Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 13 December 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	43
Summarised incident total	9

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot-2017/01967	An articulated haul truck was leaving the pit floor loaded with material and as it turned onto the main ramp, one of the rear tyres blew out. The shift in load caused the body of the truck to overturn. The cabin of the haul truck remained upright and the driver was not injured.	Mine operators using articulated dump trucks should: → ensure prestart checks include inspections of tyres for defects → tyres are at correct operating pressures → tyres are changed at the appropriate wear limit → tyres are not operated above original equipment manufacturer recommendations of load or Tkph → roads are maintained to reduce the likelihood of punctures to as low as is reasonably practicable.
Dangerous incident SinNot-2017/01961	A contractor was carrying out painting and sand blasting activities in a coal handling and preparation plant. While sand blasting, the jet nozzle and hose entered his protective clothing (apron) and	Mine operators who conduct abrasive blasting (or manage contractors who conduct abrasive blasting) should: → review the code of practice for abrasive blasting issued by SafeWork NSW

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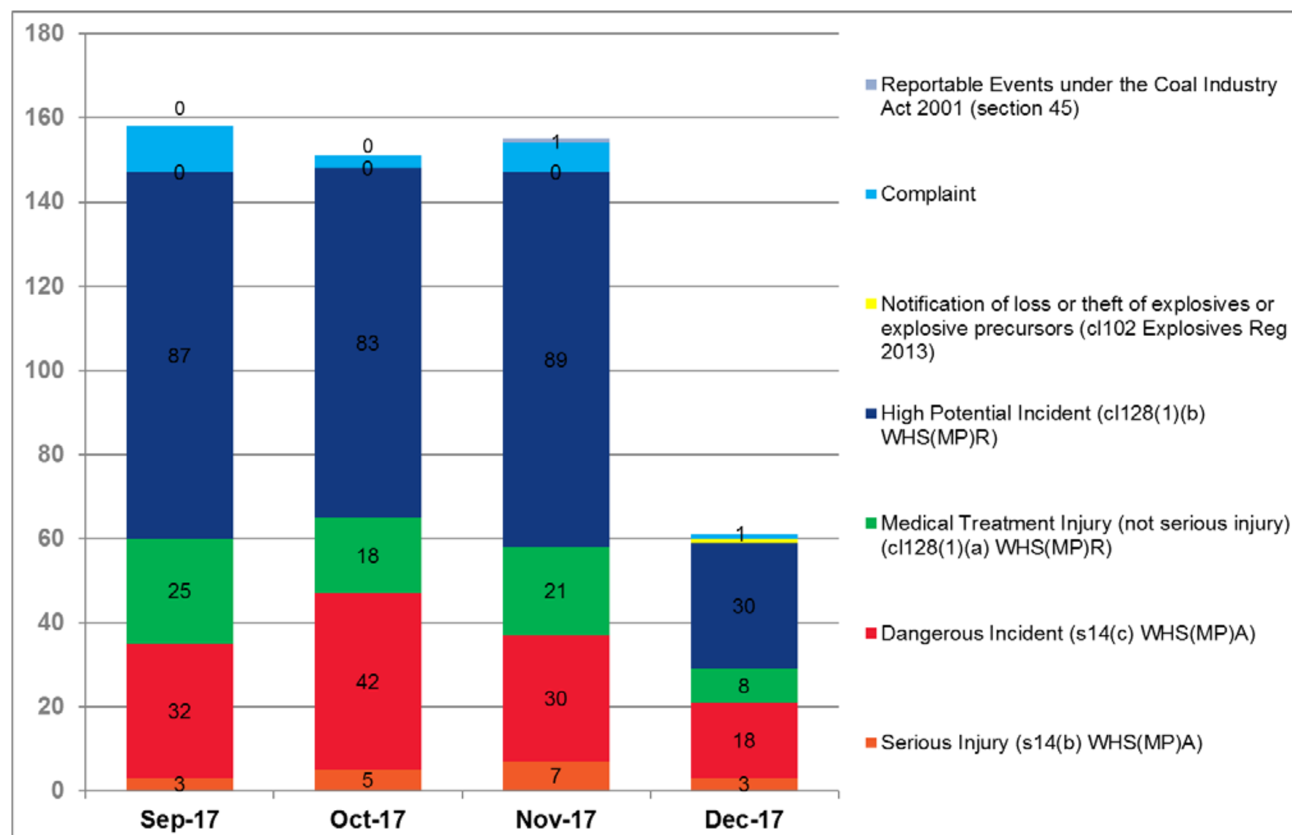
	into his airstream helmet. This resulted in it striking him on the right side of his temple and causing a laceration. He was taken to hospital for assessment.	→ ensure abrasive blasting equipment is compliant with requirements of the code of practice, including deadman controls to be under the direct control of the operator.
Dangerous incident SinNot-2017/01960	A rock weighing about 2 kg fell from a wall. No one was in the area at the time.	Mine operators should review the effectiveness of inspections of older work areas for stability of wall and roof material that may degrade over time.
Dangerous incident SinNot-2017/01959	A roof fall occurred at a four-way intersection just behind the main north conveyor LTU. It went up about 4 m high and was about 10 m in diameter.	Mine operators should review the critical controls in their strata failure management plans to identify and quickly respond to any areas of concern. Some mines have implemented a strata defect system including trigger action response plans (TARPs), which specify a timely response. This system is considered good practice and has reduced the incidence of roof falls at these operations. It is important that all personnel are familiar with the TARPs. They should understand the action that need to be taken if a change is detected.
Serious injury SinNot-2017/01955	A worker was hit by the ramp of a low loader when the chain retaining the ramp broke. The worker was hit on the head (he was wearing a hard hat) but suffered a compound fracture of the right tibia. The truck and low loader had just been delivering a dozer to the mine and was being prepared to leave the mine. The first ramp had been raised and secured with the chain. The second ramp was not lifting. While attempting to get the ramp to lift, the chain on the first ramp broke and allowed the first ramp to drop. The worker was walking past the	Mine operators should: → consider the position of workers when loads are being moved. This should include no-go zones → ensure that adequate supervision is present when workers not familiar with site-specific procedures are performing work → ensure workers are appropriately trained in assessing risks associated with every task → ensure that equipment is regularly maintained and is fit for purpose.

