

Week ending 2 August 2017

This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the NSW Resources Regulator: phone 1300 814 609 24 hours a day, 7 days a week.

At a glance

Type	Number
Reportable incident total	46
Summarised incident total	10

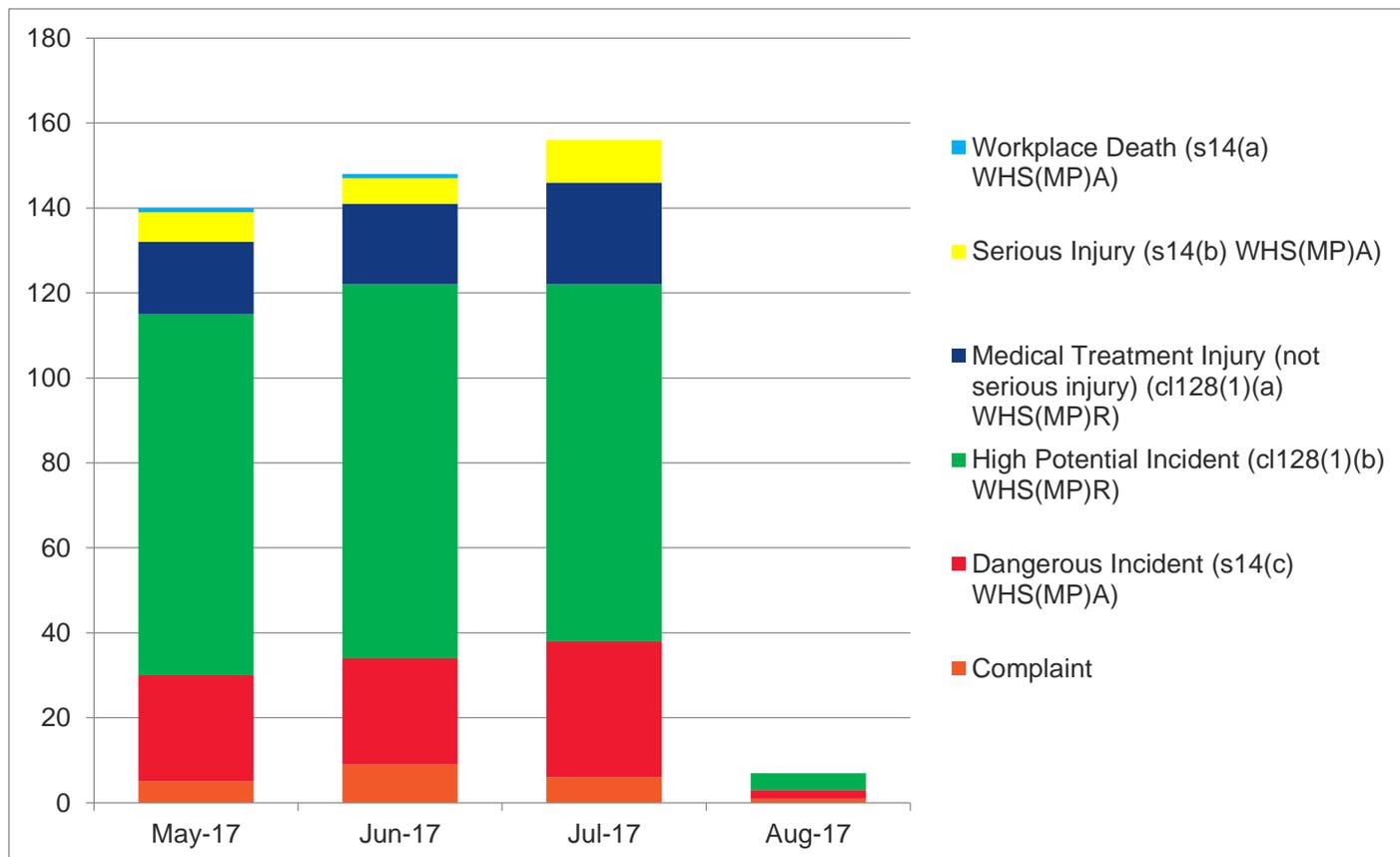
Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot 2017/01173	A near miss occurred at an intersection because the operator of a haul truck failed to stop at a stop sign. On approaching the intersection, the operator of a light vehicle saw the haul truck coming from the right and braked. The light vehicle stopped within approximately 18 m of the haul truck.	<p>The incident highlights the importance of having effective controls in relation to the interaction of light vehicles and heavy vehicles at surface mine sites. Roads or other vehicle operating areas are identified as a principal hazard within the Work Health and Safety (Mines and Petroleum Sites) Regulation 2014.</p> <p>Refer to the recommendations in the fatal incident.</p> <ul style="list-style-type: none">• IIR13-06 Collision between haul truck and light vehicle• Investigation into a fatal collision at Ravensworth open cut mine on 30 November 2013

