Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 23 May 2018

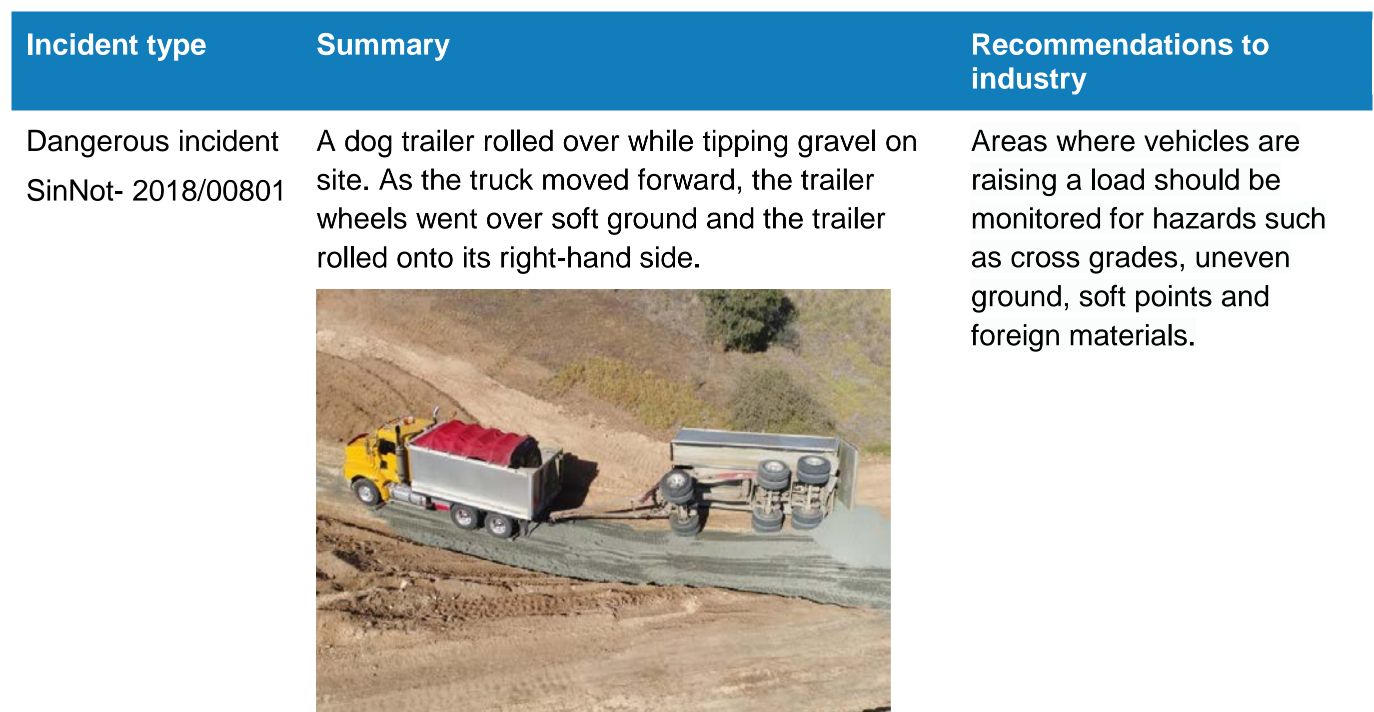
This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the NSW Resources Regulator: phone 1300 814 609 24 hours a day, 7 days a week.

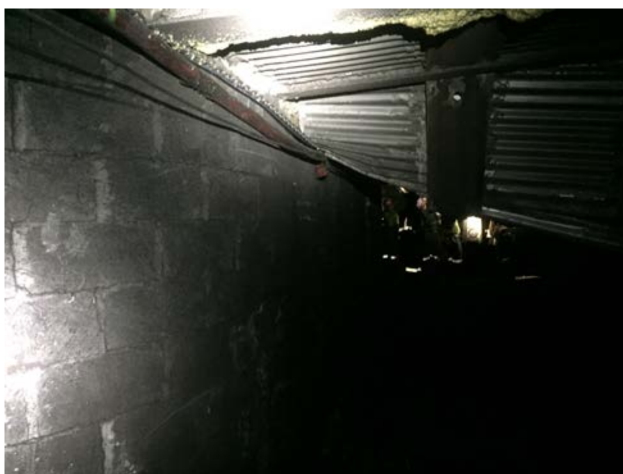
At a glance

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

Type	Number
Reportable incident total	62
Summarised incident total	9

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot- 2018/00801	A dog trailer rolled over while tipping gravel on site. As the truck moved forward, the trailer wheels went over soft ground and the trailer rolled onto its right-hand side. 	Areas where vehicles are raising a load should be monitored for hazards such as cross grades, uneven ground, soft points and foreign materials.

