Planning & Environment
Resources Regulator

REPORTABLE INCIDENTS | WHS (MINES) LEGISLATION

Weekly incident summary

10 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

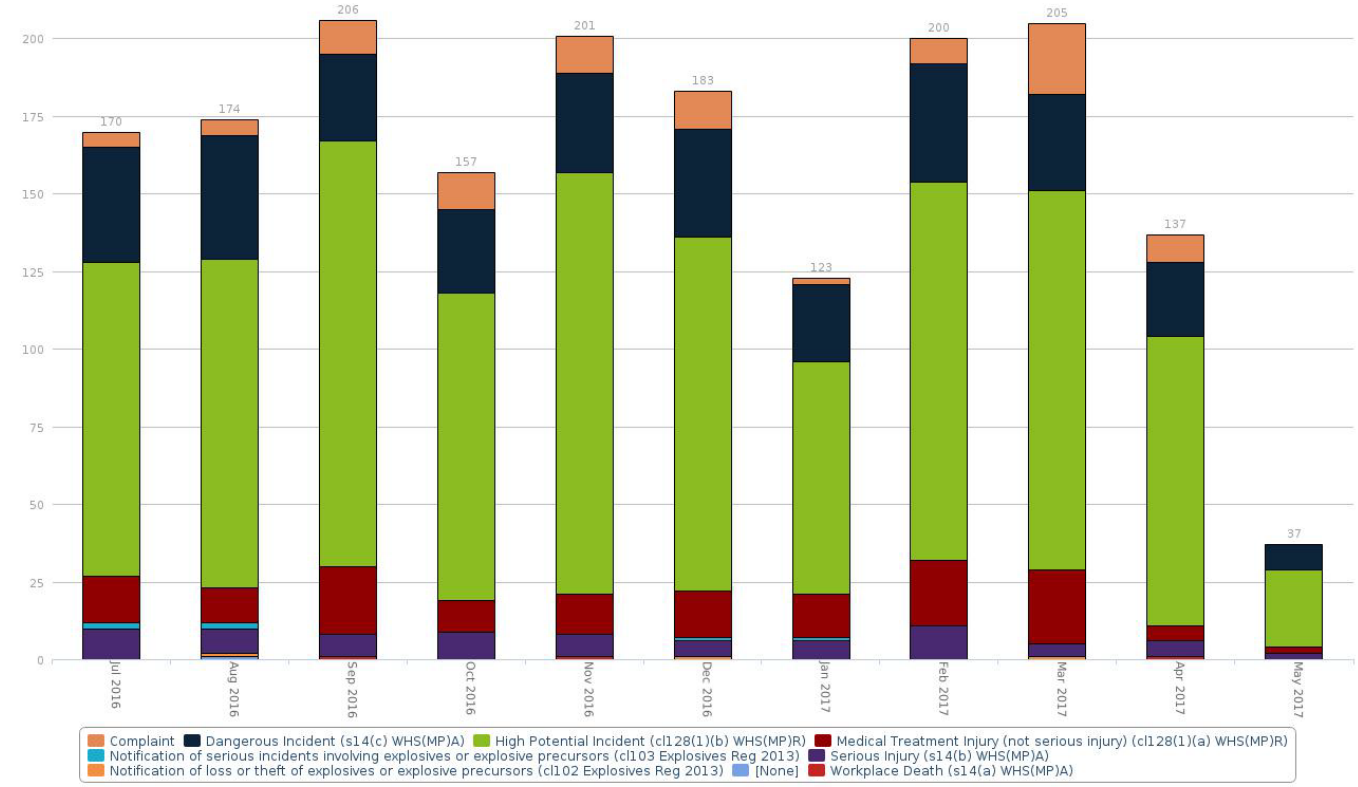
Reportable incidents total: 24 Summarised incidents: 3

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 2017/00721	An electrical apprentice suffered an electric shock while verifying the isolation of a 415 volt generator. The apprentice was about to fit an improvised lock out device when the incident occurred. The worker was working inside a motor control cubicle. The point of contact was his fourth finger on his left hand. The operator reported to the regulator that the isolation handle of the fusible switch had not been turned off before the apprentice entered the cubicle. A multimeter was on the ground in front of the drive module. We do not know if a non-contact tester was used before applying the leads of the multimeter. Ambulance paramedics attended to the apprentice, who was then transported to Singleton Hospital.	This incident highlights that operators should ensure that: • the level of supervision for all apprentices is relative to the risks associated with the task • before starting electrical work, hazards have been assessed and the risks are controlled • accurate, well-documented isolation procedures and permit systems are in-place • processes for testing to prove electrical equipment is de-energised are documented. The processes should also include the use of non-contact testers, where possible, before the use of contact test equipment. The test equipment must be fit for purpose. • training and assessments are adequate to ensure people are competent to carry out tasks safely • fit-for-purpose facilities are provided for verifying and securing energy isolation points • surface electrical installations are compliant to the requirements set out in AS/NZS 3000.
Serious injury SInNot 2017/00720	A worker suffered a crush injury to his fifth finger on his left hand. He also suffered a laceration and suspected	Mine operators should speak with their workers and reinforce how important it is to remain totally within the confines of mobile plant while it

Incident type	Summary	Comment to industry
	fracture of his fourth finger on the same hand. His fingers were injured after becoming jammed between a PET canopy and the rib. Ambulance paramedics drove to the mine site and transported the worker to hospital.	is being operated.
Dangerous incident SInNot 2017/00719	A piece of flat bar steel fell from a shaft collar to the shaft bottom. The piece was 1.5 m long x 50 mm wide x 6 mm thick. A multi-level shaft stage was in the shaft when the flat bar fell. The stage contained three workers and was about 900 m below the shaft collar. The flat bar hit the stage and continued to the bottom of the shaft. No workers were injured. The flat bar had been tack-welded to a pipe trolley in what was described as a 'trial'. The trolley was used until the flat bar broke off and fell down the shaft.	Whenever equipment is introduced to a mine site or is modified, proper change management procedures should be followed. Plant should not be used unless it has been fully commissioned. Temporary repairs or modifications must have sufficient strength to withstand in-service loads. Material falling down a shaft poses a serious risk to the health and safety of any person in the shaft. Appropriate control measures are required to prevent the risk of material falling down a shaft. Mine operators must ensure they comply with clause 49 (6) of the Work Health and Safety (Mines and Petroleum Sites) Regulation 2014.

Number of incidents, by commencement date and incident type



Recent incident publications

Incident information release: Fatality in underground metalliferous mine

Safety alert: Synthetic fibre sling fails

Safety bulletin: Uninterruptible power supply installations at mines

Guide: Maintenance of competence scheme for practising certificates

Policy: Causal investigation policy

You can find all our incident related publications (that is, 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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