

## REPORTABLE INCIDENTS | WHS MINES LEGISLATION

# Weekly incident summary

**15 June 2016**

*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 and summarised in this report. For more comprehensive statistical data refer to our [Annual Performance Measures Reports](#).*

### Reportable incidents total

Level 1 incidents	→	Level 2 incidents	→	Level 3 incidents
<b>31</b>		<b>9</b>		<b>0</b>

*Note: Incidents are categorised as Level 1, 2 or 3 according to the seriousness of the incident, with 3 being the most serious.*

Injuries	Fatalities
<b>14</b>	<b>0</b>

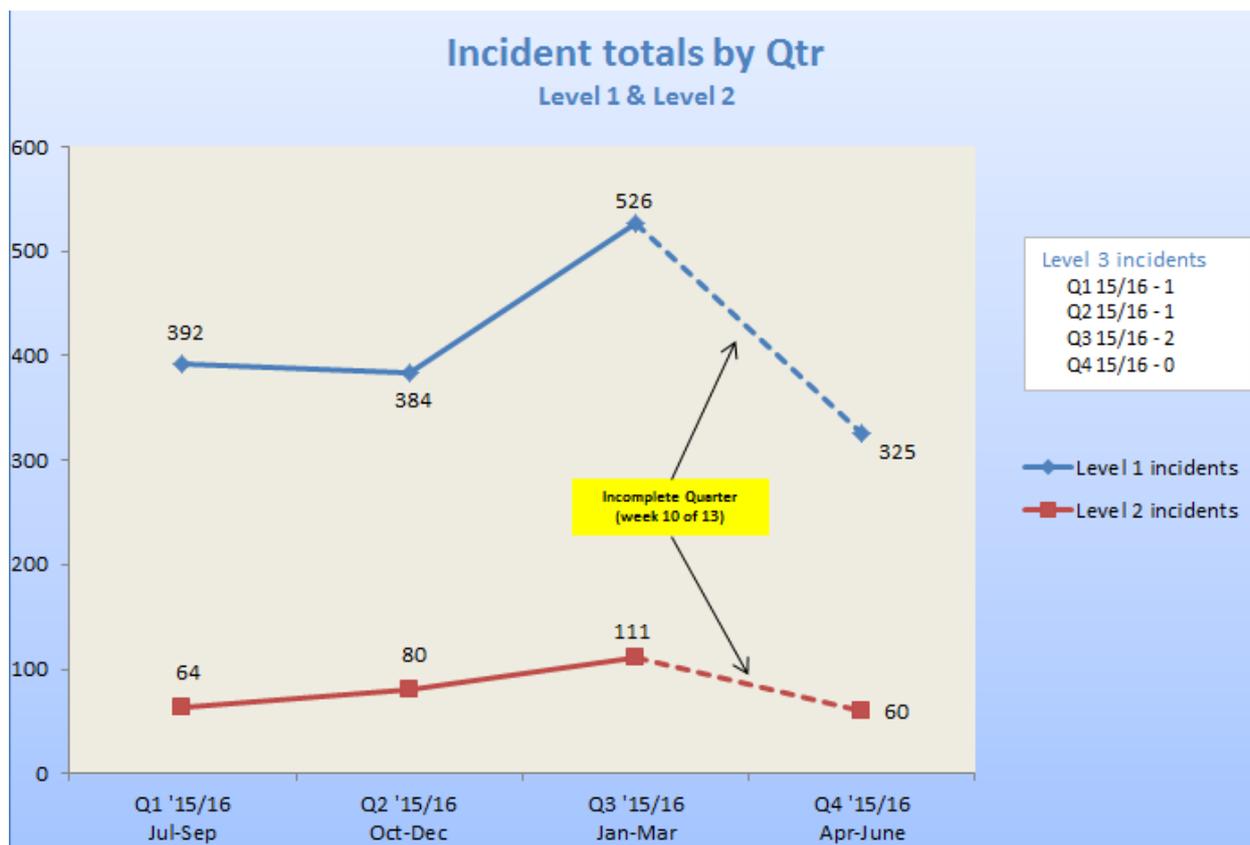
### Reportable incidents overview

*Note: While all incidents are investigated, generally only level 2 and 3 incidents are summarised below.*

Level	Incident type	Summary	Comment to industry
2	Gas 317661226001	A coal outburst caused an accumulation of methane greater than 2%. No people were placed at risk with this outburst as it occurred during a remote mining process.	The mine has reviewed its control measures for managing the outburst risk to ensure integrity of the process.
2	Electrical Energy 317661207001	While conducting insulation testing on cables on the longwall monorail, at time of discharging the tested cable, the electrician has come into contact with a phase and received an electric discharge shock.	<p>Mines should ensure insulation resistance (IR) testing is only performed by competent electricians that are trained assessed and appointed.</p> <p>Operational risk assessments for the IR testers should be available on-site along with user manuals and site procedures for their safe use and storage.</p> <p>Gas clearance certificates should be obtained prior to taking and using IR testers in a hazardous zone.</p> <p>Electricians should ensure prior to their use that the test instrument and kit is fit for purpose.</p>

