Weekly incident summary

Planning & Environment
NSW GOVERNMENT
Resources Regulator

Week ending 12 July 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

Type	Number
Reportable incident total	49
Summarised incident total	9

Summarised incidents

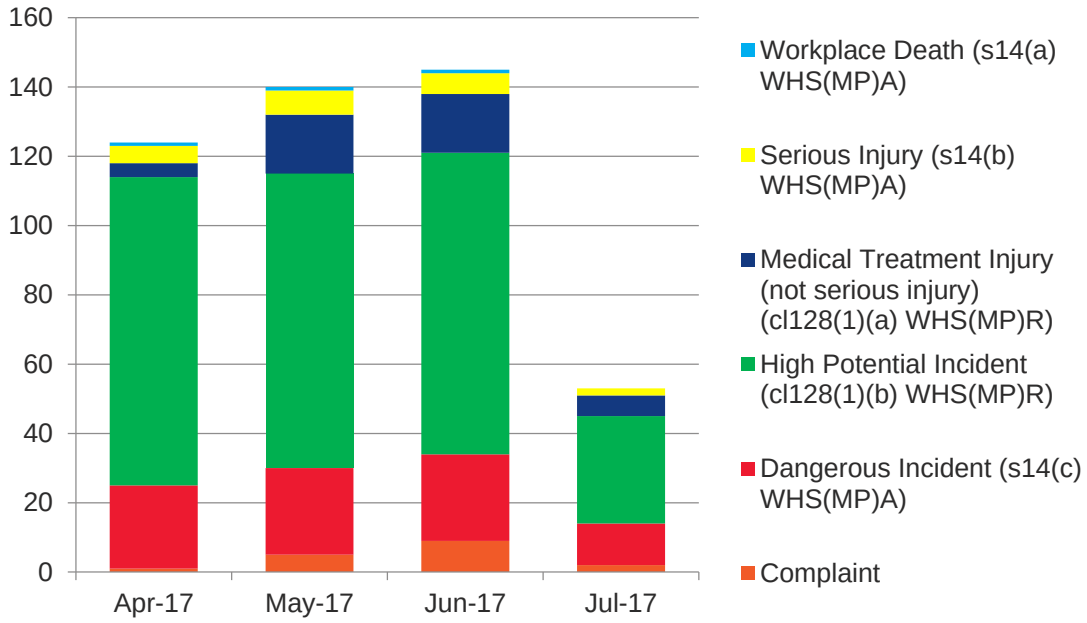
Incident type	Summary	Recommendations to industry
Dangerous incident SinNot 2017/00998	An articulated dump truck operator was tipping a load on a stockpile. Halfway through tipping this load, the body of the truck rolled onto its side. The cabin remained upright and no people were injured. The back wheel of the truck had moved too far up onto the stockpile. The mine operator conducted a risk assessment and later, made a decision to reposition the truck using an excavator.	Mine operators should identify all work activities on the mine site where trucks are used and review control measures for truck rollovers. This should consider the following risk controls to prevent a truck roll: • tipping areas should be level without cross grades • tipping areas should be stable, and capable of withstanding the truck wheel pressures and not prone to subside Refer to the department's Safety bulletin: industry reports more truck rollover incidents.

High potential incident SinNot 2017/01045	While driving inbye, there was a catastrophic failure of an engine on a FBL10 LHD vehicle. This resulted in internal components exiting the engine block. The LHD vehicle was travelling unloaded at the time of the incident. The incident occurred in the main intake airway.	The regulator will launch an investigation to determine the causal factors of the incident. Until the outcome of the investigation is available, people with management and control of plant are reminded that: • maintenance, inspection and testing should be carried out in accordance with the manufacturer's recommendations • maintenance activities should consider the duty cycle and the operating environment • explosion-protected diesel engine systems should be maintained in accordance with the conditions of item and design registration.
Dangerous incident SinNot 2017/00997	An electrician was carrying out scheduled light switch inspections. When he went to turn off a switch, he suffered an electric shock.	A soap dispenser was installed directly above a light switch. Soap ingress was evident after an investigation. Mine operators are reminded of their obligations to manage risks under the WHS (M&PS) Regulation 2014. In managing risks to health and safety associated with electricity at the mine or petroleum site, the operator must ensure: • installation work at the surface is carried out in accordance with the wiring rules (AS/NZS 3000), in particular refer to clause 32 (2), and • modifications to buildings and plant do not reduce the safety of existing electrical installations that are generated by complying with the wiring rules.
High potential incident SinNot 2017/01010	A flatbed truck was travelling down to the 9800 level. The operator attempted to brake but the brakes did not pull the truck up. The operator tried to change the truck's gears from second to first gear when the truck started 'over revving' and	Mine operators are reminded that mobile plant must be maintained to a good standard and in accordance with original equipment manufacturer's recommendations. The operating tolerances of mobile plant must be adhered to within road design

