Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 6 June 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	47
Summarised incident total	9

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot - 2018/00896	While carrying out maintenance, a winder main skip made contact with a davit arm. The arm had been used to prepare for maintenance and when the winder was operated it struck the davit arm.	Any item that has the potential to enter the shaft or be left in the shaft should have a way of being secured. Checks that all items have been secured should be included in procedures before a winder is returned to service following maintenance.
Dangerous incident SinNot - 2018/00887	A haul truck hit a parked light vehicle. A worker had driven the light vehicle to the front of the parked haul truck. The worker then started to drive the haul truck to a workshop and made contact with the light vehicle. No other person was in the vicinity.	Where light vehicles and heavy vehicles are expected to interact, designated parking areas for each type should be allocated, marked and, where possible, segregated. Pedestrian access and interactions with vehicles should also be considered.

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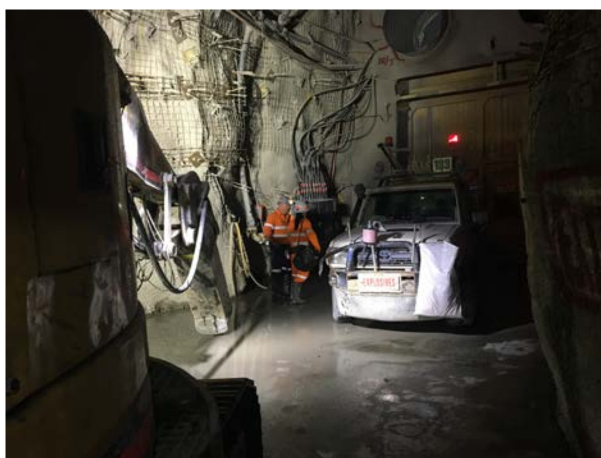
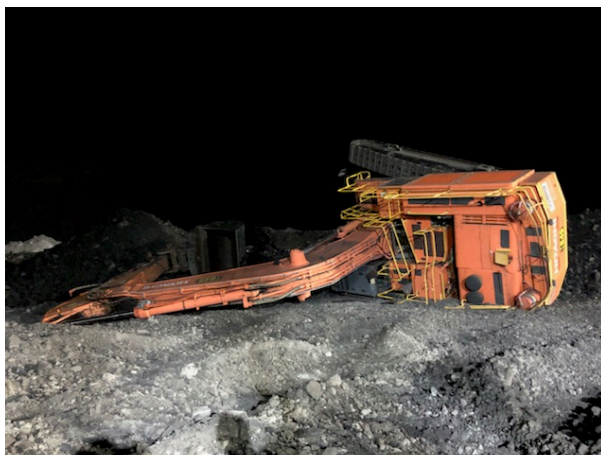
Dangerous incident SinNot - 2018/00879	An excavator was tramming underground when it hit a light vehicle. The excavator was carrying a hydraulic hammer at the time. As it trammed around a corner, the operator did not see the parked light vehicle. 	Mine transport management plans and transport rules should consider the risk of heavy equipment moving around the mine while carrying loads or attachments.
Dangerous incident SinNot - 2018/00877	A large pressure bump occurred in a development roadway. Workers on the continuous miner at the time were peppered workers with coal on a continuous miner. A dust storm followed. The rib moved and parts of the rib were fractured.	All mines must assess the risk and implement specific control measures, following the hierarchy of controls, for mining induced seismic activity (clause 44B WHS (Mines and Petroleum Sites) Regulation 2014).

		Where control measures do not sufficiently control the hazard they must be reviewed and, as necessary, revised.
Dangerous incident SinNot - 2018/00873	A worker suffered suspected neck injuries when an excavator was loading a dump truck. The mounts on a hydraulic tank on the dump truck failed during the incident. 	When conducting risk assessments, developing operational procedures and training packages for consideration should be given to material size and forces encountered during loading.
Dangerous incident SinNot - 2018/00872	An articulated water cart trailer overturned while backing into position to spray cannon on the ROM. The trailer backed onto a windrow and overturned onto right hand side.	There have been repeated cases reported to the Resources Regulator of articulated vehicles overturning recently. The stability of articulated vehicles is a known risk and mines should manage this. Consideration should be given to factors such as (but not limited to):

		→ operating grades → uneven surfaces (holes, rocks, foreign material) → tipping of loads → hang-up of loads → movement of loads → speed of operation → tyre failure → movement of water and unbalancing of loads in water carts. Assessment of safe operation of ATD's will continue to be a priority for the Resources Regulator in coming months
Dangerous incident SinNot - 2018/00860	An excavator overturned while cleaning up a bench. The bench was 1.5m high. 	Equipment operators must maintain situational awareness and remain vigilant of the risk of machine roll overs The circumstances of this incident also underpins the importance of wearing seatbelts as a mitigating control. When planning tasks and travel paths, supervisors must consider roll over hazards.
Dangerous incident SinNot - 2018/00856	A fire occurred underground when a pulley bearing in a loop take-up collapsed. A technician saw smoke while completing an inspection and raised the alarm.	Controls should be in place to monitor for fires on conveyors including: → routine belt inspections

- condition monitoring
- maintenance programs to ensure high standards of housekeeping around these installations
- CO detectors in a designated location
- adequate firefighting equipment available.

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.

Date received	Publication	Issue/topic
29/05/2018	Worksafe NZ	• There have been two recent incidents involving remote control unit failure in mining and quarrying operations that WorkSafe wishes to bring to the attention of the sector. There was no harm caused in either occasion but the potential is high for injuries should recommended steps below not be followed. https://worksafe.govt.nz/about-us/news-and-media/safety-alert-mining-and-quarry-operations-unintended-track-movement-due-to-remote-control-unit-failure/
29/05/2018	HSE	• A construction company has been fined after a tipper vehicle driven by one of its employees came into contact with overhead power lines during the construction of a waste transfer station. We have had similar incidents on our sites. http://press.hse.gov.uk/2018/company-fined-more-than-500k-following-overhead-power-lines-incident/?cr=25-May-2018&eban=govdel-press-release&utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=
01/06/2018	WA dept. of mines	• In February 2017, two underground workers were using an integrated tool carrier (IT) to complete a task at the intersection of a decline and a link drive. To access the work area the IT was parked in the decline with the front of the machine articulated (35°) around the corner of the intersection. The decline had a cross slope angle of 10.3°.

https://gallery.mailchimp.com/b98820d3d212ccdebbb0ad930/files/21ac035a-631e-4248-9e0c-bebef781373f/June_Integrated_tool_carrier_tips_over_underground.pdf

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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