Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 31 January 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	40
Summarised incident total	16

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot-2018/00147	While joining rods in the process of diamond drilling in an underground metalliferous mine, a flame came out of the hole. The flame was immediately extinguished using a diverter and fire extinguisher.	Mine operators should review their procedures for appropriate ventilation to control flammable gas. Mine operators should also review their procedures associated with drilling relating to how flammable gas is detected and controlled.
Dangerous incident SinNot-2018/00146	A water truck was descending a haul road when the truck travelled from a wet section of the road to a dry section. The truck hit a bump in the road and the driver braked. The truck began to skid then rolled onto its side. The section of road was straight and the road was not over watered.	Incident investigations are ongoing. This incident is a reminder for all drivers and operators of trucks and heavy vehicles to drive to conditions.
Dangerous incident SinNot-2018/00143	An ignition of methane occurred at the coal face during production in a development panel. A continuous miner intersected a known strata fault when the ignition occurred. No injuries were reported.	A section 195 notice was issued to the mine to prevent workers from going underground. Mine operators should review: → procedures for appropriate ventilation to control flammable gas

		→ how areas of potentially flammable gases are identified and controlled → their broad-brush risk assessments to determine if frictional ignitions are a principal hazard for the mine.
Dangerous incident SinNot-2018/00141	A fitter was servicing a dozer. While using the grease gun, the fitting became stuck on the grease nipple. When the fitting became free the fitter was splattered with grease. The incident was treated as a potential fluid injection.	Mines should communicate the incident through site communication and check that grease points and greasing equipment is serviced, maintained and free from mechanical damage.
Dangerous incident SinNot-2018/00138	A 25-tonne crane was parked four metres from a materials chute above a material feeder onto a conveyor belt. A worker was in the chute, about to carry out a welding job. The crane did not have the park brake applied and rolled towards the opening. The chute lip prevented the crane from entering the chute. The crane driver had left for a shift change and had not put wheel chocks in place as per site procedure.	Lessons that should be communicated through tool box talks including: → compliance with correct parking procedures → being situationally aware of hazards. Mine operators should consider: → audible warning systems and/or visual alarms that warn of the lack of park brake application → interlocking that automatically applies the park brake when the operator leaves the operator's position (i.e. door interlock). Functional testing of park brake application warning systems. → the recommendations in safety bulletin SB13-02 Unplanned movements of vehicles - too many near misses.
Dangerous incident SinNot-2018/00137	An alarm was activated on the dashboard of a new truck on a mine site. A worker parked the truck and proceeded to notify the supervisor. A fitter of an oncoming shift went to check out the reported alarm. When the fitter arrived with the	→ The incident investigation for the root cause is ongoing, although it appears to be electrical. → The incident should be communicated at site tool box talks.