	speeding up. The operator attempted to steer the truck onto the decline and get it back under-control. He took evasive action and steered the truck into the wall, making impact four times before the machine came to rest. The truck was loaded with an estimated 8 tonnes of fuel and mesh at the time of the incident. The mine operator has ordered an independent mechanical assessment of the truck.	parameters. The mine operator should consider: • maintenance, inspection and testing of braking systems of mobile plant • that the frequency of maintenance and inspections is appropriate for the mine operating environment and the type of plant • both vehicles owned by the mine and any contractor vehicles should be included in the review. Operators of trucks should ensure that they drive according to the conditions.
Dangerous incident SinNot 2017/01040	An excavator was operating at a bench within a mine. The excavator was a Hitachi brand 'EX3600' model. During operation, the excavator slid off the operating bench, reportedly falling four or five metres. At the time, the excavator was digging the toe of the bench towards the highwall. It came to rest at a 45 degree angle. The operator of the excavator was not injured.	There were several factors that contributed to this incident. These include: • digging outside the limits of the machine • lack of supervision, and failure to identify the hazard, that is, an excessively high bench in proportion to the machine • uncompacted ground • working too close to the edge of benches or ramps, and • inadequate hazard identification. The regulator recommends operators ensure that the following are actioned to reduce risk: • working pads are adequately compacted and constructed • tasks are supervised and potential hazards are identified • when working on benches, excavator tracks are parallel to the face and positioned an adequate distance from the edge. This includes taking into account the stability of the edge in terms of geological structure, blast damage and undercutting.

		• operator training and assessment takes into account specific conditions and activities at the site • operators understand original equipment manufacturer's operating instructions, including load limits at various boom extension distances, stability parameters, and safe operating procedures.
Dangerous incident SinNot 2017/01011	A load haul dump truck was coming out of a cut-through bucket. As it exited, it collided with a truck travelling on the main transport road. This resulted in damage to the front driver's side pillar. No people were injured.	Underground operations must review their controls when vehicles are operating in and around main travel roads. The review must consider traffic control and making others aware of the operating vehicle. The review must also consider the frequency of work in the area and other factors that may affect visibility. This could include, for example, seam grades.
High potential incident SinNot 2017/00999	The syntron feeder of a surface bin broke away from its restraints. The bin weighed approximately 2000 tonnes. As it broke away from its restraints, it fell onto the conveyor gate. The knife gate buckled and material dropped out. An exclusion zone was in force at the time of the incident as there was wet product in the bin. The bin was being run out with a sucker truck on standby. The excess wet material in the bin resulted in damage to the knife gate, syntron anchors, chute side wall and the receiving conveyor.	We recommend mine operators consider: • the importance of no-go zones when running out this type of material • engineering design review and making changes to the chute at the bottom of the bin • a review of the design of the bin to minimise fluid into the surface bin • the importance of annual structural audits of surface bins and having a clear scope.
Serious injury SinNot 2017/01012	A dump truck operator was operating a truck at a mine. He slipped from the truck ladder and fell to the ground. Medical personnel assessed the operator and he was sent home. At a later time, the operator sought further medical treatment. Medical personnel found that he had suffered two broken ribs and a fractured eye	Mine operators should reinforce the safety risks inherent in accessing mobile equipment. Ways to manage these risks include ensuring that: • people have three points of contact when entering and exiting vehicles • boot laces are tied and soles are in good condition

	socket.	• access steps are clear of debris • items carried by operators do not prevent secure contact with hand rails.
Dangerous incident SinNot 2017/01017	A handrail at a coal handling and preparation plant shifted when a worker leaned against it. The handrail was 3.5 metres above ground level. It was located at the breaker feeder. The worker fell onto a scrap metal chute but was not injured. The handrail was designed to facilitate servicing of motors and drives. The locking bolt used to secure the handrail was not reinserted after recent maintenance activities.	Where this type of hazard exists, consideration as to the suitability of controls for the risk is required. Critical controls may require more than one action or activity to manage the risk.



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

- Safety alert: Lack of pillar support - underground opal mines
- Safety alert: Non-compliant gas monitors

- Investigation information release: Fatality on the surface of an 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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