Present: Professor David Mee (in the Chair), Dr Bo Feng, Ms Mary Cavanough, Mr Matthew Gear, Mrs Kim Lamb, Mr Doug Malcolm, Dr Micah Nehring, Ms Janelle Scown, Mr Bojan Vlacic.

Apologies: Professor Mingxing Zhang.

Minutes: The minutes of the meeting held on 10 June 2015, having been previously circulated, were taken as read and confirmed.

Business Arising out of the Minutes (meeting 2.2015)

The following have been actioned –

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Item</th>
<th>Action required</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/2015</td>
<td>2a</td>
<td>The School’s OH&amp;S Guide was circulated to all staff.</td>
</tr>
<tr>
<td>2/2015</td>
<td>2a</td>
<td>Inclusion of specific electrical safety information in the University’s on line general safety induction and in laboratory inductions.</td>
</tr>
<tr>
<td>2/2015</td>
<td>2b</td>
<td>P&amp;F advised of the staff member falling (email sent to UQ OH&amp;S in the first instance)</td>
</tr>
<tr>
<td>2/2015</td>
<td>2c</td>
<td>A notice regarding the need to report incidents in a timely manner has been placed in the School’s newsletter.</td>
</tr>
</tbody>
</table>

Items in progress

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Item</th>
<th>Action required</th>
<th>Responsible Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/2014</td>
<td>2</td>
<td>On line database for undergraduate student training and thesis induction</td>
<td>Faculty WH&amp;S</td>
</tr>
<tr>
<td>2/2015</td>
<td>Business arising</td>
<td>Revised laboratory inspection schedule</td>
<td>School Manager</td>
</tr>
</tbody>
</table>

1. Report from the Faculty WH&S Advisor

Ms Scown reported on her recent activities within the School.

Work was being done with the QGECE and the new high pressure test loop facility at the Pinjarra Hills site. The documentation prepared by Mr Gwynne-Jones was of a high standard.

Work was also being done with the UQ Racing team (FSAE, UAV) following on from the recent move to another site in the Engineering precinct. Both the FSAE and UAV groups shared space in Level 1 of the Hawken Engineering Building. The safety requirements for this facility which was mainly used by undergraduate students were being developed and a safety inspection would occur in the near future.

The membership of the Faculty's Operational OH&S Committee, which was largely comprised of school managers, was under review. Feedback on membership from the School was welcomed.

Management of the School's entries in the risk assessment database would be a priority. Other feedback on the risk assessment database was welcomed as the University was investigating the purchase of a new database.

The School Manager would investigate the feasibility of adding and removing staff from groups within the database as part of the induction and departure processes.

A-KL/JS
2. **Incident Reports**

   Members discussed incidents which have been reported to the Head of School since the meeting on 10 June 2015.

   a. **Sprain/Strain (9386)**

      On 30 March 2015, a member of UniQuest staff reported issues with using a stereo microscope in a laboratory. She was referred for medical attention and changes to the workstation were recommended.

   b. **Nail sticking out of a table (5432)**

      In April 2012, an undergraduate student reported cutting his finger on a desk in Room C406 of the Hawken Engineering Building. It was discovered that a nail was protruding from the desk. The nail was removed in April 2016 and the student was administered first aid. This incident was only discovered as unfinalised within the system in June 2015 and was sent to the Head of School on 25 June 2015.

   c. **UQ Mine (8799)**

      A member of the School’s technical staff reported a near miss during the severe hail and thunderstorm in November 2014. Windows were damaged and had anyone been standing nearby, there could have been injury. It was recommended that the windows be checked for structural integrity. This incident reached the Head of School on 25 June 2015.

   d. **Cut to a hand (9186)**

      On 4 April 2015, a postgraduate student reported that while manipulating a ring spanner on a valve, the student’s hand slipped and he was cut on the hand. He obtained treatment at the University’s Health Service. It was recommended that protection be placed near sharp corners when using hand tools on model components.

   e. **Sprain/Strain (9187)**

      On 9 April 2015, a member of the School’s technical staff injured her shoulder while attempting to move several full bins to gain access to an empty pathological waste bin. It was recommended that bins be emptied more regularly and not left stacked full inside the building.

   f. **Razor Blade cut (9490)**

      On 4 June 2015, a School RHD student was working in the Centre for Microscopy and Microanalysis and cut her finger while cutting resin with a razor blade. The student attended the University’s Health Service. The incident was submitted to the student’s supervisor on 16 June 2015. However, the incident was only approved by the Head of School on 27 August following on from the Faculty’s OH&S Advisor advising the School that the matter remained unresolved.

