Weekly incident summary

Planning & Environment
NSW GOVERNMENT Resources Regulator

Week ending 22 November 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	38
Summarised incident total	7

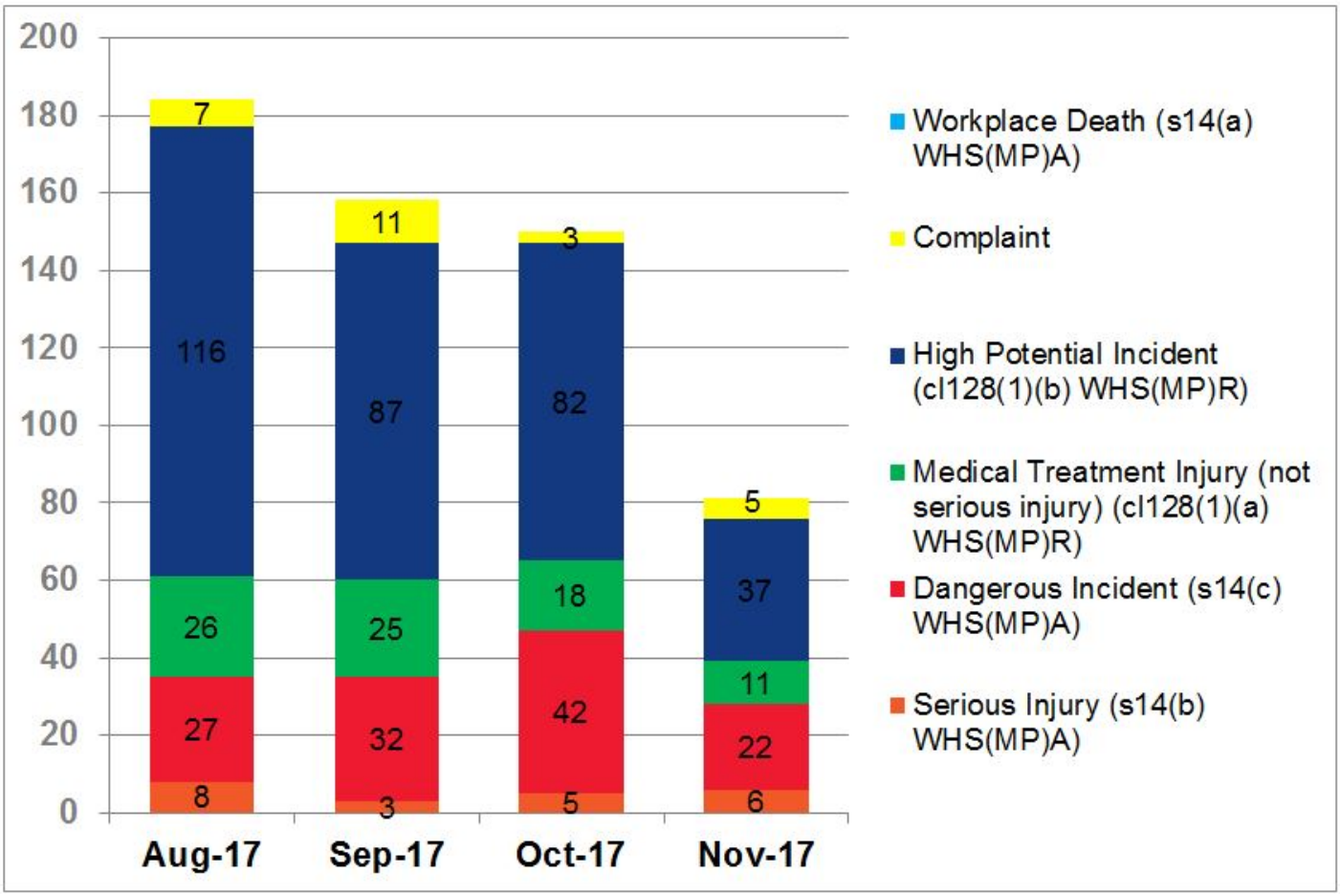
Summarised incidents

Incident type	Summary	Recommendations to industry
Serious injury SinNot-2017/01849	An electrician involved in the installation of a water treatment plant was rolling cable off a drum and wedged his left arm between the rear of the ute tray and the drum. His arm was broken and he was taken to hospital for treatment. 	Mine operators should have systems in place that allow for recognition of changes to tasks resulting from damaged or defective equipment Supervisors should continually review hazard awareness of all workers, especially when equipment is damaged and how this can change its normal performance. Workers should always consider if they are placing parts of their body in a place of potential harm.
Dangerous incident SinNot-2017/01836	An operator was using a front end loader to clean up around a haul truck when he reversed into a truck. A cover was damaged on the loader, which then moved forward and cracked the back window. 	Mine operators should have systems in place that manage risks associated with equipment working in close proximity to other plant and structures When mobile plant is operating in close proximity, equipment operators should remain in continual communication and maintain an awareness of the other's position. Workers should be trained in site-specific procedures relating to working in close proximity to other plant and structures. Regular site safety observations should be

		performed by supervisors to ensure compliance with site procedures. When reversing mobile plant, operators should check down both sides as well as to the rear of the equipment. The use of proximity awareness systems such as cameras and alarms may assist vehicle operators. **Refer to:** MDG 2007 - *Guideline for the selection and implementation of collision management systems for mining*
Dangerous incident SinNot-2017/01833	An operator stopped at a diesel tag board and smelled something unusual and discovered flames coming from under a steel cover at a conveyor boot end. The operator hosed the area with water and removed the cover to make an inspection to ensure the fire was fully extinguished. 	Mine operators should ensure the following are in place for conveyor systems at their mine: • Conveyor pulleys are designed with the appropriate life for the intended duty. • Carbon monoxide monitoring or particulates of combustion sensors are be installed in appropriate locations to assist in the early detection of fire and heatings • Alarm set points and trigger action response plans should be developed that suit each installation • A water source is readily available to quickly extinguish a fire at any place along a conveyor belt • Conveyor inspections are undertaken regularly • Temperature for head and tail pulley bearings. Consider the applicable recommendations in MDG 1032 *Prevention of coal mine fires* and AS/NZS 4024.3611 **Refer to:** • Mechanical engineering control plan code of practice • MDG 1032 Guideline for the prevention, early detection and suppression of fires in coal mines • AS/NZS 4024.3611 Safety of machinery, Conveyors – Belt conveyors for bulk material handing is incorporated into the mechanical engineering control plan code.