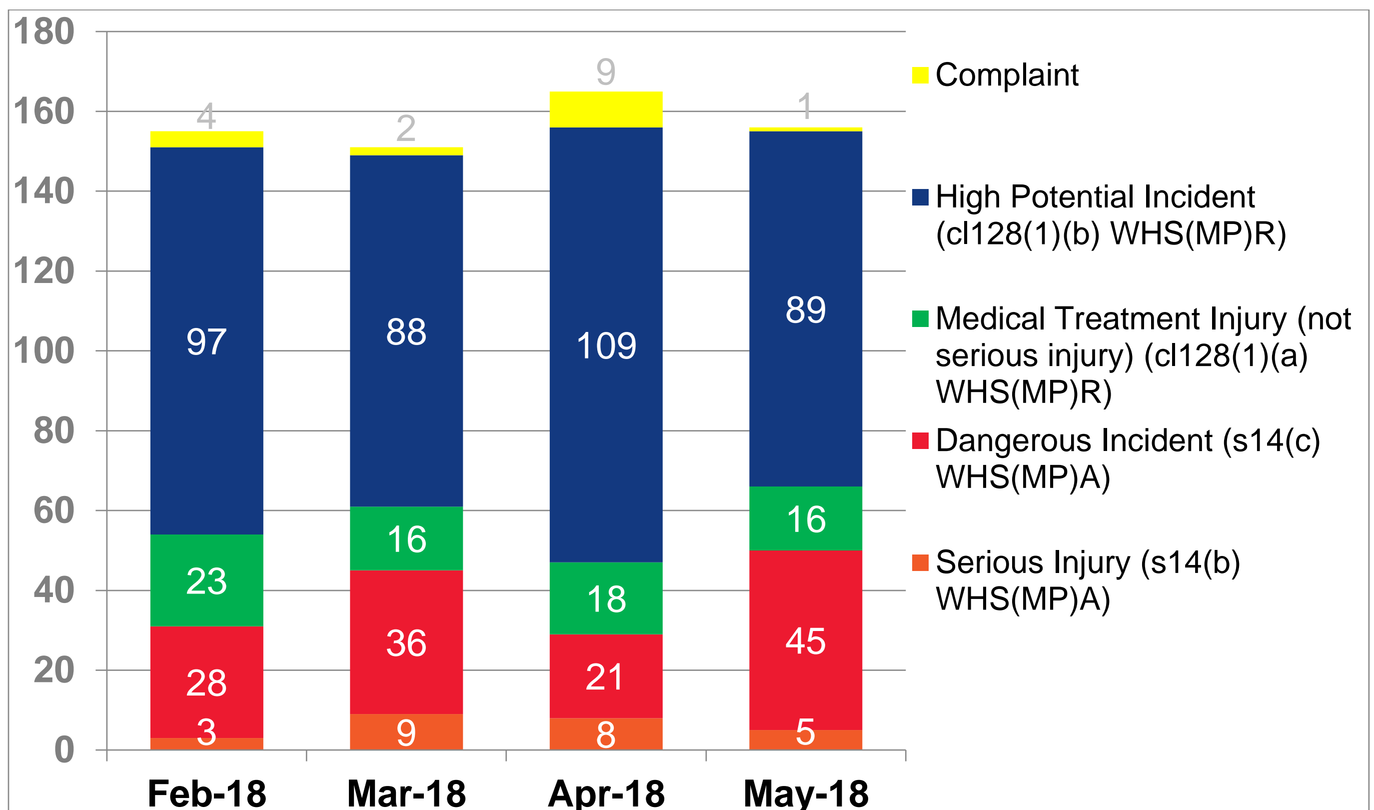
Dangerous incident SinNot- 2018/00796	A ventilation overcast and compressed air line were damaged when they were contacted by a shuttle car being towed by a LHD. The overcast was pulled down as a result of the contact. The overcast was part of ventilation circuit to waste areas, and ventilation to working parts of the mine were not impacted. 	Before relocating large equipment in underground mines, a profile run should be undertaken to protect mine infrastructure from damage during the task.
Dangerous incident SinNot- 2018/00793	A service truck and front-end loader collided. The truck entered the loader's work area and incorrectly anticipated the loader movements. No positive communication was conducted. 	Safety bulletin [SB18-06 Lack of positive communications] was published in April 2018. This alert addresses this incident. Positive communication systems need to include all workers on site including contractors.

Dangerous incident SinNot- 2018/00789	A operator was unable to safely exit from the cab of their loaded haul truck for three hours after inadvertently hitting the brake or accelerator pedal, causing the truck to tip up and sit on the rear of its tray. The truck was queued on a ramp and started to roll backwards. The operator initially failed to detect this movement and reacted suddenly. The operator reported they may have had a micro-sleep. 	Schedule 2 of the Work Health and Safety (Mines and Petroleum Sites) Regulation 2014 includes the requirement that the health control plan must address fitness for work, which includes fatigue.
Dangerous incident SinNot- 2018/00781	An articulated water cart hit a tree. The operator exited the machine, it then rolled forward 10 metres into the tree. 	The principal hazard management plan for roads or other vehicle operating areas should include procedures detailing the requirement that mobile equipment is parked fundamentally stable.
Dangerous incident SinNot- 2018/00779	An articulated dump truck has rolled. The truck was tipping its load when the incident occurred.	Areas where vehicles are raising a load should be monitored for hazards such as cross grades, uneven ground, soft points and foreign materials. This is the 22nd reported roll-over of articulated dump truck

