



## REPORTABLE INCIDENTS | WHS MINES LEGISLATION

# Weekly incident summary

5 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: 47 Summarised incidents: 7**

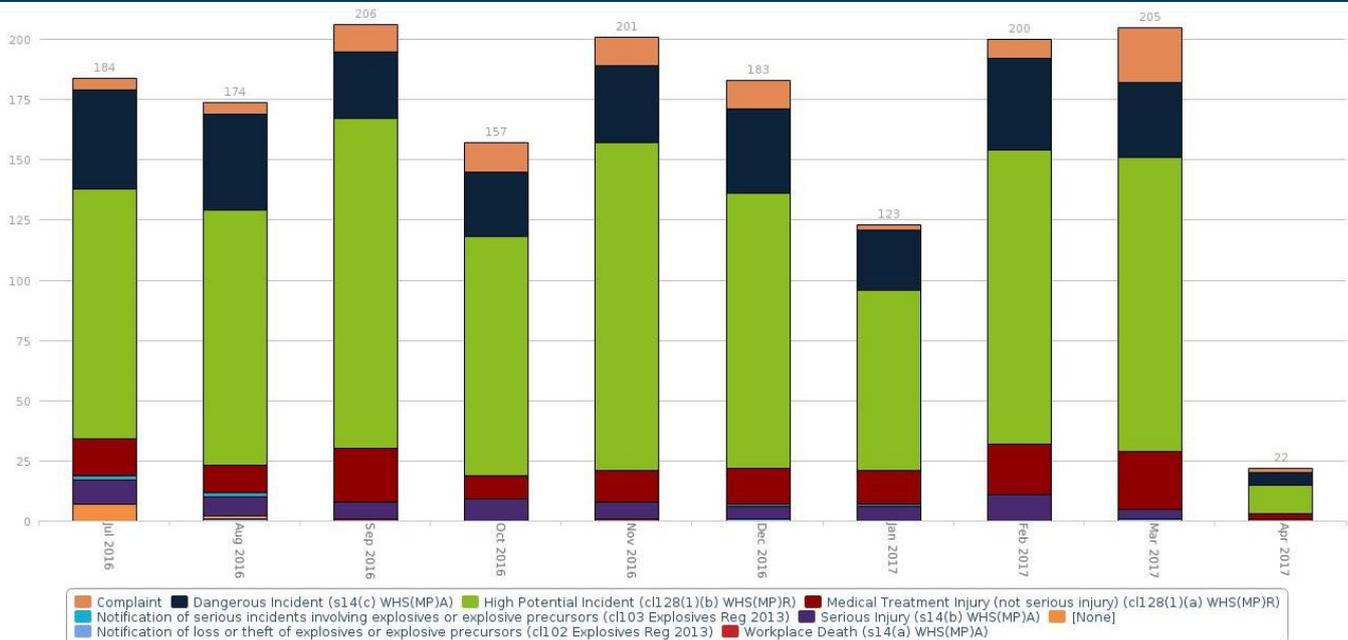
**Summarised incidents** – incidents of note for which operators should consider the comments provided and determine if action needs to be taken.

Incident type	Summary	Comment to industry
Dangerous incident SInNot 2017/00539	<p>A worker was stowing a roof support during a longwall change out using a chock trailer. The support was reversed into a heading. It hit a 6 inch compressed air pipeline. This caused the end of the pipe to be ejected. The end of the pipe landed approximately 10 m away, beside the roof support and on the driver's side of a LHD.</p> <p>Although the pipeline was isolated about 100 m upstream, residual pressure in the line provided the energy to eject the pipe.</p>	<p>This incident demonstrates the importance of dissipating all stored energy after energy isolation. Mine operators should remind workers of how to make sure energy is effectively isolated. Key steps are:</p> <ul style="list-style-type: none"><li>• <b>isolate</b> the energy source</li><li>• <b>lock</b> the isolation method</li><li>• <b>dissipate</b> any stored energy</li><li>• <b>verify</b> effective isolation is achieved.</li></ul> <p>Refer to SB12-03 <a href="#">Fluid power isolation failures</a> and the <a href="#">Mechanical engineering control plan code of practice</a>.</p>
Dangerous incident SInNot 2017/00529	<p>A rock fell backwards out of a loader bucket while material was being loaded in a quarry. As it fell, the rock struck the top of the loader's cabin and rebounded onto the hydraulic lift rams. This damaged the front windscreen and dashboard of the loader. The operator reportedly suffered a sore knee and was taken for medical assessment.</p>	<p>Mine operators must ensure buckets are not overloaded with materials or unbalanced, and material is of an appropriate size. Mobile plant must be fit for purpose. Mine operator should ensure they comply with Clause 214 and 215 of the Work Health and Safety Regulation 2011. The mine operator must manage the risk of things falling on the operator of the plant and ensure a suitable combination of operator protective devices for the plant is being used.</p>

