Weekly incident summary

Planning & Environment Resources Regulator

Week ending 16 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

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

Type	Number
Reportable incident total	37
Summarised incident total	8

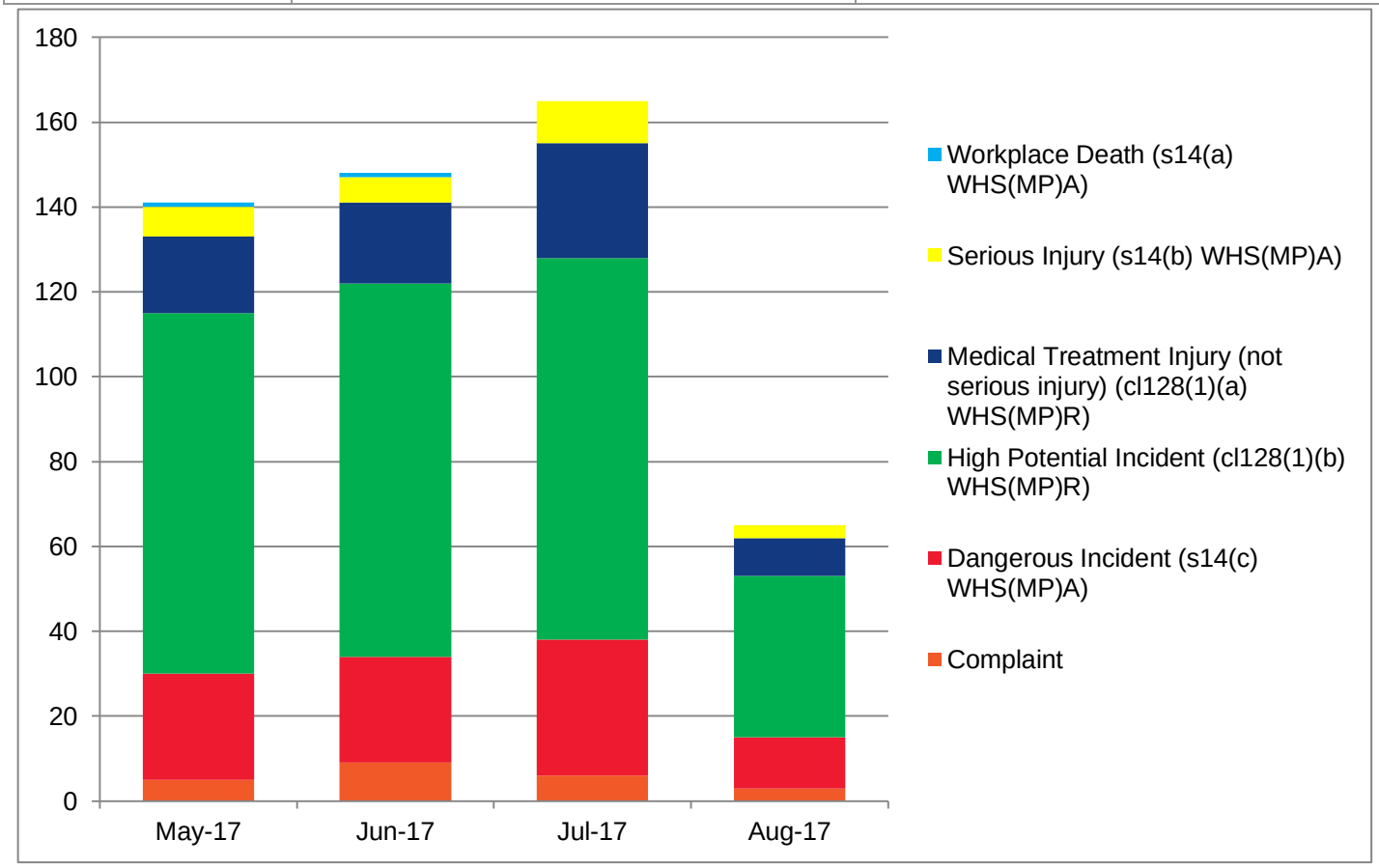
Summarised incidents

Incident type	Summary	Recommendations to industry
Complaint SinNot 2017/01236	An industry safety and health representative identified that a coal mine was operating with an expired exemption. The exemption expired after two years.	It is the mine operator's responsibility to ensure that where exemptions are granted, there is compliance with all conditions, including expiration dates.

