Planning & Environment
Resources Regulator

REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

24 May 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: 38 Summarised incidents: 4

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
Workplace death SInNot 2017/00771	On 14 May 2017 at about 3.30pm, a 55-year-old man was found unconscious on a mine roadway about 788 metres below the surface of the mine. The man was given first aid including CPR and transported to Broken Hill Base Hospital where he was pronounced deceased.	Investigations are continuing. The cause of death will be determined by the NSW Coroner.
Dangerous incident SInNot 2017/00794	Flyrock hit and damaged a ute when the rock was ejected during blasting operations at a mine. There were six people standing alongside the ute at the time. No one was injured. The operator reported that the people and ute were positioned inside the blast exclusion zone, 245m from the blast. The blast exclusion zone required a distance of 500m.	Mines should review their blasting procedures and, where necessary, retrain the blast crew personnel and mine officials in the procedures, including the application of the exclusion zone to all personnel. Considerations could include: • the use of GPS to determine that sentries and the blast crew are outside the exclusion zones • logging in the blast pack the actual location from which the shot was fired • logging stemming use for each hole to identify bridging or other potential issues that may lead to insufficient stemming being used in a hole • using pre-determined firing locations to ensure personnel are placed outside the exclusion zone.
Dangerous incident SInNot 2017/00784	During maintenance work of a shaft, a cage was being driven slowly. The skip hit the plat gate, and stopped. Two workers were in the cage. An electrical engineer, mechanical engineer and safety manager carried out a risk	Winder controls should not allow movement of the cage while the plat is not fully engaged, or not fully retracted for the appropriate mode or stage of the operation.

Incident type	Summary	Comment to industry
	assessment and chained up the plat gate, to make it safe. They then lowered the cage to allow the workers to get out.	Mines should review winder risk assessment and operating procedures and ensure emergency scenarios are adequately addressed. This is especially important for scenarios where workers are on board the winder when there is a failure of the winder system or infrastructure. Before resetting winder faults a thorough investigated must be completed by a competent person. Mines should review their emergency management plans to include if and when external rescue resources are notified and mobilised for different scenarios.
Serious injury SInNot 2017/00780	An operator putting in an 8 foot (2.4m) roof bolt using a hand-held roof bolter slipped off the dolly car. He was struck on the third finger of his left hand, removing the tip of the finger.	This incident highlights the importance of hazard awareness in and around roof and rib bolting. Consideration must be made on the appropriateness of hand-held bolters in each situation. When using hand-held bolters, safe standing zones should be established and should take into account all potential pinch points. Hand bolters must be maintained and subjected to pre-start inspections. Operator training, procedures, and supervision are all factors that need to be considered.

Recent incident publications

Coal Services Standing Dust Committee Information Bulletin: 2016 Airborne Dust Results

Standing Dust Committee Information Bulletin: Respiratory Protective Equipment Review

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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