      It was also discovered that the student had not indicated that she had read the two risk assessments that were developed as part of the procedure to be followed. The Head of School noted that it was important that the research group continue to improve its safety culture. The Head of School also advised the academic supervisor that a group could be should be set up in the risk assessment database with all pertinent risk assessments included.

   g. **Pressure release (9557)**

      On 2 July 2015, a RHD student was working in the X2 expansion tube and was attempting to undo the primary capstan nut. He asked a member of staff for assistance. They believed the reservoir was back to atmospheric pressure as there were no indications that this was not the case. They managed to loosen the nut and discovered that the pressure was still above atmospheric pressure. When the capstan was undone, the piston and buffer plate were pushed from the tube and the buffer plate fell on the floor. No one was injured; however, there was a potential for injury.
2. Incident Reports (cont’d)

g. Pressure release (9557) (cont’d)

   Signage would be placed nearby to warn users to check to see that the tube was fully
   vented before opening. Changes to operating procedures were made and updated training was provided.
   The incident was submitted to the student’s supervisor on 6 July but did not reach the supervisor until 3
   September. The incident was approved by the Head of School on 3 September 2015 following on from
   the Faculty’s OH&S Advisor advising the School that the matter was unresolved.

h. Furnace Leak (9706)

   On 6 August, 2015, an induction furnace in Room 616 of the Advanced Engineering
   Building was being used to melt a small experimental ferrous alloy. The power was switched off at the
   end of the experiment; however, the chiller was routinely run for a further 30–40 minutes to ensure a
   complete cooling of the power unit’s electronics. It was noticed that coolant was pooling on the floor;
   the equipment was switched off and the water mopped up. The Faculty Workshop Group’s electrician
   was contacted and the matter was investigated. It was found that there was a hairline fracture in one of
   the nuts used to secure copper tubing to a copper heatsink at the top of the power unit and that coolant
   had sprayed onto all of the electronics located inside the power unit. No injury resulted; however, the
   potential for injury existed. It was recommended that the nuts be replaced by better quality components
   (e.g. Swagelok). The manufacturer was notified.

i. Nabotherm Furnace (9776)

   On 22 July 2015, a postgraduate student was using the Nabotherm furnace in the foundry
   to preheat casting tools. The tools were tapped to remove dross residue and then placed on the platform
   with the other tools that had been used. The stirring rod and drossing spoon fell inside the furnace and
   two sparks were seen. The furnace power was shut down. No one was injured. There was a risk
   assessment, the appropriate inductions had been done, and appropriate PPE was being worn. The Head
   of School was concerned that the student did not do the incident report, that her name was spelled
   incorrectly in the incident report and there was a four week delay in lodging the incident in the system.
   The laboratory manager was now aware of the procedure to follow.

j. Cycling accident (9786)

   On 26 August 2015, a member of the School’s academic staff fell off of his bicycle while
   cycling home. He reported that there was a mechanical failure of his bike seat. He injured both wrists
   (one fracture, one sprain) and attended the emergency room. The staff member also contacted the
   University’s Workplace Injury Management Team.

k. 9826: Broken High Pressure Hose (9826)

   On 24 July 2015, CRC Mining staff were conducting a waterjet assisted ODC trial at
   the Unanderra site in Wollongong when the mechanism to prevent the cutter from rotating failed.
   Bolts holding the stopper-bracket sheared allowing the cutter assembly to rotate which provided a
   rotational strain on the hose assembly and sheared off the HP fitting. There was no safety risk to
   operating personnel due to the HP water exclusion zones, and primary and secondary hose
   restraints. Upon the hose failing, the HP water pump was immediately shut down via the
   emergency stop button on the control pendant by one of the two CRCMining pump operators. The
   broken hose was disconnected from the HP fitting and the stopper-bracket was welded to the
   machine head-assembly to strengthen its attachment.

l. Forehead Wound (9827)

   On 7 September 2015, while painting machinery framework elevated on trestles at
   the Pinjarra Hills site, a CRC Mining staff member bent forward to access a lower area to avert his
   eyes from afternoon sun, and his forehead struck an unseen protruding bracket. First aid was
   applied and the protruding bracket was wrapped with red cloth. A tetanus vaccine was obtained as
   precaution.
3. **Hazard Reports**

Members noted the draft Hazard Report which was prepared following in from an electrical issue in the X3 Shock Tunnel. The resulting incident report (9631) was actioned via the School of Mathematics and Physics as the student’s supervisor was a member of staff in that School.

