Weekly incident summary

Planning & Environment
NSW GOVERNMENT Resources Regulator

Week ending 19 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

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

Type	Number
Reportable incident total	51
Summarised incident total	12

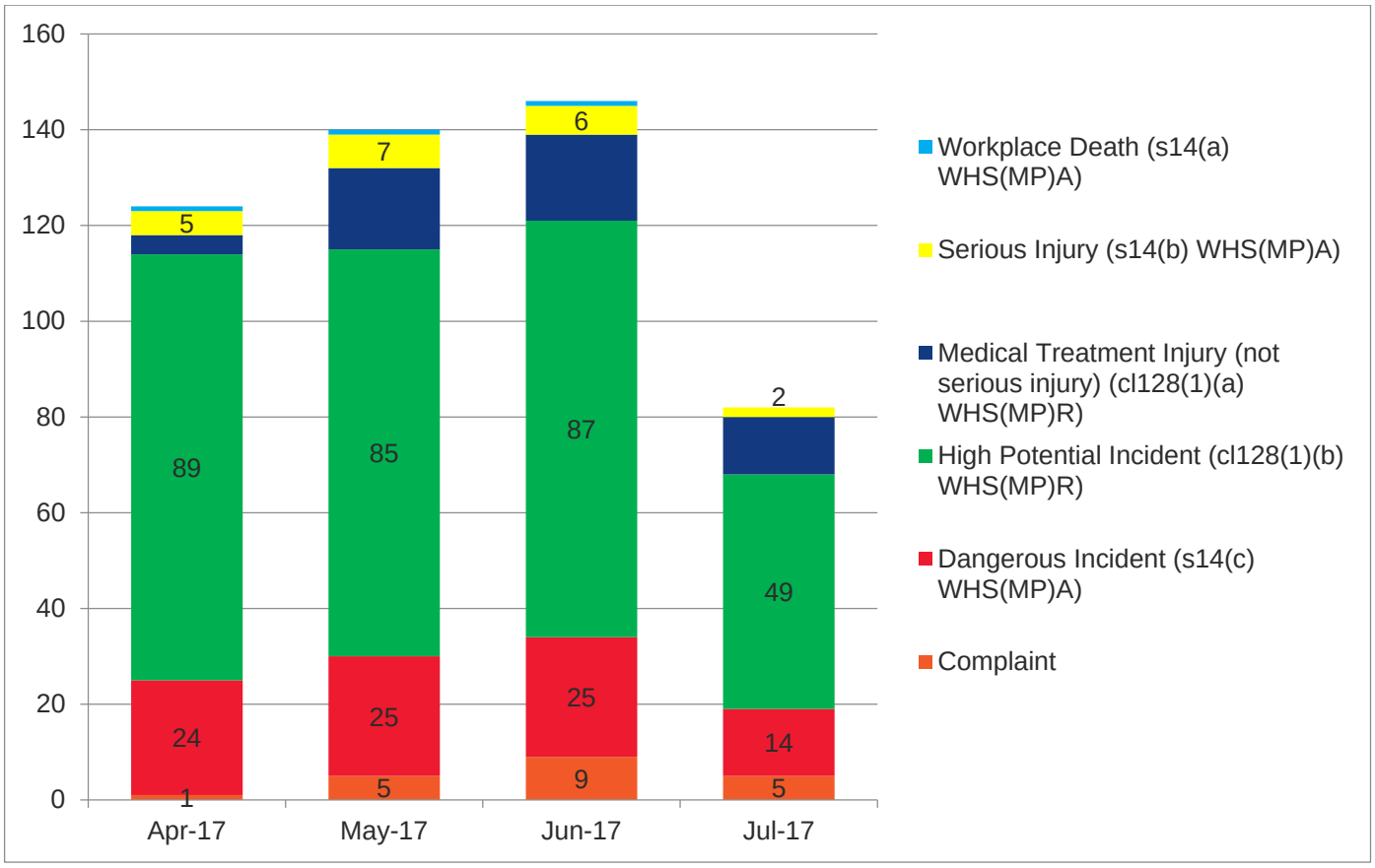
Summarised incidents

Incident type	Summary	Recommendations to industry
High potential incident SinNot 2017/01051	While cutting out of the maingate, the shearer trailing drum lifted 400mm off the floor level while it was changing states. An operator saw the trailing drum lift and stopped the operation to investigate. The mine site has reinstated the original parameters with a full 360 audit (maingate to tailgate/tailgate to maingate)conducted which has proven that the system is now suitable for continued cutting with no further issues.	System software parameters, their access and change must be controlled. The loading of the software and parameters, especially at times of longwall change-out in readiness for wet commissioning, should be undertaken by one person and then verified by another person. Any changes to parameters must be signed off by the appropriate mine personnel before installation and then correct operation of the modified parameters verified before normal operations recommence. Commissioning procedures should ensure all scenarios are considered where the equipment may fail to operate as intended (both in automation and manual). For longwalls, the procedures should also include a full cutting cycle (360 degree) before releasing the shearer back into normal operations. The mine operator should ensure all no-go zones are identified and enforced before the start of commissioning.

