

REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

15 March 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

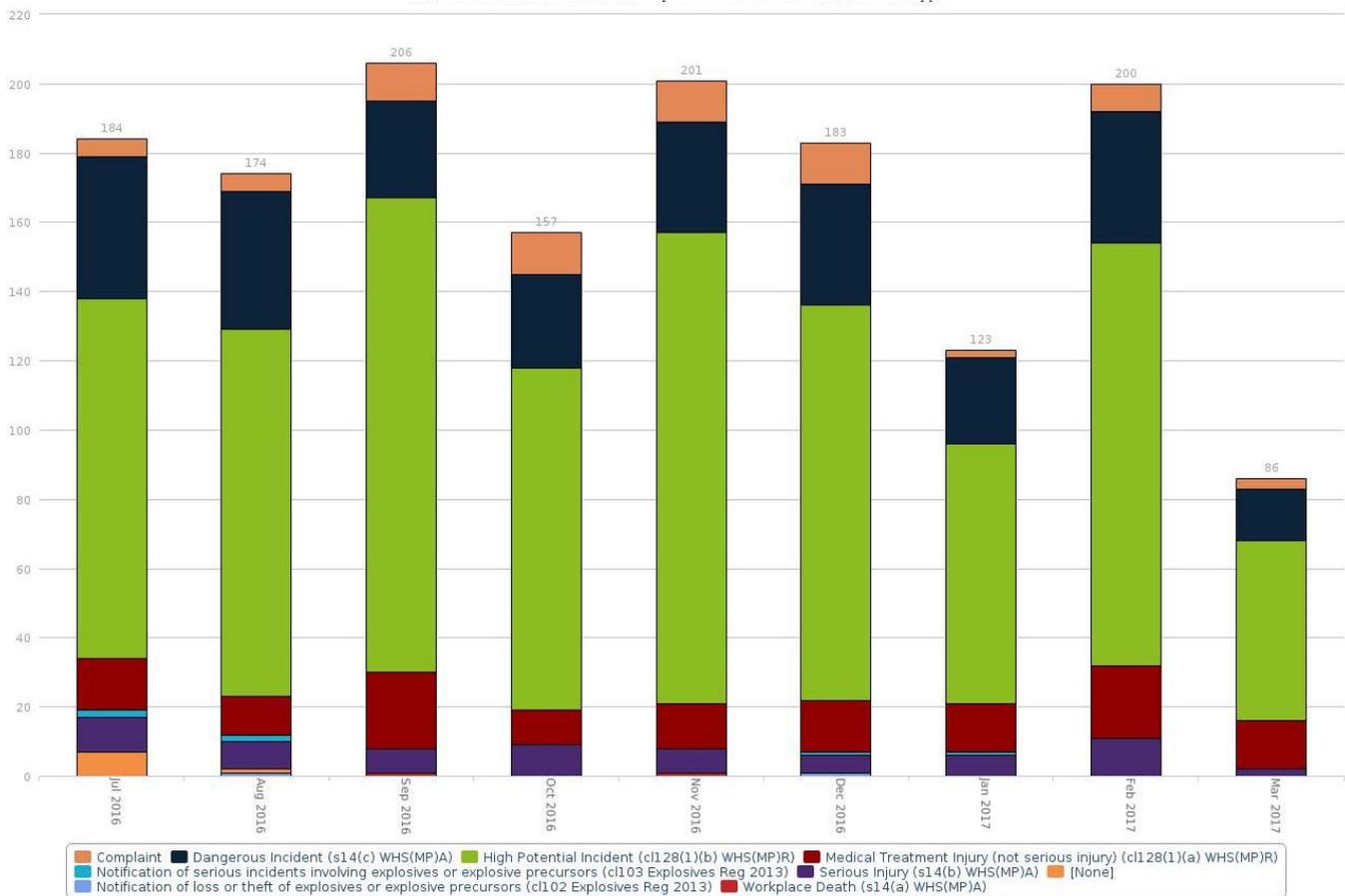
Reportable incidents total: 49 Summarised incidents: 5

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 2017/00408	Two dump trucks collided while manoeuvring into position on a loading bench. An excavator was cleaning up the area at the time. The rear truck's guard rails and fire suppression system recorded some damage. There were no injuries to the operators.	Vehicle collisions are reoccurring reasonably frequently. Industry is reminded to ensure risk controls are in place and all personnel are aware and follow these controls. Some of the controls that should be in place and reviewed periodically include: <ul style="list-style-type: none"> • positive and clear radio communications from the area controller • operating procedures • sufficient lighting when operating at night • operator competency and supervision.
Dangerous incident SInNot 2017/00405	An operator investigating a reject bin gate close limit fault was hosing down an area before reaching in to feel for the limit switch. When he touched the limit switch he thought he received an electric shock. The operator called an electrician to investigate, who also received what the electrician described as an electric shock. The control circuit to the limit switch was 110Vac.	Control systems in coal handling processing plants (CHPPs) use significant numbers of electrical/electronic field devices for measuring, position sensing, blockage detection and for other purposes. In older plants these devices are most often operating at above extra low voltage (ELV) and within wet environments. Operators of these plants should consider the ingress protection (IP) levels for these devices under all operating conditions, including cleaning using high-pressure water devices. Programs should be put in place to upgrade these field devices to ELV-type and/or provide suitable earth leakage detection for the interruption of low level hazardous leakage currents.
Dangerous incident SInNot	A watercart lost control on a hard but wet section of the road on a crest while it was watering the roads of a mine. The	Mines should review their traffic management systems in light of this incident. Relevant issues are controls for wet roadways, adjusting speed

Incident type	Summary	Comment to industry
2017/00387	watercart hit a dry section and rolled over. The driver was reported as coherent. He suffered a few bumps and was shaken. He was taken to hospital for treatment and returned to the site the same day.	to conditions and ongoing awareness training for operators.
High potential incident SInNot 2017/00383	The driver of an underground haul truck pulled into a fuel bay and shut down the engine to refuel. The quick-fill coupler was connected and the driver began to refuel. He noticed flames coming from the engine bay. The driver ceased refuelling and immediately activated the fire suppression system. The fire was extinguished and the driver remained with the truck to ensure there was no flare up.	The fire was started when the quick-fill breather over-pressurised, spraying diesel onto the turbo. All mines that use quick-fill systems should assess their systems. Mine Operators should consider the recommendations in SB15-03 Fires ignite while refuelling mobile plant with quick-fill fuel systems .
High potential incident SInNot 2017/00375	The level of gas in a mine exceeded limits, recording greater than 2% CH ₄ . The gas peaked at 5.04% at a mixing chamber. In order to reduce pressure off a brattice wing to make repairs, a deputy closed a regulator adjacent to the wing. This caused a change in ventilation. It resulted in more air going through a goaf area and a reduction in fresh air for dilution.	Mines should review their ventilation control plans and ventilation change authorities to ensure systems are in place to stop unauthorised ventilation changes. Mines should make sure that all mine personnel, including statutory officials, are trained in the requirements of the ventilation change authority. Appropriate locking of VCDs (Ventilation Control Devices) should be completed with the appropriate level of authority. This depends on the level of risk to the ventilation system that each VCD has.

Number of incident notifications, by commencement month and incident type



Recent incident publications

Investigation report: Fatality at Ridgeway Mine on 6 September 2015

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

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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (March 2017). 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.