The incident involved a RHD student was using a locally modified laser pointer mounted on an optics table near the X3 dump tank. He reached across the table to remove a window from the dump tank and when he touched the dump tank, he reported a tingling sensation in his fingers. He shut down all electronics and removed cables from the electrical socket. The voltage regulator was tested and was found to be faulty and not up to Australian standards. It had not been tested and tagged and this was not noticed prior to using it. The voltage regulator was destroyed and it was also determined the laser control circuitry was not appropriate. A new regulator was purchased and the circuitry was modified. The hazard report was superfluous to the matter.

The hazard report would be completed and submitted to the Head of School and the matter would be reviewed at the next meeting of the School’s OH&S Committee.

4. **Incident Investigations**

a. **Unauthorised electrical work (9324)**

Members noted the outcome of the incident investigation on unauthorised electrical work being performed in a School laboratory (incident 9324).

On 12 May 2015, a member of the Faculty Workshop Group observed a postgraduate student attempting to do some wiring of a piece of equipment located in Room 622 of the Advanced Engineering Building. The student admitted he had removed the two control panels from the microwave sintering unit and had wired the pump into the main switch of the control box (415 volts). The unit was plugged into the wall but the power was turned off. The matter was discussed at the School’s Occupational Health and Safety Committee at its meeting on 10 June 2015. The incident was deemed to be reportable and was referred to the University’s OH&S Division.

b. **Final Report – Foundry Fire**

Members noted the outcome of the incident investigation into the Foundry Fire in January 2015 (incidents 8890 8893 8894 8895).

5. **School Safety Seminars**

a. **Biennial School Safety Seminar**

The compulsory biennial School safety seminar was scheduled on 4 November 2015. It is proposed to replicate a scenario-based learning experience that was part of the recent UQ OH&S Forum.

b. **Laser Safety Talk 2015**

Members noted that 21 staff and students attended the 2015 Laser Safety talk which was run by Dr Tim McIntyre from the School of Mathematics and Physics.

6. **Foundry Induction Material**

Members noted that the Foundry had been closed for approximately two months following on from the fire on 29 January 2015. During the period of closure, Mr Jonathan Read and others worked to revise the training and induction process for the Foundry.

It was resolved at the 10 June 2015 meeting of the School’s Occupational Health and Safety Committee that the training materials be obtained so that they could be adapted for other groups to use for training and induction purposes. Mr Read was commended for his efforts in preparing the excellent documents. These would be widely circulated to staff in the School.
7. **BSI external audit for recertification – CRC Mining**

   Members noted the outcome of the external OH&S audit at CRC Mining. A further three years certification was granted. However, manual handling training was required to be implemented and the Centre was expected to audit risk assessments more regularly.

8. **OH&S Training for Casual Demonstrators**

   The implementation of compulsory on line training for casual demonstrators appointed in Semester 2 2015 was successful. It was now a requirement that all compulsory on line modules be completed prior to the appointment being finalised.

9. **Communication on OH&S Matters**

   Members noted that the following communications were sent to staff (3 June 2015 – 9 September 2015).

   - MechMining all staff (29 June 2015): Reminder to do a compulsory OH&S supervisor course.
   - MechMining Everyone (17 August 2015): Lunchbox seminar – cycling safety.
   - MechMining all staff (17 August 2015): Notice of UQ OH&S forum on 19 August.

**School Newsletter (3 June 2015 – 7 September 2015)**

   - 15 June: notice that School’s OH&S minutes from the meeting on 10 June were on the School’s intranet.
   - 20 July: Notice for training for RU OK Day.
   - 20 July: Notice for UQ’s Wellness Portal.
   - 27 July, 3 August: RCD Notice of RCD testing.
   - 10, 17 August: measles notice updates.
   - 7 September: notice of UQ procedures regarding incident reporting.

**OH&S Notices**

   - Nil – see newsletter items.

**Advice Sought and Received**

   - The Faculty’s OH&S Advisor provided advice to a staff member who would be attending a field trip with a student with a known and managed medical issue.
   - The Faculty’s OH&S Advisor provided advice to a RHD student who had a medical issue. The advice included seeking advice from his medical doctor.
   - The Head of Division (Mining Engineering) advised the Head of School that the Local Mining Games would be held at the UQ Experimental Mine on 5 September. The advice included the rules and the risk management plan.

10. **Faculty OH&S Committee Minutes**

   Members noted the Faculty OH&S Committee met last on 17 July 2015.