

REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

4 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

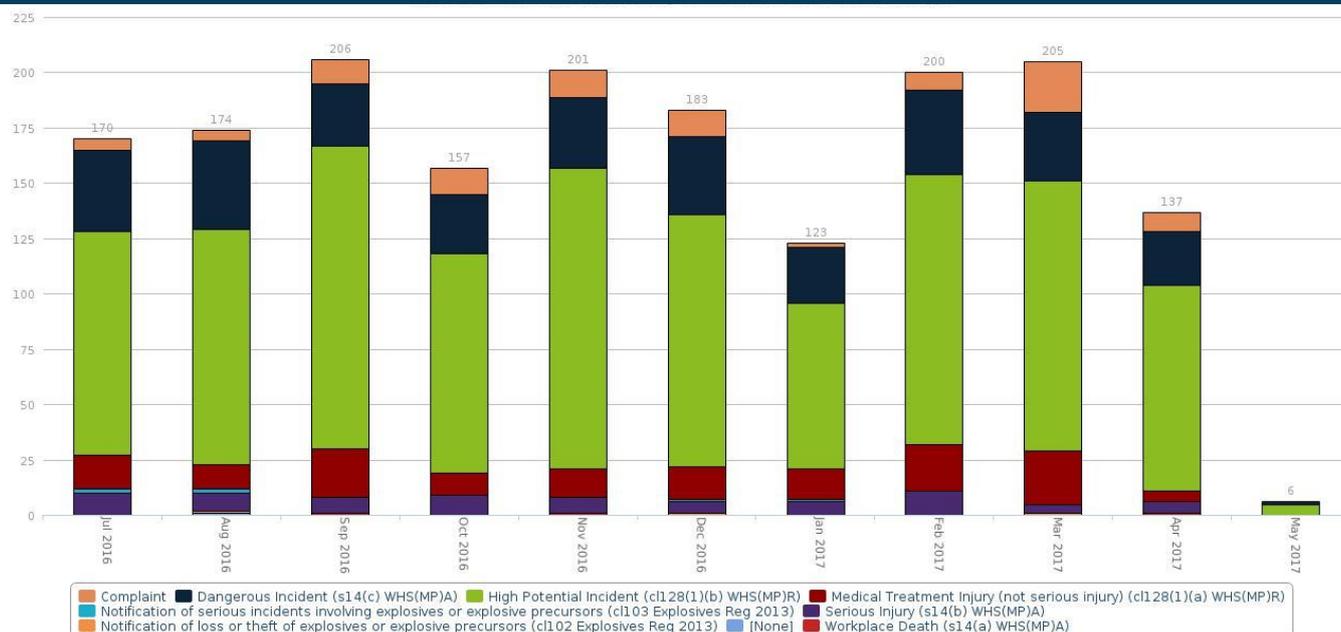
Reportable incidents total: 23 Summarised incidents: 5

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
High potential incident SInNot 2017/00682	A fire broke out when hydraulic oil came into contact with a turbo. A mine investigation determined that the hydraulic hose from the supply line to the pilot manifold rubbed on an adjacent hose. This led to the failure of the hydraulic hose. Hydraulic oil sprayed from the hose onto the exhaust system. This was the third fire on mobile plant that has occurred at the mine this year.	Repeated fires on mobile plant requires thorough investigation to eliminate any possible common failures and hazards. Effective maintenance practices are essential in preventing the ignition of combustible fluids from hose or pipe failures. Where practicable, hoses should be segregated from hot surfaces using hard barriers. Non-flammable coolants should be used. Mine operators should consider guidance in Australian Standard 5062:2016, <i>Fire protection for mobile and transportable equipment</i> .
Serious injury SInNot 2017/00681	An apprentice fitter was preparing to clean a vehicle in a heavy vehicle wash bay. Water that was ejected from a high volume water cannon blew off the apprentice's hard hat and safety glasses. The apprentice suffered trauma to his left eye. The heavy gloves worn by the apprentice mitigated a potentially serious laceration. Ambulance paramedics were called to treat him. The paramedics called Westpac Rescue Helicopter to transport the apprentice to the John Hunter Hospital in Newcastle.	Mine operators should: <ul style="list-style-type: none"> • review their maintenance procedures to ensure high pressure water cannons in truck wash down bays operate as they are designed • develop systems to determine which people are competent to operate high pressure water cannons • ensure safe work procedures are in place for wash down bays and operators are trained in safe job procedures • develop a standard system for the supervision of apprentices that includes detailing the responsibilities and duties of the supervisor and the apprentice • train all apprentice supervisors and apprentices in the standard system for supervision of apprentices.

Incident type	Summary	Comment to industry
Dangerous incident SInNot 2017/00679	While working in an underground cut-through, a load haul dump (LHD) operator raised a full bucket and in doing so, pushed a high tension (HT) cable through a roof bolt. This tripped the closest outbye circuit breaker on earth leakage. Several other circuit breakers were also tripped.	Stowing material in cut-throughs where cables are installed presents the possibility of machinery coming into contact with the cables. Mine operators should consider controls such as cable rerouting, additional mechanical protection and/or isolation prior to stowage activities being undertaken. Operators should also consider the implementation of a formal system, including permits, for management of material stowage. This system should also include suitable refresher training at appropriate intervals. By using a thorough cleaning program, mines should maintain signs and demarcation tags hung from HT cables to ensure they are clearly visible.
Dangerous incident SInNot 2017/00678	The operator of a water cart noticed that smoke was coming from the rear of his machine. He stopped the machine and activated the automatic fire suppression system. However the machine continued to smoulder. The operator tried to extinguish the fire using a hand-held extinguisher but the fire reignited. The fire was finally extinguished when a second water cart arrived and assisted. The water cart was significantly damaged.	Automatic fire suppression systems should be sized correctly, maintained and tested to the original equipment manufacturer's specifications. Systems should be thoroughly investigated when they fail to extinguish fires. Effective maintenance practices are essential in preventing the ignition of combustible fluids when hoses or pipes fail. Where practicable, hoses should be segregated from hot surfaces using hard barriers. Non-flammable coolants should be used. Operators should consider guidance in Australian Standard 5062:2016, <i>Fire protection for mobile and transportable equipment</i> . Mines should conduct a review of driver training and responder training to confirm that relevant workers are trained to respond appropriately to a mobile plant fire.
Complaint SInNot 2017/00672	The regulator has received a complaint alleging that an individual (the complainant) was harassed at work.	The complaint is being investigated by the regulator. Information on bullying and harassment is available on the bullying page on our website . Safe Work Australia also publishes guides to preventing and responding to workplace bullying and a worker's guide to dealing with bullying. See their website for more details: safeworkaustralia.gov.au

Number of incidents, by commencement month and incident type



Recent incident publications

SA17-03 [Pneumatic air tool fitting fails](#)

SA17-04 [Synthetic fibre sling fails](#)

SB17-04 [Uninterruptible power supply installations at mines](#)

IIR17-04 [Fatality in underground metalliferous mine](#)

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 or contact one of our offices:

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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (May 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 Planning and Environment or the user's independent advisor.