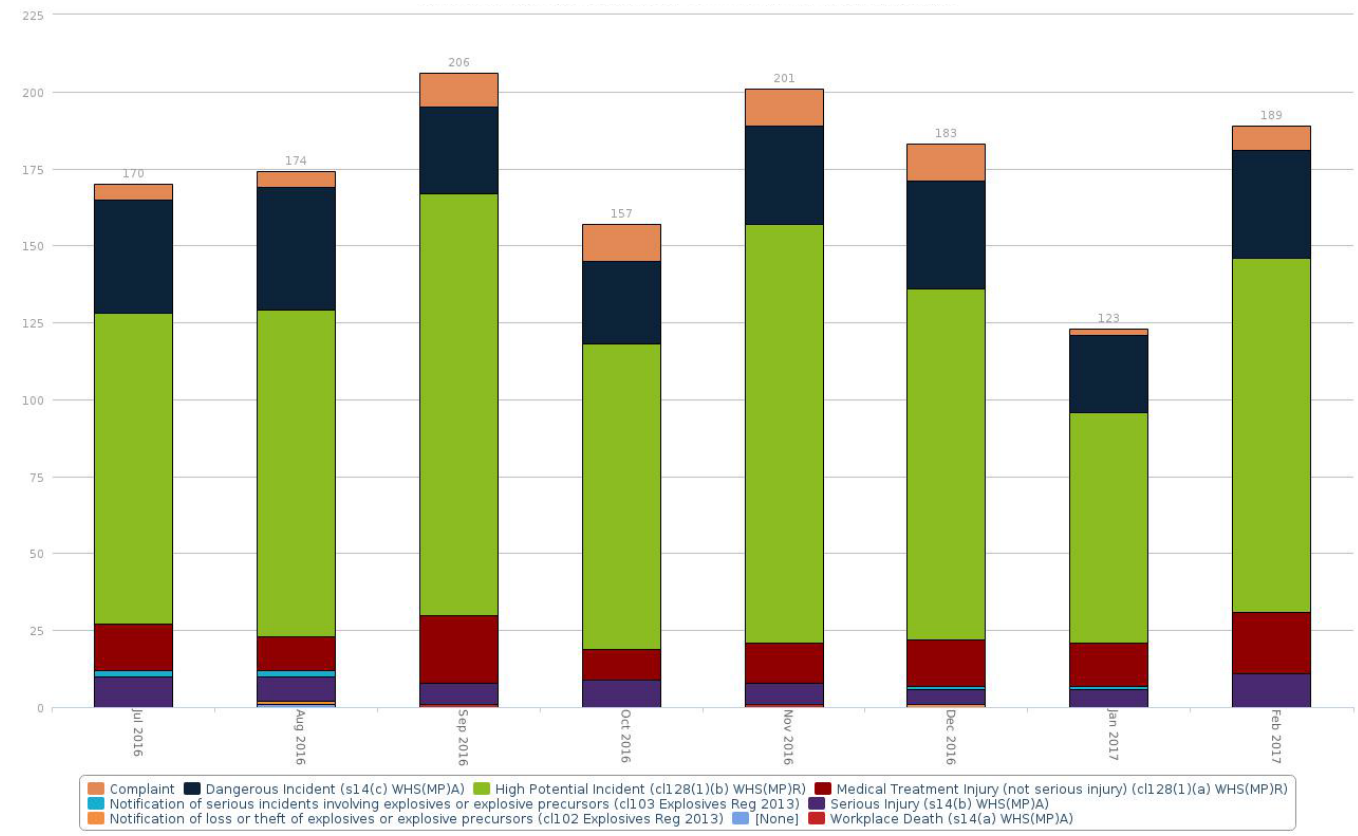
Reportable incidents total: 59 Summarised incidents: 5

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 2017/00289	The brakes of a Manitou telehandler failed when an operator started it. The telehandler broke through a bund wall about 10 m from the pit edge. The operator jumped from the vehicle before it drove off the pit edge, where the vehicle fell 30 m to the pit floor. No people were at the bottom of the pit when the incident occurred.	Mines must ensure safety critical systems on mobile plant remains functional. Mines should review the recommendations in: • SA06-12 Maintenance of Safety Critical Systems - Braking, Steering & Warning systems • SB10-03 Mobile plant - safety critical systems • SB09-05 Failure of mobile equipment braking systems and procedures • SA09-01 Driver injured in dump truck rollover Fit-for-purpose barriers, such as bunding or windrows, should be in place to prevent uncontrolled mobile plant going over embankments.
Serious injury SInNot 2017/00297	An operator who was working on a sub-level cave was struck by an isolation valve at the end of a hose. While the drill jumbo was tramming into position, the hose did not unwind and tensioned the hose line. The tension broke off the fitting, subsequently hitting the operator on the left leg. He suffered a suspected fracture of the tibia and fibula.	It is a known hazard that there is potential for trailing cables and water hoses to not reel out freely while drill rigs are running out these services. Exclusion zones should be established and effectively enforced to ensure workers are not exposed to unexpected failures of anchor points and associated equipment when running out water hoses and trailing cables. Good maintenance practices must be in place to ensure that cable or hose reels are operating correctly. Pre-start inspections should check that cables and hoses are correctly wound onto their reels.

Incident type	Summary	Comment to industry
		Refer to SA13-04 Jumbo Trailing Cable Incident
High potential incident SInNot 2017/00314	A fall of roof has occurred in a development panel while the continuous miner was back-holing in a predicted fault zone. The collapse has extended to a height of 2.5 m above the normal roof horizon over a length of 13 m and width of 4 m. The normal roof support for the area consists of 1.8m roof bolts. No persons were injured or equipment damaged. It would appear that Trigger Action Response Plan (TARP) used to identify changes in strata conditions was present but may not have been acted upon.	Mine operators should review the critical controls in their strata failure management plan to identify and quickly respond to any area of concern. Some mines have implemented a strata defect system including TARPs, which specify a timely response. This system is considered good practice and has reduced the incidence of roof falls at these operations. It is important that all personnel are familiar with the TARPs. They should understand the actions that need to be taken if a change is detected.
Dangerous incident SInNot 2017/00309	An operator was cleaning under a conveyor with a backhoe using a T-attachment. The attachment is used to drag material out from under the conveyor. A strip of metal came into contact with the attachment and flicked up a golf ball-sized rock through the open rear cabin window. The rock smashed through the front window and came to rest on the front of the machine. The rock did not hit the operator, who was in the cabin.	Mine operators must ensure risk assessments identify and assess potential risks so that adequate controls are implemented. Plant needs to be fit-for-purpose. In this case, consider guards and/or purpose-built attachments, such as those with little or no flex in the rake attachment.
Dangerous incident SInNot 2017/00278	While placing a pallet back on shelving, the back board frame of a forklift became caught in a pallet located about 4 m above the ground. The pallet had a heater attached to it. As the load was lowered, it caused the heater pallet to flip over. The load came into contact with the forklift on the way down, damaging its top-revolving light. The forklift was new on the site.	Mine operators should note: • they should have a robust change management process that identifies operational differences between the new and old plant • heavy, unbalanced loads should be stored at lower heights on pallet racking • pallets should be stored within the pallet racking system • falling object protection must be provided on forklifts • forklift operators must hold the appropriate licence (see SafeWork NSW: Forklift licences for more details).

Number of incident notifications, by commencement month and incident type



Recent incident publications

IIR17-01 Light vehicle collides with mine entry gate

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

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

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