REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

15 February 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.

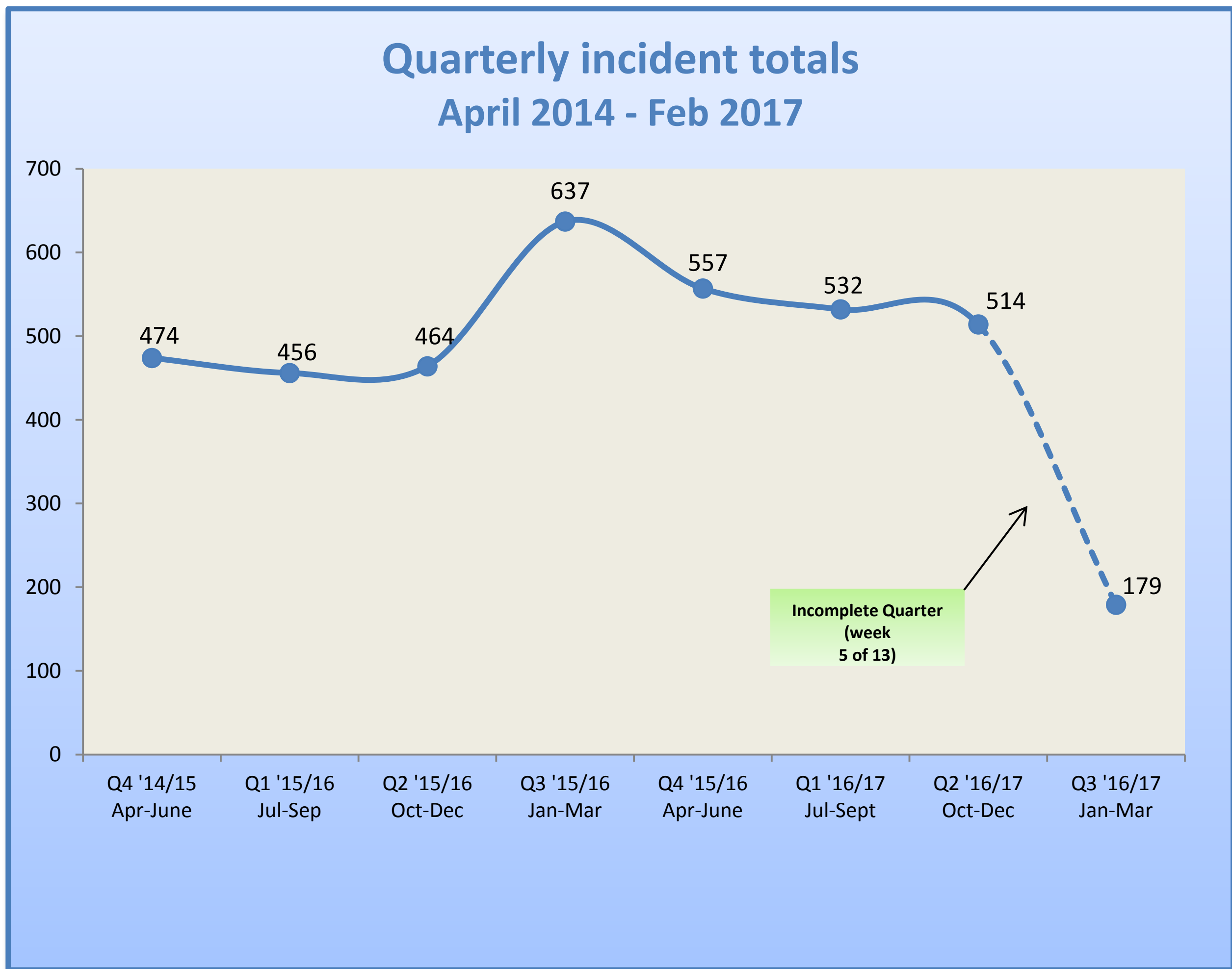
To report an incident call 1300 814 609 24 hours a day, 7 days a week

