Planning & Environment
Resources Regulator

REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

12 April 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

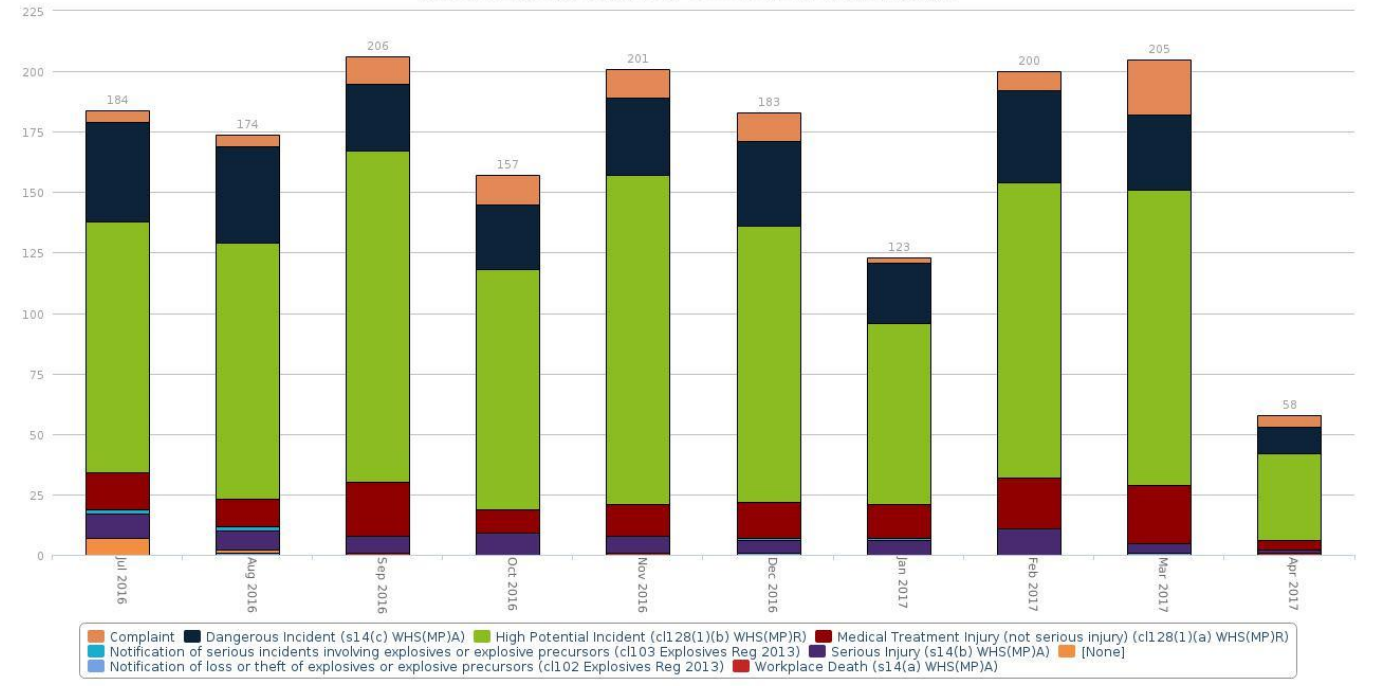
Reportable incidents total: 43 Summarised incidents: 4

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
Dangerous incident SInNot 2017/00593	An operator was using a crane to lift replacement legs for a skyline conveyor when one of the two slings being used broke. The leg then swung in an uncontrolled manner and landed next to an elevated work platform (EWP) where two operators were guiding the legs into position. The two operators exited via the skyline conveyor. The EWP was not damaged. The direct cause of the incident was the failure of a synthetic fibre sling that had been attached under a bolted flange.	Synthetic fibre slings are susceptible to damage and can tear if exposed to sharp edges or corners. Chain or wire rope slings should be used where the load to be lifted has sharp edges or attached components such as cleats or bolts at the point where the sling is to be attached. The potential for slings to rotate around the anchor point as a load is lifted from ground should be assessed. Lift plans should identify all hazards, assess risks to workers and include the specification of all lifting components to be used and when certain types should not be used.
Complaint SInNot 2017/00579	The department has received a complaint regarding the maintenance and management of self-rescuers. The complainant alleges that self-rescuers were stored incorrectly.	Mine operators should follow manufacturer's recommendations for how a breathing apparatus is used and stored. MDG 3609 - Escape breathing apparatus for underground mining applications sets out standards for the design and ongoing performance of breathing apparatus. It includes the requirement for mine operators, in consultation with the supplier and an appropriate employee representative, to draw up a risk-based scheme for regular maintenance and checks on the apparatus.

Incident type	Summary	Comment to industry
Dangerous incident SInNot 2017/00577	A truck driver was tipping a load at a tip head a couple of metres from the rill, when the edge of the tip head slumped, dropping about 2-3 m, bringing the truck to an angle of about 45 degrees. The operator was not hurt and the truck tray was down at the time. The slump was a couple of metres from the edge and the truck was stable. The tip edge was about 15-20 m high. It is suspected that the stabilising material at the base of the tip head may not have been sufficient. The mine reported it had been raining heavily in the days before the incident, which may have been a contributing factor.	Slumping due to rain events is foreseeable and mine operators should address this hazard in risk assessments. The effect(s) of heavy rainfall should also be considered in geotechnical assessments of dump design.
High potential incident SInNot 2017/00568	Burial of mine roof supports by roof fall. An incident occurred while lifting off using three breaker-line supports The fall occurred over No 3 & No 2 supports. The fall was about 2.3 m high and 3 m in front of the two supports. The fall was in line with No. 1 support which was advanced at the time. Workers were behind the continuous miner at the time of the fall, as required by the operating procedures.	The relative positioning and sequencing of supports is critical in maintaining effective control of the roof. Operators must ensure when carrying out pillar extraction, the roof support system(s) are operated in sequence and maintained in accordance with safe working procedures.

Number of incidents, by commencement month and incident type



Recent incident publications

SB17-03 Rocks breach catch bund

SA17-02 Fall from height risk

Investigation report: Fatality at Ridgeway Mine on 6 September 2015

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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