Complaint SinNot 2017/01172	Workers made a complaint of bullying and harassment to the regulator. The bullying and harassment is allegedly spread across shotfiring, mining and maintenance departments.	The complaint is being investigated by the department. Information on bullying and harassment is available on our website at: www.resourcesandenergy.nsw.gov.au/miners-and-explorers/safety-and-health/topics/bullying-in-the-workplace SafeWork 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: www.safeworkaustralia.gov.au
High potential incident SinNot 2017/01170	The methane gas level was reported to have risen above 2% in the longwall return roadway. The highest reading was 3.04%.	All underground operators are reminded that they have a responsibility to review their ventilation management plans after any exceedance. Attention should be drawn to the relationship to the conformance with the standards of the VCDs and the location of gas monitoring sensors and alarm settings.
Dangerous incident SinNot 2017/01154	An articulated dump truck lost control after the operator braked in wet road conditions. The tray rolled onto its side. The cabin remained upright. The driver was uninjured.	This type of incident has occurred on numerous occasions across mine sites within NSW. Mine operators are reminded to adopt the hierarchy of controls for the management of hazards with reference to this type of incident and confirm the suitability of mobile plant for task. Mine operators are reminded of the Safety Bulletin 17-01 , in reference to truck rollovers.
Dangerous incident SinNot 2017/01145	The park brake on a front end loader was reported as having failed during refuelling. The operator applied the park brake and walked away from the machine. When he was about 40 m from the loader he heard a scraping sound. He turned around and saw that the loader was moving. He returned and stopped the machine using the service brake.	Risks must be eliminated, so far as reasonably practicable, so due consideration is required when considering mobile plant refuelling locations and ensuring plant is parked in a fundamentally stable position. Refuelling arrangements for mobile plant should be risk assessed and managed for all mine sites. The potential risk of plant/worker interaction and fire should be controlled. Mobile plant braking systems should be maintained and checked. <ul style="list-style-type: none"> • SB09-05 Failure of mobile equipment braking systems and procedures
Dangerous incident SinNot 2017/01142	Production had only recently commenced in a newly formed longwall panel. As the goaf formed, falls resulted, pushing out a plug of methane gas (2.2%).	Operators should review their windblast management plans and withdrawal trigger action response plans (TARPs) in relation to the formation of the first goaf before the start of any new longwall extraction.
Dangerous incident SinNot 2017/01138	A rear dump truck tipped its load and was driving away from the crusher with the tray elevated. The tray made contact with an energised power line, causing a support 'cross arm' on the pole to break. The operator was unaware of incident.	Mine operators are reminded to review their sites for this risk and ensure site procedures and worker training for travelling near or under powerlines is established and appropriate. Mine operators should identify and delineate

		<p>access corridors and transport routes under overhead power lines and establish warning systems or 'goal posts' to indicate physical clearance limits and to alert operators. Consideration should be given to installation of underground cables to manage this risk.</p> <p>Confirm that emergency procedures for accidental contact with energised power lines are established and understood by workers.</p> <p>Reference should be made to the Safework NSW Code of Practice for Work Near Overhead Power Lines</p> <p>Mine operators should also refer to SB15-05 Plant contacting overhead powerlines and structures</p> <p>SA 99-23 Truck driver raises tray under powerlines</p>
<p>Medical treatment injury SinNot 2017/01137</p>	<p>A piece of stone fell from the roof and bounced off the rib striking a miner driver in the leg. An ambulance was called and the injured worker was taken to hospital for assessment.</p>	<p>This incident highlights the need for the mine operators to review and revise the strata control measures for the formation of right hand breakaways and the subsequent straight cut (in accordance with WHS Regulation clause 38).</p> <p>The review should encompass the support required before starting the breakaway and the subsequent straight cut, and personnel positioning during those activities. The aim is to ensure there is sufficient distance between the operator and unsupported roof so as that any failure of the unsupported roof does not impact on the operator.</p>
<p>Serious injury SinNot 2017/01165</p>	<p>An operator suffered a crush injury to his toes. The operator was cleaning out his boot when he placed his left foot on the top of the stabilising ram on the shotcrete pump while the stabilising jack was being operated in preparation for moving the shotcrete pump.</p>	<p>Mines should remind workers of:</p> <ul style="list-style-type: none"> the need for effective communication between workers standing well clear of stabilising rams when these rams are being operated to stabilise mobile plant. <p>If it is essential for the short term removal of personal protective equipment, move to a safe place and ensure there is no risk of harm while it is removed.</p>
<p>High potential incident SinNot 2017/01176</p>	<p>A mine reported the failure of a soapy water test from injectors on three machines.</p> <p>This incident is under investigation, however, with one machine, the mine mechanical trades identified that a build-up of contaminants on the injector and the sealing face contributed to the failure</p>	<p>Mines and licenced registered service facilities should review their maintenance strategies around the sealing and checking of injectors, using OEM recommended maintenance.</p>

of the closed joint of the injectors. The contaminants allowed a gas path to be created between the housing and the gasket resulting in the loss of integrity of the explosion protected closed joint.



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.

Recent publications

- **Safety alert:** [Longwall faces – safe access and emergency exits](#)
- **Investigation information release:** [Flyrock incident at open cut coal mine](#)
- **Mine Safety News:** [Resources Regulator compliance priorities](#)

Disclaimer

The information contained in this publication is based on knowledge and understanding at the time of writing. However, because of advances in knowledge, users are reminded of the need to ensure that information on which they rely is up to date and to check the currency of the information with the appropriate officer of NSW Department of Planning and Environment or the user’s independent advisor.

Office use only	
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Mine safety reference	ISR17-30
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