High potential incident SinNot 2017/01062	A battery failure in the back-up system for the controls within the surface substation caused the power to the main fans to trip. This resulted in a loss of power to the underground and surface areas of the mine. The mine manager immediately enacted the withdrawal trigger action response plan (TARPs) and withdrew persons from the mine. Once all personnel were confirmed as being withdrawn from the mine, the main fans were restarted in a controlled manner under direction of the ventilation officer but the methane level in the return leading from the longwall rose above 2%, reaching a maximum level of 4.7%.	Electrical protection systems form part of the safety network associated with the safe use of electricity and should have appropriate levels of functional safety. Mine operators should identify all mine critical infrastructure, risk assess it and ensure the electrical power supplies provide a suitable level of reliability.
High potential incident SinNot 2017/01051	The methane level in the longwall return rose above 2% for 45 minutes, with a peak level of 2.17%. The background level was 0.7% before the incident.	Sites are reminded to review their TARPS that are in-place to control these events such that methane does not exceed 2% in areas where persons travel or work as per clause 72 WHS (Mines and Petroleum Sites) Regulation 2014.
Dangerous incident SinNot 2017/01046	A small fire occurred on a truck near the muffler while driving up a decline. The driver noticed smoke and operated the fire suppression system, which extinguished the fire. A piece of combustible waste material (cardboard) that was being loaded onto a truck lodged between the exhaust and the purifier igniting during transportation.	Mine operators should: • maintain housekeeping standards to remove combustible materials so far as is reasonably practicable • verify that fire extinguishers and fire suppression systems are inspected and maintained in accordance with manufacturers' recommendations • review and revise (as necessary) vehicle fire risk assessments with consideration to AS5062. Review control measures for high surface temperatures of engine exhaust components for the prevention of uncontrolled fires.
High potential incident SinNot 2017/01085	An empty haul truck was travelling south-west on a haul road. As the truck neared an intersection, it was travelling about 35kmh when the operator misjudged the distance between the truck and a light vehicle that was giving way to a water truck that was turning into their path. The operator activated the dynamic retard pedal, slowed the speed off the truck and brought it to a stop with a tyre in the road windrow. The distance between the front of the haul truck and the back of the light vehicle was about 15 metres. The condition of the road was normal, the weather was fine and dry and there were	The incident highlights the importance of having an effective risk management program in relation to the interaction of light and heavy vehicles at surface mine sites. It is also a timely reminder to ensure that workers are adequately trained and that the requirements of the roads or other vehicle operating areas principal hazard management plan are followed. Review the report and associated recommendations within: Ravensworth open cut investigation report of a fatality that occurred in November 2013 – Heavy and light vehicle interaction.

	no known defects on the truck.	
Dangerous incident SinNot 2017/01074	Two LHDs collided on the surface of a mine. One LHD was parked up with a worker nearby when the other machine transporting stowage material collided with the parked machine. The impact moved the parked LHD about 400mm.	Underground operations should review their surface transport controls to ensure the risk of vehicle / pedestrian interaction is removed as far as is reasonably practicable. Competent workers and operators should inspect surface transport areas and should be trained in the safe operation and park-up requirements of mobile plant.
Dangerous incident SinNot 2017/01068	A loaded truck was descending a ramp when the operator noticed that the retarder was not holding the truck back. The truck was approaching an intersection and the operator had committed to turn the corner. The driver decided not to brake because he was concerned the truck would roll over. The truck turned wide and hit a noise bund on the left side of road then came to a stop, leaving the truck leaning at a precarious angle.	Speed may have been a factor, with the operation of braking / retard systems not effectively engaged or operated. It is recommended that mine operators review the training of their operators to ensure that mobile plant is operated within its specifications.
High potential incident SinNot 2017/01092	Methane greater than 2% was found at the back of the continuous miner. Power had tripped to the section at the start of the shift, causing loss of auxiliary fan ventilation to the face. The section transformer had tripped on earth continuity.	The cause of the power failure was identified as a harmonics filter on the VSD of the traction system of a shuttle car, placing excessive noise on the earth continuity system. Mine operators are reminded to ensure de-gassing procedures are in place and that they should include methods to purge electrical enclosures from potential explosive concentrations of gas.
Dangerous incident SinNot 2017/01049	Three haul trucks were tipping their final loads at the end of the shift. Other mobile equipment was in the area to gain access to parking. Due to a high volume of radio communication between mobile equipment operators, a mix-up occurred and a haul truck that was reversing hit a light vehicle.	Mine sites should establish safe park-up areas and develop specific controls for the management of vehicle interactions. Take consideration to separating light and heavy vehicles as far as is reasonably practicable, and verify control implementation. Sites are reminded to review their principal hazard management plans.
Dangerous incident SinNot 2017/01079	An articulated dump truck ran off the road and rolled over. The trailer rolled completely over and the cabin went onto its side. The operator was able to exit from the machine and was uninjured.	This type of incident has occurred on numerous occasions across mine sites within NSW. Mine operators are reminded to adopt the hierarchy of control for the management of hazards with reference to this type of incident and confirm the suitability of mobile plant for task. Mine operators are reminded of the Safety Bulletin 17-01, in reference to truck rollovers.

Dangerous incident SinNot 2017/01080	A rear dump truck was returning from the tip head when the operator slowed to make a turn, at this time the 'A-frame' has failed, with the tray of the truck coming to rest on the rear tyres. The operator was rescued from the cab using an elevated work platform and taken to hospital.	People with management or control of large haul trucks should review the adequacy and effectiveness of periodic inspections of axle or wheel location components noting the following: • components need to be properly cleaned before visual inspections for the presence of cracks or developing faults • safe access should be provided to make a complete inspection of identified components. The use and frequency of non-destructive testing techniques should also be considered. Sites are reminded to review their mechanical engineering control plan.
High potential incident SinNot 2017/01015	A load haul dump vehicle failed to shut down when the on/off switch was activated.	Pneumatic cylinders are often single line components in the automatic safety shutdown system of an ExDES making the maintenance, inspection and proof testing of such components critical to the reliability of the safety function. Mine operators with management and control of ExDES that have singular fuel shutdown cylinders should review maintenance practices. Maintenance, inspection and testing should be carried out in accordance with manufacturers' recommendations and with regard to site environmental conditions and experience.



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

- Investigation information release: Flyrock incident at open cut coal mine
- Safety alert: Longwall faces: safe access and emergency exits

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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