

Week ending 7 February 2018

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

High level summary of emerging trends and our recommendations to operators.

Type	Number
Reportable incident total	34
Summarised incident total	10

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot-2018/00182	<p>During the unloading of a trailer at the processing site the trailer has rolled onto its side when the 3rd stage of the hoist ram has been reached.</p> <p>The truck's cabin has lent to the passenger's side but didn't rollover.</p> <p>The dump is on the crest. There were no injuries.</p>	<p>Mine operators should review the following in relation to this incident:</p> <ul style="list-style-type: none">→ Ensure operators are trained in the use of the specific vehicle type.→ Operators in training should be supervised according to their level of experience.→ Communication systems such as two-way radios should be checked for correct operation during pre-start checks.→ Truck suspension systems should be maintained and without defects to operate as intended.→ Tipping areas should be flat or within specified limits for the truck.→ Warning devices should be supplied for operators if the truck breaches cross grade limits.→ Review SA04-24 Dump truck tip.

Dangerous incident
SinNot-2018/00178

A haul truck road train that was taking coal from a washery bin to a rail-loop stockpile was driven into a bund wall at low speed. The bund was protecting a drainage channel. A review of video data obtained from the truck's DSS safety system indicated the driver may have had a micro-sleep

Mine operators should review their fatigue policy and how it is complied with on site.

Mine operators should review haulage road risk controls (bunding; guard railing etc) and to ensure they are adequate.

Dangerous incident
SinNot-2018/00177

A contractor was regassing a light vehicle when he felt an electric shock from a 240-volt re-gassing machine. The contractor did not report the incident until the end of his shift, so the site was not preserved at the time of the incident and the exact time is unknown.

On initial investigation, the regas machine tested correctly however, the extension lead was found to have damaged earth.

Mine operators should review:

- training and confirm that workers understand their obligations to report incidents at the time of the event.
- electrical control plans to ensure that workers conduct quality pre-use checks to all equipment before it is used.

Serious injury
SinNot-2018/00164

Police informed the mine a child had an accident on the mountain behind the administration area on site.

The area, which was locked, was opened to allow the ambulance and police to find the child.

The injured child was found at 9.30 am and a rescue helicopter flew the child to a hospital in Sydney.

Mine operators should review their site security controls to prevent unlawful trespassers.

They should take into consideration that the general public may not be aware of the potential hazards of a mine site.

Dangerous incident
SinNot-2018/00163

While trying to clear a blocked diaphragm pump, a worker isolated the compressed air line. The worker then opened the bleed valve in the delivery line while putting their face in the line of fire.

Dirt and grit hit the worker in the face and eyes. The worker was

Mine operators should review:

- how the potential hazards associated with a blocked discharge hose/pipe are recognised and controlled.
- the direction that bleed valves discharge.

wearing safety glasses that were blown off.
The worker was transported by ambulance to hospital for treatment.

<p>Dangerous incident SinNot-2018/00160</p>	<p>Three workers were 15 m away from where a 30 kg piece of steel landed after it fell from the underside of the floor above in the concentrator pump floor in a surface mill.</p>	<p>Mine operators should review suitability of structural integrity and inspection programs for areas of high vibration and/or corrosion.</p>
<p>Dangerous incident SinNot-2018/00159</p>	<p>A crew was operating a new belt maintenance station to retract belt from the main gate conveyor. After 30 m was retracted, a clip became caught on the pinch roller. When the crew re-attempted to get the clip through 14 of the 24 x 3/8" mounting bolts sheared sending several bolts in the direction of two of the crew who were standing 5 m from the belt maintenance station. From initial site investigations, there may have been a hydraulic issue with a blocked drain case port.</p>	<p>In relation to hydraulic systems and equipment, mine operators should ensure:</p> <ul style="list-style-type: none"> → case drains and return lines are installed as per design drawings → workers have adequate information, training and competencies for the task → commissioning activities and checks for maximum working pressure, relief settings, flows etc are completed.
<p>Dangerous incident SinNot-2018/00158</p>	<p>A worker was using a water pressure cleaner at up to 5Kpsi pressure to scale salt from the top of a service. The worker stopped to change out the lance before depressurising. The worker had a hand on the end of lance and a co-worker hit the trigger, injuring the worker's hand.</p>	<p>Refer to the recommendations in SA18-03 Two workers suffer serious fluid pressure injuries in separate incidents</p>
<p>Serious injury SinNot-2018/00155</p>	<p>A contract operator suffered a deep cut to his finger during the installation of 6 m high tension roof bolts using a load haul dump hydraulic bolter. The hole had been drilled and the operator was installing the bolt in to the hole when the plate slid back down the</p>	<p>Mine operators and contracting companies should review procedures associated with the installation of roof bolts to ensure all potential hazards have been considered and appropriate controls have been introduced.</p>

bolt, cutting his finger. The operator was wearing gloves at the time of the incident.

