



REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

8 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

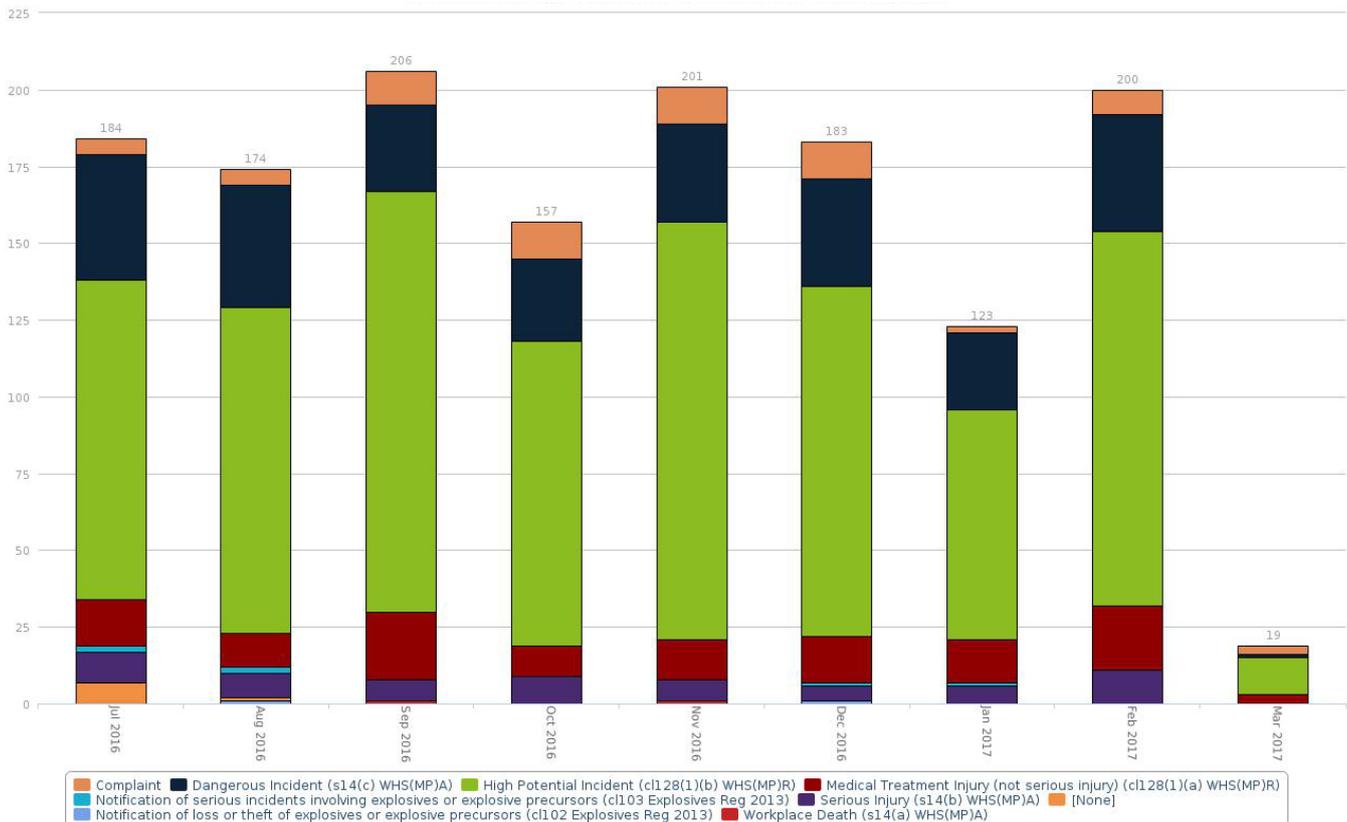
Reportable incidents total: 59 Summarised incidents: 5

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 2017/00360	Two workers in the basket of a boom-type elevated work platform (EWP) were undoing pipework using an impact gun. The workers put the gun down on the platform controls. The basket began to rise without the foot-operated deadman being utilised.	Unplanned movements of EWPs are a serious risk to the health and safety of workers, particularly when in close proximity to fixed objects and at heights. EWP safety devices such as guards, interlocks, emergency stops and deadman controls must be regularly tested. EWPs must be regularly maintained and inspected by competent persons. Further information and recommendations can be found in SB15-04 Collisions of mobile elevated work platforms increase .
Dangerous incident SInNot 2017/00359	An ejection of flyrock landed outside the exclusion zone and was seen by a sentry 100 metres away. Inspection by the shotfirer found that the hole was drilled too close to the edge. The hole was downloaded in response to the closeness to the edge. Despite this, the under-loaded face hole burst from the shot.	Mine operators should review quality assurance systems in relation to all aspects of the drill and blast process. If any anomalies are found, additional controls should be implemented, such as moving sentries further out and modifying exclusion zones to ensure the safety of personnel until the shot has been fired.
High potential incident SInNot 2017/00355	A continuous miner was being used under remoting mining procedures due to identified outburst indicators. As the continuous miner cut the floor an outburst was initiated resulting in the release of a large volume of methane and the ejection of coal from the face. Procedures in place at the time protected workers from the consequences of the outburst. It was noted that gas monitoring in the immediate area of the outburst were poisoned (CO2 maximum	Operators of mines in coal seams prone to the outburst hazard should review systems that address the identification of zones where remote mining should be undertaken. Operators should also review the implementation and audit of controls for remote mining. Mine operators should also review gas monitoring requirements taking into consideration the range of gas that the sensor may be exposed to.

Incident type	Summary	Comment to industry
	5.5%).	
Dangerous incident SInNot 2017/00349	A crane operator was placing a steel plate in position so that it could be cut with a plasma cutter. The two magnets holding the plate unexpectedly released and the steel plate fell 200 mm onto the gate and the plasma cutting bed. A second operator was programming the cutter in the vicinity, inside the gated plasma cutter working area.	Chain spreader bars should be used when lifting a heavy plate using multiple magnets and chains to a single lifting hook. This allows the magnets to maintain vertical contact during the lift. We do not recommend using triangular chains on multiple magnets as they will tend to peel off the magnetic contact area.
Dangerous incident SInNot 2017/00321	A deputy had headed to a closed gate valve to re-energise a water range. When he opened the valve, a 2-inch gate valve adjacent to the closed valve expelled the spindle, grazing the deputy's jaw. The deputy fell back, striking the back of his head. The deputy lost consciousness for a short period of time. Other people isolated the water and brought the deputy to the surface. The deputy was checked by paramedics and taken to hospital.	The gate valve had been highlighted as being faulty but no action had been taken. This is because the defect failed to reach the defect management system (refer to section 4.5.6 of the Mechanical engineering control plan code of practice). This system should be documented and should incorporate: <ul style="list-style-type: none"> • a way to document how the defect was found and its defect • a way to prevent the use of mechanical plant or structures until a defect has been assessed by a competent person • recording action taken to remedy or control the defect • a competent person reviewing the plant or structure and verifying it is safe to use • eliminate, if possible, the defect from occurring again.

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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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.