		in the past 12 months, and has been the subject of recent safety alerts. The Resources Regulator considers this trend is intolerable and will be undertaking a focused compliance campaign on the operation of all terrain dump trucks over the coming weeks, with a zero-tolerance approach to less-than-adequate operating procedures and potentially defective plant.
Dangerous incident SinNot- 2018/00775	A fire occurred in the loop take-up of a trunk conveyor. The cause of the fire was identified as a collapsed return roller. 	Failure of conveyor idlers is a known risk. Controls should include: 1. routine belt inspections where the focus is on thoroughly completing the task 2. condition monitoring 3. CO detectors in a designated location.
Dangerous incident SinNot- 2018/00773	A collision occurred between a grader and haul truck. The grader was travelling down a ramp when the operator reported to have had a micro sleep and travelled toward the haul truck travelling up the ramp. The front of the grader made contact with the sidewall of the truck tyres.	Schedule 2 of the Work Health and Safety (Mines and Petroleum Sites) Regulation 2014 includes the requirement that the health control plan must address fitness for work, which includes fatigue. Segregation between vehicles travelling in opposite directions should be

considered when developing the principal hazard management plan for roads or other vehicle operating areas.

Serious injury SinNot- 2018/00770	An owner/operator of an opal mine fell 10 metres down a shaft, hitting the hoist bucket and suffering serious injuries.	A method of safe access and egress should be provided to all workers at mines.



Other safety publications of note

Date received	Source	Topic/s and suggestions
18/5/2018	MinEx Safety Alerts NZ	→ An employee was using a portable high pressure hydraulic pump to power a hydraulic ram to push links apart on a track chain. The hose-tail failed at the hose tail crimp, whipping back striking the employee on the left eye. Despite wearing safety glasses, the employee lost sight in the left eye. https://gallery.mailchimp.com/b98820d3d212ccdebbb0ad930/files/815d4db8-5848-45da-b409-b63b4566bb20/Working_with_high_pressure_hydraulic_hoses.pdf → Fatigue related death: Employer found guilty under sections 36(1)(a), 48(1) and (2)(c) of the Health and Safety at Work Act (NZ) 2015. https://worksafe.govt.nz/about-us/news-and-media/tractor-driver-had-worked-almost-200-hours-in-the-fortnight-leading-up-to-his-death/ → **Surface – Limestone**– On April 5, 2018, a concrete pumper truck contacted a 13.2 KV overhead powerline. The powerline broke and fell on the cab of a tractor trailer truck. The driver of the tractor trailer remained inside the cab of the truck until the powerline was de-energized. This close call accident resulted in no injuries. https://gallery.mailchimp.com/b98820d3d212ccdebbb0ad930/files/fb061ca2-69ab-4d55-ab2d-c372a482a0a4/May_Surface_Powerline_May10.pdf
17/5/2018	HSE	→ A dump truck was parked at a slight incline on a heap of excavated soil, adjacent to a partially backfilled trench. The dumper had been left unattended with the engine running when the failure of its handbrake caused it to roll forward into the trench and pin a worker against a pile of stacked concrete blocks. The worker suffered six broken ribs, a collapsed lung, multiple arm fractures and a broken nose. http://press.hse.gov.uk/2018/construction-company-fined-after-employee-crushed-by-dumper/?cr=10-May-2018&eban=govdel-press-release&utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=
18/5/2018	MHSA	→ On April 19, 2018, a miner was trouble shooting an electrical issue on a skid mounted control centre for a pumping system when they came in contact with 4160 volts. The miner appeared uninjured but was hospitalized overnight for observation.

		https://www.msha.gov/mnm-serious-accident-alert-surface-electrical → **METAL/NONMETAL MINE FATALITY –** On December 30, 2017, an employee in a pickup truck approached the quarry loadout area to get the front-end loader (FEL) operator for lunch. The FEL backed into the pickup, pushing it sideways and crushing the driver's side of the pickup cab, trapping the victim inside the truck. The pickup truck caught fire and efforts by the FEL operator and a nearby contractor to put the fire out using fire extinguishers were not successful. https://www.msha.gov/data-reports/fatality-reports/2017/fatality-13-december-30-2017/final-report
25/5/2018	MinEx Safety Alerts NZ	→ A sub-contractor was tipping a load of waste product from recent storm damaged roads, when the load shifted putting extreme pressure on the single lift ram. The ram broke and hit the truck cabin, smashing the rear window. No-one was hurt in the incident. https://gallery.mailchimp.com/b98820d3d212ccdebbb0ad930/files/6f42d7a4-c2a5-4e90-aea2-8054971f96d2/Tipper_ram_breaks.pdf → See attached incident summary report from QLD mines.

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.

Office use only	
CM9 reference	DOC18/330522
Mine safety reference	ISR 18-20
Date published	29 May 2018