Incident type	Summary	Comment to industry
High potential incident SInNot 2017/00527	A fall of roof was reported in a mine. The fall resulted in the loss of the mine's secondary emergency exit.	Mine operators are reminded of the importance of monitoring changes in strata conditions and reviewing reported changes in the strata, particularly in older parts of mines.  Refer to the <a href="#">NSW code of practice: strata control in underground coal mines</a> .
High potential incident SInNot 2017/00522	A worker was operating a machine when the service brake failed and the machine did not stop. The operator then applied the park brake valve, which stopped the machine. The piston (spool) had failed, leading to the failure of the service brake valve. The broken valve prevented the loss of pressure to automatically trigger the posi-stop brake system.  Prior to the incident, the original equipment manufacturer (OEM) had issued a safety bulletin and updates on this valve.	Mine operators should review information on safety critical components from OEMs and take their recommendations into consideration.  Safety critical components that are essential to the operation of braking systems should be replaced and overhauled at intervals: <ul style="list-style-type: none"> <li>• recommended by the manufacturer, or</li> <li>• if there are no recommendations, as recommended by a competent person.</li> </ul>
Dangerous incident SInNot 2017/00521	A worker was lifting material using a pendant crane. He placed his left hand on the material while holding the crane pendant. The worker believes he suffered an electric shock. He attended a local hospital and was released after an examination and an ECG test.	Water that enters an electrical enclosure can cause insulation failure and lead to electric shocks. It has been reported by workers that push buttons installed in plastic enclosures may be vulnerable to this issue. This is the case whether the buttons are run on low voltage or extra-low voltage circuits.  All electrical equipment should be located in non-hostile environments, where possible. Equipment that <b>is</b> exposed to hostile environments should be regularly opened and inspected for evidence of water or dust. If water has entered, remedial action should be taken to restore the equipment to its original state.  Installing push button operators in well-earthed, metal-clad enclosures provides another layer of protection against this shock mechanism.
Dangerous incident SInNot 2017/00520	A fire occurred in the front tyre of a load-haul dump loader. The loader was fitted with a solid fill tyre made of polyurethane. The fire was extinguished and no one was injured.  It is likely that the locking ring behind the tyre came loose and caused a frictional ignition fire. The tyre may also have been under-filled, causing excessive deflection of the tyre. Both claims are yet to be confirmed.	Mines that use solid fill type tyres should review the recommendations in SA08-08 <a href="#">Overheated tyres require miners to use self-rescuers</a> .

Incident type	Summary	Comment to industry
Dangerous incident SInNot 2017/00512	A load-haul dump (LHD) made contact with an energised, high tension cable. There was no electric arcing reported. Damage was recorded to the outer sheave only. There was no damage to the cable armouring.	<p>Transport rules must identify the maximum profiles of loads that can be safely transported in roadways. They must also identify any special procedures that are required where loads are different from the specified profiles.</p> <p>All cables should be installed in locations where the possibility of damage is minimised. They should be installed either:</p> <ul style="list-style-type: none"> <li>• in roadways that are not used for material transportation</li> <li>• at heights above those required for material and transport movements, or</li> <li>• by installing guards over the cables.</li> </ul> <p>Mine operators must consider the specific locations where cables must pass through, including obstructions, such as air and water pipes.</p> <p>Protection relay settings should be set to achieve the quickest operating times at the lowest values that would allow for reliable operation.</p>

Number of incident notifications, by commencement month and incident type



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## 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](mailto:mine.safety@industry.nsw.gov.au) or visit one of our offices:

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### WEST METEX

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