Level	Incident type	Summary	Comment to industry
2	Work Environment 317661199001	While unloading a flat top truck of 30 concrete blocks, one of the concrete blocks dropped to the ground. It was found that the lifting chain slipped out of the dog which was used to shorten chains used for the task. This happened after unloading approximately 28 blocks. No workers in the immediate area.	<p>The work area was under the control of a certificated dogman and rigger. It came to light that the haulier arrived at the site earlier than expected and that long chains, which were being used for another task, were used to unload the blocks in order to expedite the departure of the haulier from site. The integrity of the dog and chain linkage was not inspected for every lift.</p> <p>Mine operators should ensure that fit-for-purpose lifting tackle is used for each particular task at hand, despite operational pressures.</p>
2	Mechanical Equipment 317661222001	A haul truck was travelling loaded to the dump. A grader was grading the haul road on the incorrect side of the road facing the approaching haul truck. The haul truck and grader collided causing damage to both the haul truck and the grader.	<p>Mine operators should have procedures in place that require workers verify proximity detection devices are functioning as designed prior to operating machinery.</p> <p>Mine operators are also reminded to review the effectiveness of controls applied to fatigue management.</p>
2	Hazardous Materials 317661236001	A gold room worker received partial burns to the forehead and ear, and a hot fragment into his eye when turning out a gold bar. The centre of the bar was not fully solidified and reacted with cold water on the floor where the bar was turned out. The worker expected the bar to be cool and had changed from full face protection to safety glasses. High antimony content is causing the melt to behave differently when compared to normal gold smelts.	<p>Mine operators should review their gold room procedures with particular attention to supervision, risk assessments, task observations and PPE compliance.</p> <p>Full face protection should be mandatory at all times whenever handling hot bars. Cooling off areas should be clearly defined and maintained in a clean dry state with minimum cooling off periods enforced.</p>
2	Electrical Energy 317661232001	A contracted fitter received an electric shock when he attempted to power a diesel heater in the workshop.	<p>A cover screw was found to have penetrated the insulation of 240V wiring in the heater unit. The heater had recently been off-site for repairs.</p> <p>Mine operators should ensure repairs on electrical equipment are only undertaken by competent persons. Mine operators should also ensure these units are subject to regular detailed inspections by competent electrical tradespersons.</p>
1	Mechanical Equipment 317661319001	Operators were elevating a set of three service lines (no more than 100mm) to allow access for a LHD. They released the cumalong after securing the pipes when the air line 6" clamp lever unclamped as the middle pipe levelled. The service lines were not isolated during the task.	<p>Mine operators should develop a commissioning checklist system to confirm safety clips are installed in quick release style coupling after each installation and before energising. Mine procedures should consider isolation and depressurisation on air lines when lines are worked on.</p>

Level	Incident type	Summary	Comment to industry
2	Mechanical Equipment 317661315001	An operator was in the process of installing primary roof support off the Continuous Miner. During this process, an escape of fluid occurred from the main supply hose to the drill rig valve bank. This escape of fluid contacted the operator on the left thigh.	Mine operators should be reminded of the benefits of hose sleeve protection (mine sleeve), which in this case protected the worker from the potential of a serious injury.
2	Strata/Ground Control 317661327001	While charging an underground development face, a shotfirer was struck on the left shoulder by a 30kg rock that fell from the back, between the mesh and the face.	This incident highlights the very important requirement for mine operators to frequently review scaling crew competencies and levels of supervision while scaling at the face.  Competency training should include site specific geological and geotechnical issue awareness. In adverse conditions a permit to work system for post scaling tasks should also be considered.
2	Work Environment 317661167001	A CHPP operator was accessing the conveyor tunnel to restart a sump pump in preparation for cleanup activities (a coal spill had occurred due to a vibratory feeder continuing to run when the conveyor stopped). While walking down the tunnel (inclined and narrow access), the operator slipped, landing on his left arm. A fracture of the humerus (arm) was confirmed. Water sprays had been recently used in the area to clean the tunnel which had made the walkway surface wet.	When designing and installing conveyor systems, mine operators need to consider the risks associated when walking or working alongside conveyor systems. Walkways should be designed so that persons can walk normally without impediment.  Furthermore, conveyor systems should also include appropriate guarding (compliant with Australian standards), hand rails and non-slip surfaces for steep grades.



## Recent incident publications

**No recent incident publications.**

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

Should you wish to seek further information, please contact one of our offices:

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