Reportable incidents total: 48 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
Medical treatment injury SInNot 2017/00201	An operator suffered a crush injury to his foot while in the process of loading supplies onto a materials pod. The operator was hand-loading supplies onto the pod, which was located on the front of a forklift prior to being loaded onto the dollycar trailer. The pod slipped off the forklift tynes while the operator was positioned beside the supply pod.	Forklift operators should place loads onto the ground when they are not being transported. No person should place themselves or any part of their body under any suspended load. Where equipment, such as materials pods, are to be moved, they should be designed with dedicated lift points, such as forklift tyne slots, or otherwise slung by a competent rigger, before being lifted.
Serious injury SInNot 2017/00194	Thirty metres of drill steel string was released from a roof, where it fell and crushed the right hand of a contract driller's off-sider. The incident resulted in the loss of two fingers on the right hand. An exploration drill rig was being used underground to drill an inter-seam borehole for an electric cable installation. After repairing a broken drill string, the operator raised the drill string to commence reaming operations. At this time the grippers were released, allowing the drill string to fall. The off-sider had his right hand on the drill chuck area and the falling drill string struck his hand. This resulted in crush injuries and the amputation of two fingers.	Horizontal exploration drills should not be used in vertical drilling applications, unless a risk assessment has reviewed the adequacy of risk controls for the proposed change in use at the drilling plant. • Both drilling operators and driller's assistants must be trained and competent in the proposed drilling task and risk controls. • No-go zones for driller's assistants need to be maintained during the drilling process at all times. • Mine operators should periodically check the work procedures of contractors.

Incident type	Summary	Comment to industry
Dangerous incident SInNot 2017/00181	A fire was reported underground in the loop take-up on a belt storage unit. The drive and LTU had been replaced and recommissioned around three months earlier. The investigation determined that mounting bolts on the larger of the two pulleys had loosened. This loosening allowed the pulley to move 12 mm out of alignment. It is notable that three of the four wander switches on the carriage were not correctly set.	The functionality of all safety-related equipment, such as a belt wander trip, should be confirmed and documented during commissioning checks on conveyor belts. Operators are reminded of the design, commissioning, operation and maintenance requirements in: • AS/NZS 4024.3610:2015 Conveyors – General requirements • AS/NZS 4024.3611:2015 Conveyors – Belt conveyors for bulk materials handling. These documents are incorporated in the Mechanical engineering control plan code of practice.
Complaint SInNot 2017/00174	A complainant has alleged that a child was attempting to look down an old and disused mine shaft at Lightning Ridge. While looking down the shaft, the child allegedly held on to a star picket to stabilise himself and the picket snapped off at ground level. Star pickets are used for securing the shaft by fencing it.	The department is investigating the allegation. People have been fatally injured falling down mine shafts. Old mine shafts can be dangerous. The rock or soil around the shaft may be unstable and the shaft timbers may be rotten. People must not walk anywhere near a shaft opening. For further information regarding the Lightning Ridge mine fields, contact the mine safety office at Lot 60, Morilla Street, Lightning Ridge or by calling (02) 6829 9200.
Dangerous incident SInNot 2017/00171	A 400 tonne excavator was loading off the D parting Strip 13 in Pit 7 when the machine slipped down a 3 m bench. The operator exited the machine uninjured. He was assessed by emergency response personnel.	Mine operators should review operational procedures for excavators (“diggers”) loading from a bench. The review should include criteria such as bench height, the nature and stability of the bench material, dimensions of the loader and the operating criteria for the loader as defined by the original equipment manufacturer.



Recent incident publications

IIR17-01 Light vehicle collides with mine entry gate

Safety Alert, Queensland Department of Natural Resources and Mines: Driver thrown from cab in articulated truck rollover.

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:

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WEST METEX

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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (February 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.