Serious injury SinNot-2017/01831	A drill rig off-sider was hit in the face by a haul plug resulting in a fractured cheek bone and broken nose. He was taken to hospital for medical attention. 	Mine operators should review the safe standing zones associated with drilling tasks.
Dangerous incident SinNot-2017/01829	A shaft winder tripped a limit, stopping it approximately 5 m below the No 9 level plat. One worker was in the man cage at the time. He was not injured. The site's mines rescue team was activated. A ladder was used to extricate the worker from the man cage.	Mine operators should review the preventive maintenance strategies relating to winder controls, including all field devices. This should include regular testing of all equipment and safety devices. Before resetting winder faults, a thorough investigation should be completed by a competent person. Mines should review winder risk assessment and operating procedures to ensure emergency scenarios are adequately addressed. This is especially important for scenarios where workers are in the cage when there is a failure of the winder control systems. Mines should review their emergency management plans to include if and when external rescue resources are notified and mobilised for different scenarios.
Dangerous incident SinNot-2017/01825	A trained worker doing routine clean-up of plant on a stable, concrete surface misjudged the corner of the concrete edge when backing up. In the process of turning the bobcat, the back right wheel rode up onto the concrete curb putting him at an imbalance point. As he tried to correct and drive off he overbalanced and the bobcat and rolled onto its side. Other workers righted the bobcat to stop and contain further oil spills.	All mine operators should consider how they train workers on positional awareness and the potential hazards associated with lapses in concentration.

		
Dangerous incident SinNot-2017/01814	The operator of a water truck was operating the truck when she smelled something unusual. The operator pulled the truck over on the go line, applied the park brake and turned the machine off. At this time she heard a 'pop/bang' sound, as did a plant mechanic who was in the vicinity of the area at the time. The hold-down cover was not an original equipment manufacturer-supplied part and did not have provision to prevent the movement of the battery under the plate. This has resulted in the battery terminals shorting to the cover plate and overheating two of the batteries. 	Mine operators should review their preventive maintenance inspection plans for machinery that has a battery system on board as to the standard of how the battery or batteries are retained. The potential hazards associated with electrical faults associated with batteries should be clearly conveyed to the workforce.



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.

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RM8 reference	PUB17/864
Mine safety reference	ISR 17-46
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