

REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

17 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

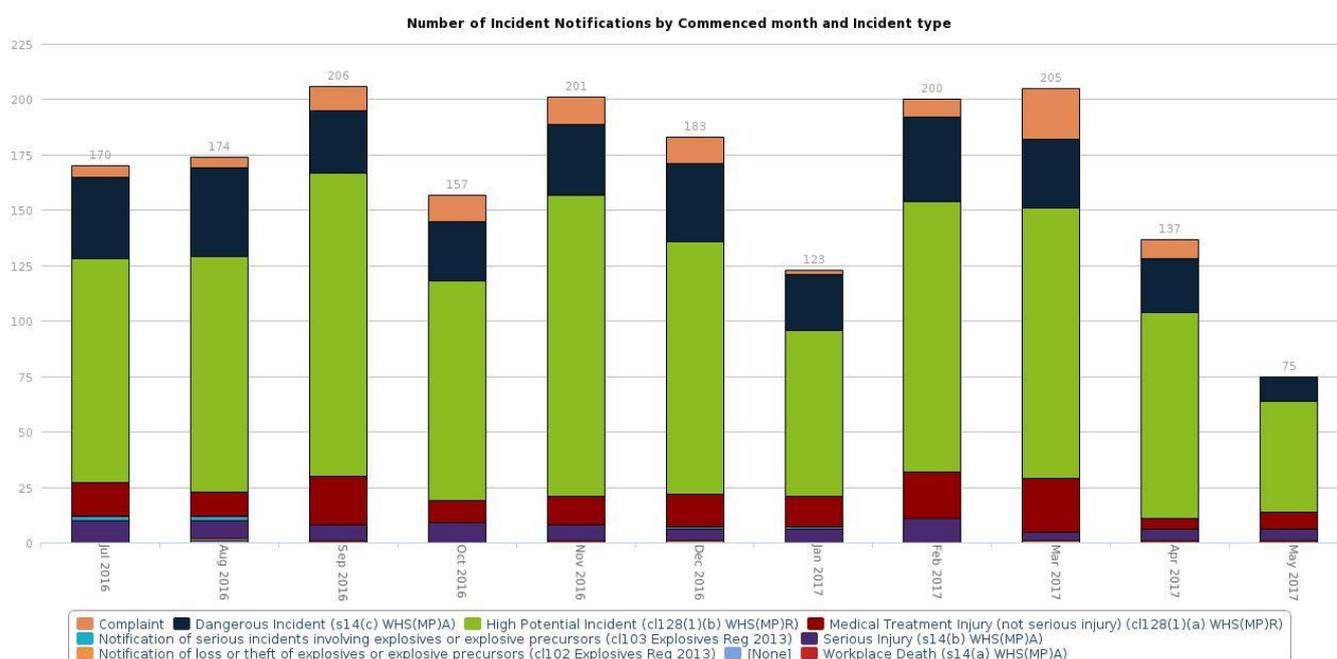
Reportable incidents total: 40 Summarised incidents: 5

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 2017/00747	A loader operator was cleaning under a mobile power screen conveyor. The loader reversed and made contact with the conveyor.	<p>Mine operators should:</p> <ul style="list-style-type: none"> remind loader operators to be careful when operating in close proximity to other small plant. Job-specific risk assessments should be carried out. consider using proximity sensors or reversing cameras. <p>Structural damage to plant needs to be checked by a qualified structural or mechanical engineer or the original equipment manufacturer (OEM) to determine the design adequacy of any structural repairs.</p>
High potential incident SInNot 2017/00745	<p>An underground mine reported a methane exceedance over 4% at the longwall maingate regulator monitor. The reason for the elevated gas level was a blockage in a methane gas drainage range.</p> <p>All underground personnel were withdrawn. The withdrawal was delayed because of a delay in responding to the initial alarm.</p>	<p>Mines should use risk assessments to review what alarms are critical to their operations and how they are:</p> <ul style="list-style-type: none"> monitored alarmed responded to escalated and re-alarmed. <p>This will help ensure the mine's response is appropriate and that no alarms are missed. If no alarms are missed, the response is less likely to be delayed.</p> <p>Training and ongoing refresher training, together with the competency of control room operators (CROs), should form part of the</p>

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Dangerous incident SInNot 2017/00742	<p>Work was being carried out in an area of an underground mine that was subject to a development application. The mine site had permission to install a boundary fence. A drill rig operated by one worker trammed under 11kV power lines and made contact with them. This led to the lines being snapped in half and ultimately tripping power to the site.</p> <p>The energy supply company attended the site and decommissioned all power back to the main incomer. The main incomer is located outside the mine site's boundary. As a precaution, the rig operator was sent to hospital and cleared of any electric shock.</p>	<p>review. First responders should also be involved in the review process.</p> <p>Drill rigs should not be driven around the mine sites with masts raised. The machines should be fitted with interlocking systems designed to prevent the machines from being driven while the mast is raised. The rig's interlocking systems need to be maintained and operational.</p> <p>Where overhead power lines are present, vehicles should only be operated on predefined traffic routes unless a specific risk assessment has been undertaken. The risk assessment should take into account safe clearance distances and the equipment being moved.</p> <p>Operators should refer to the following documents for additional information:</p> <ul style="list-style-type: none"> • SB15-05 Plant contacting overhead powerlines and structures • AS/ZS 3007:2013 Electrical equipment in mines and quarries – surface installations and processing plants • Safe Work Australia General guide for working in the vicinity of overhead and underground electric lines
Dangerous incident SInNot 2017/00741	<p>During the replacement of the bolting pod onto a continuous miner, a worker (the spotter) positioned himself in a strike zone of the racker. The operator assisted guiding the pod racker, which was connected to the long haul dumper, by stepping into the restricted area. After the racker was lined up, the worker signalled to the loader operator to eject the pod out of the racker to the continuous miner. Instead of ejecting, the racker moved to the left and hit the worker. This momentarily pinned the worker against the coal rib wall.</p>	<p>Mines should review their cassette changeout procedures where they use pod rackers. This review should consider continuous miner set up, for example, head down and stab jacks up. Additionally, the review should encompass the angle of approach of the pod racker, bolting during the pod removal and positioning, and setting up appropriate no-go zones.</p> <p>All load haul dumpers and pod rackers should be set up so that the slew/eject functions operate the same way on each machine and for every possible combination.</p> <p>The pressures and flows on the pod racker should be reviewed to ensure a safe level of control of the operation.</p>
High potential incident SInNot 2017/00729	<p>An operator was tramping a monorail outbye during a services retraction when a high pressure filter sled fell from height. The sled fell from about 1 metre. The retraction was from an 8 cut-through to 6 cut-through.</p> <p>The original equipment manufacturer had released an industry-wide safety bulletin, however, the operator did not act on its</p>	<p>Mines should:</p> <ul style="list-style-type: none"> • review safety bulletins issued by the original equipment manufacturer. When a manufacturer's recommendation is delayed or not implemented, a risk assessment should be carried out. The assessment should document how the hazard is being alternatively controlled. • audit plant for compliance with the original equipment manufacturer's bulletins,

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	<p>recommendations. The bulletin, which was issued in 2008, recommended a bolt upgrade from M12 to M14 grade 10.9 socket head cap due to failures that have been witnessed throughout the industry.</p>	<p>information or instructions and/or with a risk assessment.</p> <ul style="list-style-type: none"> have a systems-based approach to how they review and assess industry safety information. This information includes documents such as original equipment manufacturer bulletins and department-issued safety bulletins and safety alerts. The system and how it is reviewed should also be documented.



Recent incident publications

SA17-05 Hand injured by fall of drill rods

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

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