Learning from Incidents Www.MinEx.org.nz

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There are no new incidents

We have the same incidents over and over again

Why is it we don't learn?

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Some of my observations

- Tendency to "jump to conclusions" without recognising underlying root causes
- We move on quickly from HPIs
- Investigation findings are not communicated effectively
- Remedial actions are not followed up
- Loss of corporate memory (staff turnover)
- * "Our people wouldn't do that !!!"

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"There are three kinds of men. The one that learns by reading. The few who learn by observation. The rest of them have to pee for themselves."

Will Rogers

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Lessons from recent incidents Repaired cylinder Position of mast after incident

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Learnings

- A shortage of skilled workers familiar with drill maintenance (Competency/Staff shortages).
- Failure to understand the implication of cylinder not being bled (Training and Competency).
- OEM procedure inadequate, does not mention bleeding the cylinder (Adequacy of procedures).
- The task was spread over three shifts and was extended by the addition of removing extra parts(Communication).
- Work area for testing not barricaded (Separation).

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Learnings

- Always ensure positive communications between HVs and LVs. (Communication)
- Where possible don't allow LVs in HV work areas while HV's are working. There could be a better time or location for the task. (Separation)
- · Be visible and confirm all operators working in the area know where you are. (Adequacy of procedures)

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Learnings

- Where practical, mechanical devices or aids are used for traditionally manual tasks. (Substitution)
- Where possible don't allow LVs in HV work areas while HV's are working. There could be a better time or location for the task. (Separation)
- Plant operators maintain three points of contact when entering and exiting the cabins of mobile equipment. (Procedures)
- Safety boots are securely fastened, either laced up or zipped up. (Appropriate use of PPE)
- Regular workplace inspections are conducted to identify slip, trip and fall hazards, and poor housekeeping that could lead to injury. (Workplace inspections)

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Lessons from recent incidents



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Learnings

- All nip points should be guarded to ensure access is not possible. (Engineer out risk)
- No plant should be operated when guards are removed, damaged or ineffective. (Procedures)
- Guards should be designed so that they do not need to be removed for regular maintenance tasks e.g., tracking belts. (Engineer out risk)
- Regular workplace inspections are conducted to ensure guards are effective and in place. (Workplace inspections)
- All incidents with the potential for harm should be reported internally and to WorkSafe in accordance with regulations. (Incident investigations)

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Site to conduct an assessment of geology and potential geotechnical issues to identify potential slope instability issues. (Risk appraisal) Regular site inspections for ground instability are conducted, particularly after significant rainfall. (Workplace inspections) A catch bench is established between the excavator and face when working on a muck pile. (Procedures) When operating an excavator on a shot, ensure that the cab of the excavator is on the free side of the shot i.e., not facing the bench. (Procedures) WWW.MinEx.org.nz



Ensure all plant is fundamentally stable before commencing maintenance work. Clamps should be checked before cutting begins. (Procedures) Appropriate Personal Protective Equipment (PPE) is always worn when carrying out tasks that require it to be worn. (Use of PPE) Regular workplace inspections are conducted to identify unsafe activities and ensure work is conducted safely and in accordance with safe operating procedures. (Workplace inspections)

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Are there any incidents you would like to share from your experience?

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