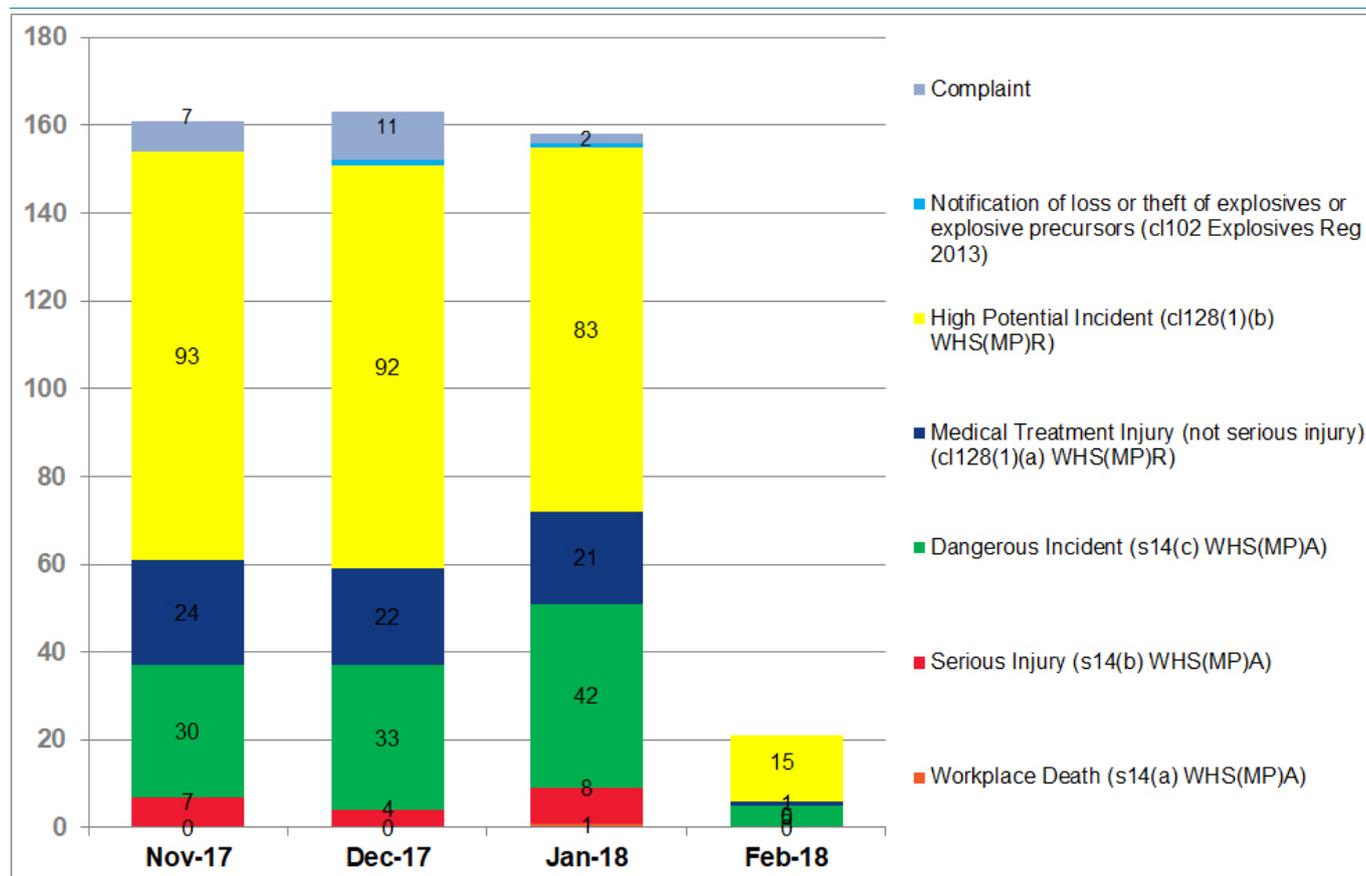
Mine operators should review how their workforce have been trained in task hazards awareness.

Dangerous incident
SinNot-2018/00151

A dump truck lost control while travelling down a ramp. The dump truck was empty with the road conditions wet from recent water cart activity and a passing storm. The dump truck slid out at 90 degrees and crossed the centre line before stopping. No injuries were reported and there were no other vehicles on the ramp at the time of the incident.

All mine operators should review:

- how a change in road conditions are communicated to all the workforce.
- how statutory officials monitor change and their corrective actions to change.



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

The Resources Regulator has developed a [health control plan](#) guide that will inform operators and other persons conducting a business or undertaking at a mine or petroleum site of their legislative requirements, to ensure the highest health and safety standards for workers are in place.

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.

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