	ramp at the time that the chain has broken.	
Dangerous incident SinNot-2017/01951	Recent rain caused stone to fall from a bench above a roadway, with a small piece hitting the roof of a light vehicle. The operator stopped the vehicle and saw more stone landing on the roadway. No one was injured.	Mine operators should: → review how strata inspections are undertaken after weather events. → consider the location of roadways in relation to the base of high walls.
Dangerous incident SinNot-2017/01947	A fire occurred on a dozer while working on the underground return of mine (ROM) stockpile. The dozer operator noticed the hydraulics failing on the machine. He drove the dozer off the stockpile to enable a fitter to inspect the machine. After parking the machine, the operator noticed smoke coming from the left-hand side of the engine bay. He called in an emergency on the two-way radio and then initiated the onboard fire suppression system. The operator then used a hand-held extinguisher to extinguish the fire. The fire was in the vicinity of the left-hand turbo.	Following a fire on mobile plant, mine operators should: → conduct a thorough investigation by a competent person to determine the cause of the fire, fuel sources and heat sources, surface temperatures and controls to prevent re-occurrences → assess and repair fire-affected areas of the plant before returning to service → train workers to identify fire risks such as fuels or oil leaks or worn hoses → review the fire risk assessment for the item of plant → report the issue to the OEM.
Dangerous incident SinNot-2017/01946	A fitter was hit on the forehead by a radiator shroud (piece of steel) that fell about 1 to 1.5 metres. The fitter was working underneath a haul truck at the time the section fell. The shroud was being refitted following the replacement of the engine in a CAT 793 haul truck.	Mine operators should review work procedures that could include the hazards associated with objects falling from height.
Dangerous incident SinNot-2017/01945	At an underground location, a flat top truck was delivering materials. A telehandler was being used to unload a cage of dry goods. On the opposite side	Mine operators should review how hazards associated with unloading trucks are assessed. Spotters should also be considered when loading and unloading trucks.

of the truck was a cage with six gas cylinders in it. When the telehandler lifted the dry goods, the cage with the gas cylinders lifted as well, toppled over and fell off the opposite side of the truck flat bed. One of the cylinders had its valve broken and the gas was released. All workers stood back and remained away from the venting cylinder. The way the cylinders were laying necessitated them being moved to make the scene safe

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.



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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