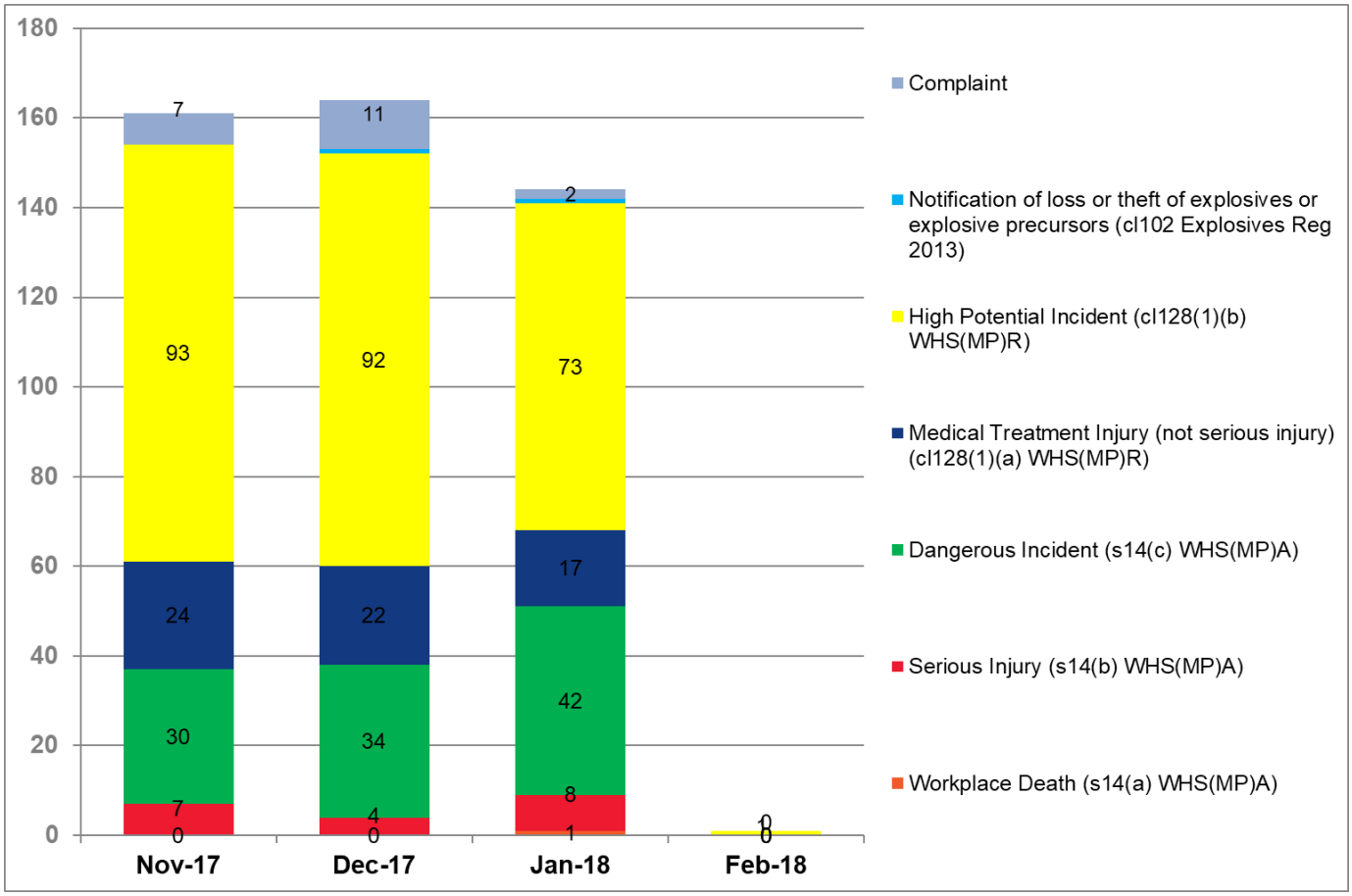
	truck operator, they saw smoke coming out of the truck window. They isolated the power at the front of the vehicle. The smoke subsided and stopped. No flames were observed. No fire extinguishers were used or operated.	→ Operators should ensure they are familiar with isolation and emergency procedures.
Dangerous incident SinNot-2018/00133	An empty truck (previously containing ammonium nitrate) leaving a site had a raised rear trailer while travelling on an exit road. The trailer made contact with a tunnel on the access road, which resulted in the trailer de-coupling from the truck.	Mine operators and people in control of plant with dump bodies should review engineering controls to prevent the vehicle being driven with the dump body in the raised position. Interlocks and warning alarms are potential controls considered to be reasonably practicable.
Dangerous incident SinNot-2018/00131	During roadworks, an excavator was shaping windrows on a haul road ramp. The worker requested additional material to fill a gap. A haul truck reversed to about three metres from the excavator. While dumping the load, a rock fell over the side of the truck and hit the excavator. There were no injuries.	Mine operators should review how statutory officials and supervisors monitor compliance to all mine rules and procedures.
Dangerous incident SinNot-2018/00127	A steel prop used to help support a steel cross beam in a belt roadway fell. The steel prop had been set into the floor but the floor was brushed about a week previously. There were mine workers about one and a half metres from where the prop landed.	Mine operators should review: → how hazards associated with any task are assessed → the quality of inspections that are completed post-task for new hazards that have been inadvertently introduced to the work area.
Dangerous incident SinNot-2018/00126	A fire was reported on a water cart. The water cart was under a water fill point when the operator noticed the fire. The operator initiated the onboard suppression system to put out the fire and then used a hand-held extinguisher on a section that was giving off smoke.	→ The fire appears to have been caused by hydraulic oil making contact with hot exhaust components. There was a hose failure from rubbing abrasion. → Mine maintenance personnel should be vigilant when conducting inspections to inspect hoses for