High potential incident SinNot 2017/01253	An incoming power supply issue caused one fan on a ventilation shaft and a gas plant to shut down. A fan at another ventilation shaft was automatically dropped off when the fan on the first ventilation shaft stopped. Workers were withdrawn to the surface.	Electrical power supply is critical to the operation of essential infrastructure such as ventilation fans. The effect of this loss of supply should be risk assessed to ensure that suitable controls are identified and provided. Safety management systems and the electrical engineering control plan may require review where critical mine infrastructure is affected by a loss of power supply. Consideration should be given to the provision of back-up (generators) or alternative drive systems (e.g. diesel engines) where the loss of power supply may adversely affect critical infrastructure.
High potential incident SinNot 2017/01252	During the inspection of a conveyor belt it was found that rib had come out and fallen against the belt structure, impeding passageway on the walkway side of the conveyor.	Mine operators should identify areas where the potential rib spall may exist, whether in roadways, pillar extraction workings or longwall faces. For identified areas: • review the support rules • assess risks and implement additional controls to avoid danger to the safety of workers from unconfined rib to ensure continued safe passage • review and, if necessary, update mine strata management plans. Refer to the NSW code of practice: strata control in underground coal mines.
High potential incident SinNot 2017/01254	A dozer was pushing material at a dumping operation when a large rock (approximately 1.5m x 1.5m) came off the side of the dozer and ran down the face of the dump to the set up operation below (approximately 40 m). It breached a 10 m containment barrier (windrow) and hit and significantly damaged a lighting plant.	Dumping above any active working area is poor practice and should not be permitted. Work activities should be planned and coordinated to manage risks caused by the work activities of different work groups on each other. It is essential that work instructions are effectively communicated and are understood by all people that may impact, or be impacted by, others. As a minimum, the controls should include more rigorous inspection regimes, increased supervision and improved barriers. Mines should review inspection plans and ensure workers and statutory officials are trained in hazard identification and rectification.

High potential incident SinNot 2017/01257	A loader arm failed at the pivot point (catastrophic failure) causing the arm and bucket to fall to the ground. The incident occurred at a stockpile area while loading 40 mm aggregate. The operator suffered a significant jolt.	Structural components on loaders need to be periodically inspected as well as being maintained to OEM recommendations. Loaders must only be operated within their designed load-rating chart. The use and frequency of non-destructive testing techniques should also be considered. Sites are reminded to review their mechanical engineering control plan.
Dangerous incident SinNot 2017/01272	The tub of a 40 tonne articulated dump truck rolled onto its side. The truck was carting scalps material at the primary fixed plant and had travelled about 200 m. As it tried to negotiate a right hand corner it appears that a mechanical failure (spring) has caused the tub to roll over. The road surface was described as being in good condition.	Suspension failures affect the stability of articulated trucks by shifting the truck's centre of gravity. A competent person must carry out periodic maintenance and inspection of suspension components. Components need to be replaced, overhauled and maintained to OEM recommendations. The recommendations in SB17-01, Industry reports more truck rollover incidents should be considered.
High potential incident SinNot 2017/01274	An electric shovel lost power. Site electrical personal were dispatched to find the cause and discovered that a haul truck had made contact with a cable sled junction box, resulting in the cable and plug being damaged. There were no injuries reported from the operator of the truck and no other damage identified to any other mining HME associated with the loss of power.	The electrical engineering control plan should contain requirements for the management of cables, in particular trailing and reeling cables. The cable management systems should include requirements for the adequate separation of cables and associated infrastructure, such as plug sleds, from mobile mining equipment. This includes the placement of demarcation markers and barriers that provide clear indication of the location of the cables. Sites must set up and maintain cable installations in accordance with the mine's cable management standards. All operational personnel and statutory officials should be trained and familiar with the requirements of the cable management standards. Regular audits by statutory officials, supervisors and electrical staff will assist with compliance for cable installations, including the positioning and demarcation of cables and sleds to avoid contact by haul trucks and other mobile machines. Guidance is provided in Section 6 of *AS/NZS 3007:2013 Electrical equipment in mines and quarries—Surface installations and associated processing plant.*

High potential incident SinNot 2017/01277	Detection of methane exceeding 2% in the general body of air	Sites are reminded to review their ventilation control plans and TARPS that are in place to control these events so that methane does not exceed 2% in areas where people travel or work (clause 72 WHS (Mines and Petroleum Sites) Regulation 2014).



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

- TAP report Fatigue management practices August 2017
- TAP consolidated report – emergency management August 2017
- Causal investigation: catastrophic engine failure in underground coal mine

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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