



### REPORTABLE INCIDENTS | WHS MINES LEGISLATION

# Weekly incident summary

#### 8 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	<b>─</b>	Level 3 incidents
33	4		0

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
11	0

# Reportable incidents overview

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

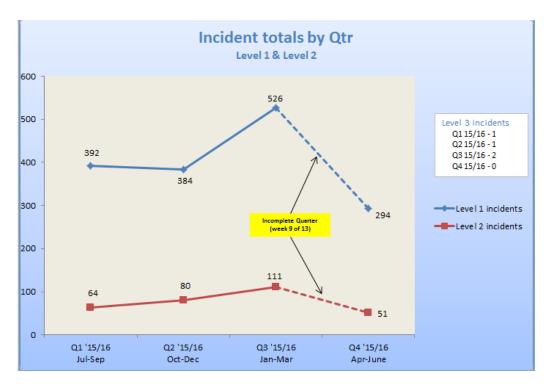
Level	Incident type	Summary	Comment to industry
2	Unplanned Movement 317661091001	Unintended movement of truck. A hire truck rolled approximately 500mm in a surface wash bay area. The operator was half in, and half out, of the cab when he realised that he had not properly engaged the park brake. The park brake on the hire truck differed to those of the permanent site trucks. Furthermore the hire truck did not have the brake alarm fitted to site trucks.	Although the truck operator had been made aware of the difference in park brake activation between the hire truck and site truck, he has been habituated in the use of the standard site truck. Mine operators must consider human factors when identifying risks. Generic pre-starts and contractual specification of the hire truck did not mandate a park brake alarm as per site standard. Mine operators should ensure that standards are maintained and new equipment is subject to a stringent pre-use audit against site requirements.
2	Collision 317661135001	A blasthole drill was being trammed to a location suitable for the drill to be refuelled away from drilled holes. After travelling 30 metres the drill collided with a parked light vehicle, pushing the vehicle 3 metres before being alerted to stop by another drill operator. The driller was focussed on avoiding drill holes while tramming the drill. The light vehicle had been parked there earlier in the shift by the same operator	Mines should review vehicle parking arrangements for all relevant areas of the operation. The parking arrangements should allow for safe movement of operational vehicles clear of those that are parked-up.

Fatality – WA Mining fatality in Western Australia.
Underground worker crushed between integrated tool carrier work basket and roof of excavation.

Comment to industry

Link to incident report:

www.dmp.wa.gov.au/Documents/Safety/MSH\_SIR\_241.pdf



## **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 <u>website</u>.

### **Further information**

E mine.safety@industry.nsw.gov.au

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

COAL (NORTH) and EAST METEX	COAL (SOUTH)	WEST METEX
Maitland	Wollongong	Orange
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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (June 2016). 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.

2 NSW Mine Safety ISR16-22 | 08/06/2016