		evidence of rubbing and abrasion or missing clamps or fixings.
Serious injury SinNot-2018/00125	A worker suffered a fluid injection injury when a hose fitting on a high pressure wash down wand failed. The hose whipped around and the person was hit on the chest and the left forearm with the high-pressure water.	→ Mine operators should inspect high pressure cleaning equipment to ensure the hose, connection fittings and lance (gun) are assembled correctly from original equipment manufacturer (OEM) recommended and rated components. → Hose-to-gun connection should contain a swivel connection or methods to prevent the connection from becoming unscrewed if twisting occurs in the hose.
Dangerous incident SinNot-2018/00124	A light vehicle made contact with an integrated tool carrier and the wall of a mine. As the vehicle approached the accident scene, the driver applied the brake but the vehicle did not respond. On applying more force to the brake, the motor speed increased. Consequently, the vehicles collided. No-one was injured.	→ Vehicle operator controls such as clutch, brake and throttle pedals should be inspected and maintained to operate effectively. → Drivers should report defective controls through pre-use inspections.
Dangerous incident SinNot-2018/00123	The handrail of a dozer was damaged when hit by an excavator bucket. The dozer was cleaning up on the off side of the excavator and moved within the swing radius of the excavator without making positive communications with the excavator operator. Note: This dozer was a hired machine and was not fitted with the proximity detection systems as fitted to mine-owned machines.	Investigation of this incident should highlight to mine operators that traffic management plans should include: → Operational risk assessments should be completed on all new plant to ensure the level of risk is not increased. → Positive communications process should be used at mines for all vehicle interactions. → Mine operators should review how statutory officials and supervisors monitor for compliance to mine rules and procedures.

Dangerous incident SinNot-2018/00122	A Cat 777 service cart skidded while travelling down the main pit access ramp. It veered to the right across the grade and then rolled over. A watercart operator had previously watered the ramp using the centre spray only. The service cart was travelling on the wet line with full tanks. This portion of the ramp was on the roof of the coal seam. The coal is hard and slippery when wet. There was a bump in the road at about the point where the rollover occurred. The truck operator stated that the retard was used further up on the ramp and was travelling at about 12 kph. The driver initiated the retard as the vehicle approached the bump in the road and this was when the rear of the service truck slid out to the left.	Principle hazard management plans for roads or other vehicle operating areas should consider factors that may affect operator visibility or ability to control a vehicle: → Fog, sunlight, storms or dust obstructions that affect lines of sight. → Vehicle operating areas should have fit-for purpose barriers such as bunding or windrows to prevent uncontrolled vehicles going over embankments. → Drivers should be reminded to travel at speeds suitable for the conditions.
Serious injury SinNot-2018/00116	An operator was in a man basket recovering ventilation tubes. As the operator was breaking the tubes for a new auxiliary fan location the operator removed the chain and pulled the tubes apart with the handle. The tubes suddenly released jamming the operator's right ring finger between the ventilation tube and the man basket resulting in a laceration to the operator's finger.	Mine operators should review what controls are in place for manual handling tasks that are carried out regularly.
Dangerous incident SinNot-2018/00102	A truck-mounted crane was to be used to assist with a repair to a shroud on the bucket of an excavator. While preparing the crane, the procedure was not followed correctly. This, in turn, put extra pressure on the crane's hook. The boom extended into the	→ Operators of truck-mounted cranes should be trained and competent in the deployment and stowage of the crane. A specific sequence and procedure may be required depending on the make and model type.

operator's standing area causing the operator to take a step back to avoid being struck.

→ Mine operators should review what training their statutory officials and supervisors have received in the requirements to preserve a scene after a notifiable incident.



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

SA18-03 Two workers suffer serious high pressure fluid injuries in separate cleaning incidents

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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