Weekly incident summary

Planning & Environment
NSW GOVERNMENT Resources Regulator

Week ending 18 October 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	34
Summarised incident total	10

Summarised incidents

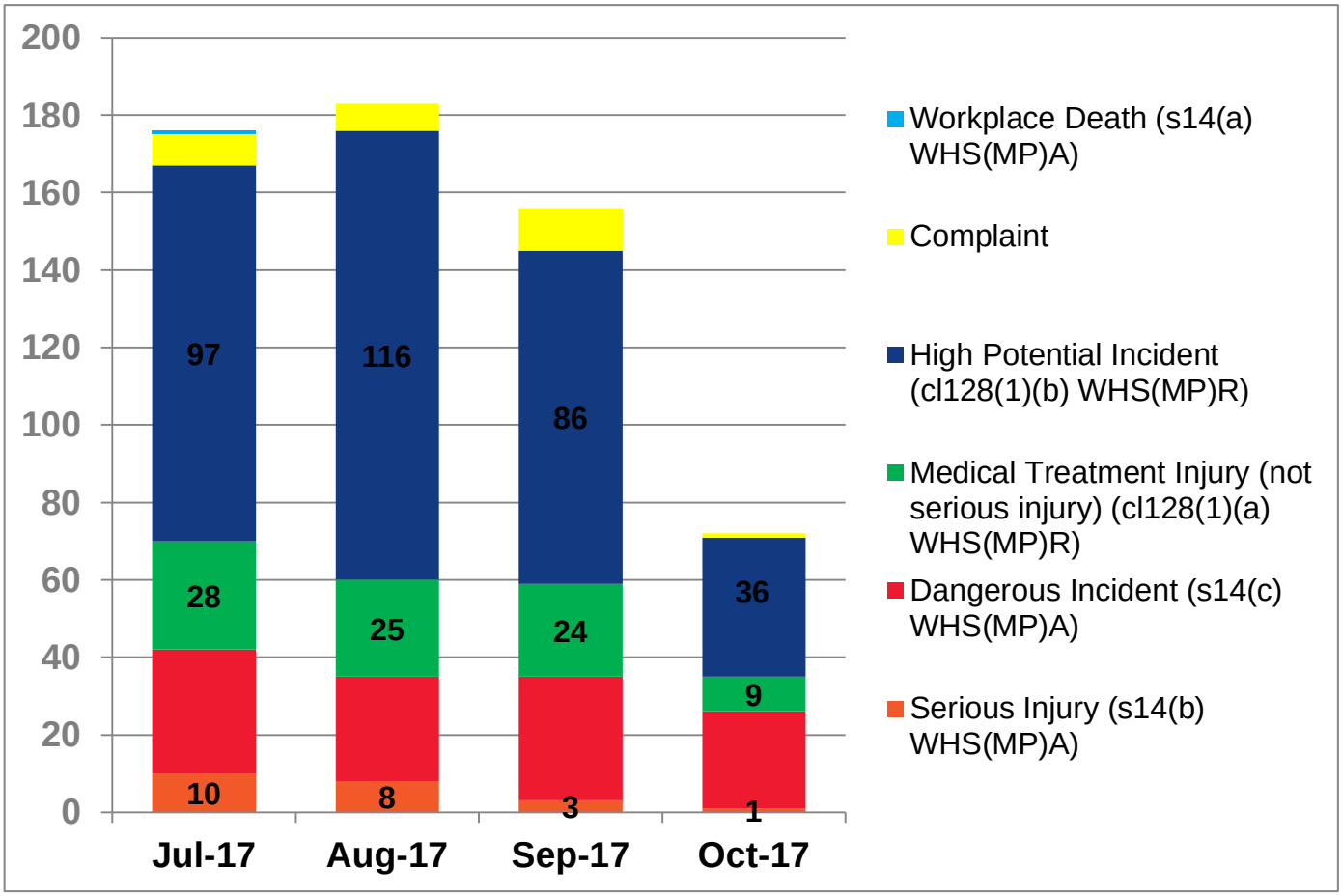
Incident type	Summary	Recommendations to industry
Dangerous incident SinNot 2017/01651	A run of mine (ROM) coal stockpile was showing signs of spontaneous combustion. A dozer was being used to push coal. The operator drove the dozer to the top of the stockpile. The dozer then slid down the stockpile sideways approximately 2.5 m. The operator suffered some bruising from the seat belt. The operator was experienced with dozers, however he was not experienced with ROM coal stockpiles. The incident was reported as a high potential, however it should have been reported as a dangerous incident. 	Operators are reminded of the potential hazards associated with a dozer on a stockpile. The recommendations in MDG28 Safety for stockpiles and reclaim tunnels should be considered. Dozer operators should have appropriate experience for the task. Mines should ensure all supervisors and workers are trained to identify and notify incidents when a notifiable incident occurs. A dangerous incident (as prescribed in cl179 of the WHS (MPS) Regulation 2014) must be reported immediately to 1300 814 609 and the incident site must be preserved until an inspector arrives on site or otherwise directed by a government official from the regulator.

Dangerous incident SInNot-2017/01662	A supervisor was driving a light vehicle from a pit office area to the stores. While driving up hill and turning a corner, the driver went to apply the brake but accidently applied the accelerator. The vehicle hit a bund between the car park and store access road and rolled the vehicle on to its side.  	Light vehicle operators should consider the potential issues that may affect their foot controls while driving light vehicles, such as clothing and footwear. Seat belts should be worn at all times. Site speed limits should be enforced.
Dangerous incident SInNot-2017/01661	A fitter jump-started a light vehicle that had a flat battery. The vehicle was parked outside a workshop. The fitter walked back to the workshop to return the jumper leads. While he was away from the vehicle, it rolled about 30 m and collided with an articulated water truck. When the fitter came back from the workshop and noticed the vehicle had rolled away and hit the water truck, he ran to it and stopped the engine, put it in gear and applied the handbrake. 	Park-up procedures for light vehicles should be reviewed, especially when workers are in or around the light vehicles. Procedures should consider: • the use of wheel chocks • stable parking. Personal risk assessments should consider gravity as a hazard. Refer to safety bulletin SB13-02, Unplanned movements of vehicles - too many near misses
Dangerous incident SInNot-2017/01663	The operator of a fully loaded truck saw flames coming from a resistor grid box. The operator stopped the truck and activated the e-stop and fire suppression system. The fire suppression system didn't adequately reach the resistor grid box to fully extinguish the fire so a water truck was called to apply water, which ultimately	Resistor grids of haul trucks operate at very high temperatures. It is important that these areas be correctly maintained and and kept free of rubbish and debris Electrical faults, loose electrical connections and damaged electrical wiring are common fire sources on mobile plant. Mines should implement systems that consider the electrical wiring

	extinguished the fire.	recommendations of *AS/NZS 4871.6:2013: Electrical equipment for mines and quarries - Diesel powered machinery and ancillary equipment*. Fire risk assessments, detection and suppression on mobile plant should be in accordance with *AS 5062 Fire protection for mobile and transportable equipment*.
Dangerous incident SinNot 2017/01647	A truck operator parked and checked that the truck was fundamentally stable. The operator then climbed down from the truck and the truck started to roll forward. The operator climbed back up the ladder and entered the cabin where the operator used the foot brake to stop the truck. The operator then moved the truck to another, flatter location before reporting the incident.	Mine operators should: • review 'park-up' procedures in relation to what is considered 'fundamentally stable'. This should also include ensuring the machine's park brake is on • retrain mobile plant operators on parking 'fundamentally stable' • conduct periodic site audits on site park-up procedures. Where possible, consideration should be given to means to automatically apply the park brake when the operator leaves the control position.
Dangerous incident SinNot 2017/01643	A driller and offsider were preparing to move a drill rig to a new hole, however the jump-up stand and rod rack were interacting. The drill rods were moved from the rod rack up against a wall to allow the rod rack to move. While the driller was positioning the rod rack, the offsider was using timber to level the rig. During this process the leg of the rod rack made contact with the drill rods positioned on the wall behind. As a result, the 13 drill rods where knocked over and fell onto the jump-up stand and onto the ground. The offsider was also hit by the rods. The offsider suffered bumps and contusions to his wrist and leg.	Mine operators should: • have procedures for the movement of drills that consider rod management • conduct worker training in hazard identification that should include those hazards presented by gravity • have fit-for-purpose drill rod handling equipment.
Dangerous incident SinNot 2017/01641	A mining truck was tipping competent material (stone) at the tip head when the operator thought the rear wheels dropped down. The operator asked the dozer operator who confirmed the rear wheels had dropped approximately 0.5 m.	Mine tipping procedures should include appropriately designed 'windrows' as a control. Ground stability should be considered in planning the dump site. Adequate lighting should be provided when tipping occurs at night.
Dangerous incident SinNot 2017/01640	A coal burst occurred in a development unit. The unit stopped and workers were removed from the area. The area was	Mine operators are reminded of the obligations under WHS (MPS) Regulation 2014 clause 44B – Mining induced seismic

	secured and the workers were uninjured. A large scale 'pressure bump' resulted in the displacement of coal from the rib over a distance of approximately 3m. Workers at the face observed the ejection of coal, however did not immediately recognise it as a coal burst. An independent geotechnical engineer and the mine's geotechnical engineer inspected the area and determined the incident to be a coal burst. Normal mining production was taking place at the time. The area is heading towards the swamp fault zone and had reduced the spacing's between the cutting test as per the mine's plan. A cutting test was taken 1 m before and was deemed to be okay. 	activity. The predictability of coal burst is not precise and, as such, mine operators should consider that where an increased coal burst potential has been identified, due to the presence of geological structure or change in stress regime, control measures should be implemented that remove workers from the place of risk. Refer to: - IIR16-05 Austar coal burst - Double fatality at Austar Coal Mine on 15 April 2014
Dangerous incident SinNot 2017/01629	An IT (integrated tool) carrier was travelling down the bank of a tailings dam. The machine lost brakes at the top section and the operator continued to steer the machine with increasing speed. The operator jumped from the machine which continued out of control through a windrow and dropped a further 10 to 12 vertical metres where the it rolled over, coming to rest on its side.	Mine operators should: • provide fit-for-purpose windrows as a mitigated control when an operator has lost control of their mobile plant • ensure brake systems remain functional • ensure pre-start checks include brake functionality • ensure operators are trained in

		emergency procedures. Refer to: SB17-01 Industry reports more truck rollover incidents. SB10-03 Mobile plant - safety critical systems SA06-12 Maintenance of Safety Critical Systems - Braking, Steering & Warning Systems
Dangerous incident SinNot 2017/01628	A loaded mining truck had completed loading and was leaving the loading area when it collided with another unloaded mining truck that had just travelled down the ramp. The collision occurred at the base of a ramp. 	Mine operators should review procedures and policy in relation to: • their procedure for 'clear communication' between heavy vehicles and light vehicles • the human and organisational factors that may come into play where there are interactions between heavy vehicles.



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

- In-service fires on mobile plant
- Safety Bulletin SB06 Safety helmets- effective working life
- Case study looks at human and organisational factors
- TAP Consolidated report – exposure to dust in underground coal mines
- Mechanical engineering safety seminar – presentations now available to view and download

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