Weekly incident summary

Planning & Environment
NSW GOVERNMENT
Resources Regulator

Week ending 11 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	37
Summarised incident total	8

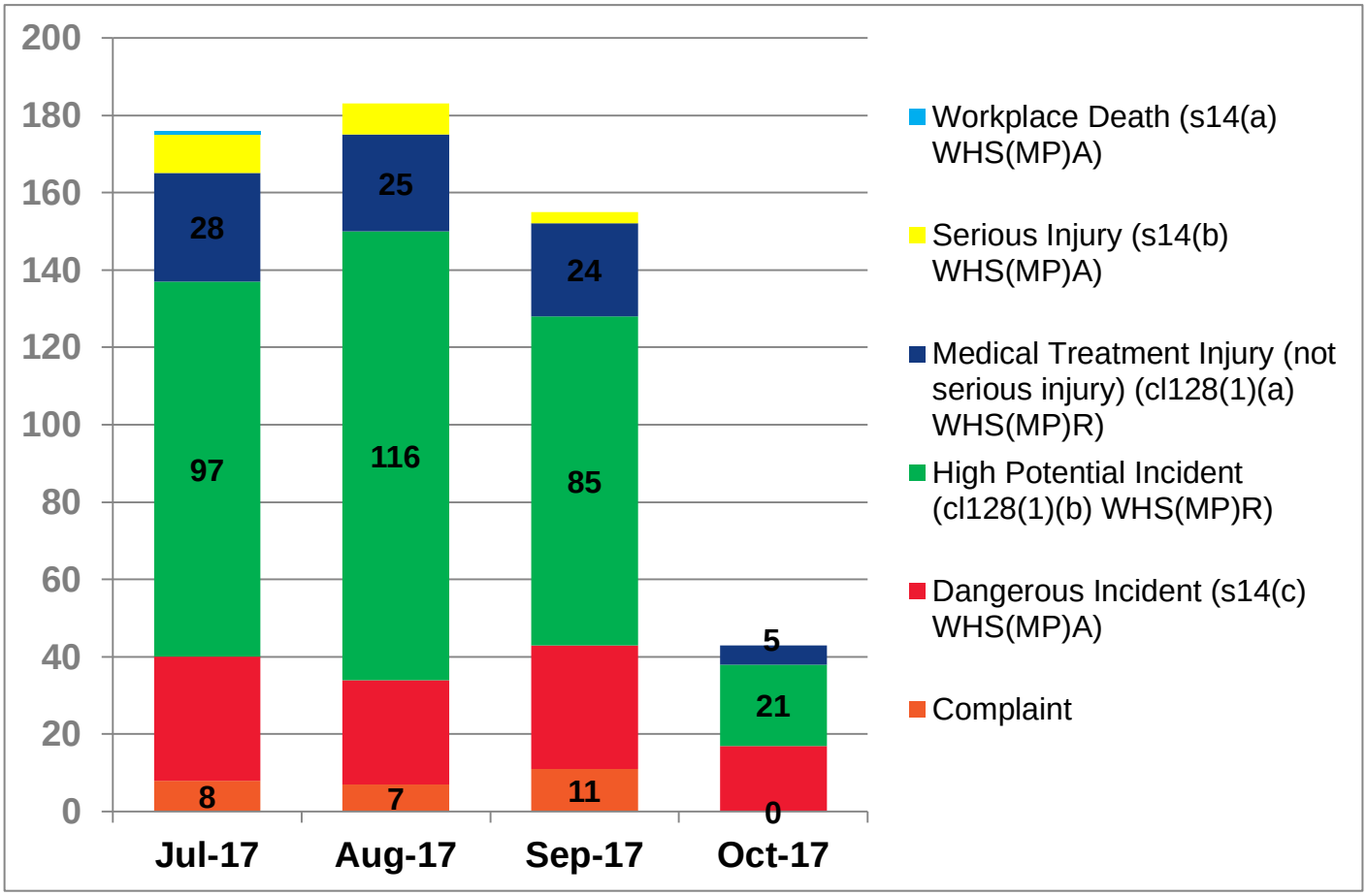
Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot 2017/01622	While an excavator was in the process of moving a 3 m log from sand in a pit, the log slipped and went through the excavator windscreen. It landed on the cabin travel controls. The operator suffered minor lacerations to his fingers. 	Mine operators are reminded to use the hierarchy of controls when considering risks associated with repetitive tasks. Mine operators are also reminded to reassess the risks when circumstances change and consider whether equipment is fit for purpose. Operators should consider the recommendations in Safety Alert SA 05-04 Injury to excavator operator.
Dangerous incident SinNot 2017/01620	A truck was driving under a coal handling preparation plant bypass coal bin while the tray was up. The track hit the beam on the coal bin.	Mine operators should review the procedure for response to truck tray-up alarms and ensure that this is included in their truck operator training packages. Mine operators should ensure, through pre-start and other periodic inspections, that engineering controls, alarms and warning devices are operating correctly before operating plant. Refer to section 4.2 of MDG 15 *Guideline for mobile and transportable equipment for use in mines.*

Dangerous incident SinNot 2017/01611	An operator of a dump truck fell asleep on a haul road. There was no other traffic at the time and no injuries were reported. The truck ran over some poly pipe in a culvert. The driver passed fitness-to-work testing.	Mine operators should review their fitness-for-work and fatigue procedures. A review of compliance with road design rules, especially windrows, should be considered. Mines should ensure windrows are installed and are of sufficient height to stop mobile plant if it becomes uncontrolled.
Dangerous incident SinNot 2017/01610	The operator of a haul truck was lowering his tray after dumping a load when the tray suddenly slammed down to the bump stops. The lower retaining bolts of the left hand cylinder retainer may have failed, causing the cylinder to fall off when lowering. An on-site audit of other haul trucks revealed more loose bolts on the cylinder retainers.	Mine operators should review the maintenance programs associated with haul trucks according to the original equipment manufacturer (OEM) recommendations. Maintenance and inspection frequency may need to be increased depending on the site's environmental or operating conditions. Relevant OEM information for torque settings, lubrication or thread locking compounds and lock washers should be provided to maintenance personnel. Torque wrenches used for servicing should be calibrated.
Dangerous incident SinNot-2017/01609	An operator using a shotcrete rig was preparing the machine for a maintenance task to repair a fault on the nozzle on the boom. While operating the remote control, a spring return to centre control overshot resulting in the boom moving unexpectedly and the boom / nozzle hit the side of the operator's head. The operator received treatment in hospital for head injuries.	All mine operators should review procedures for operating and moving machinery to ensure that no-go zones are identified and appropriate for the activities that may be required to be undertaken, including maintenance activities. The risk of injury to an operator from being in the line of fire as a result of an unplanned movement must be considered. The hierarchy of controls must be used to control the hazard.
Dangerous incident SinNot-2017/01608	An operator of an underground haul truck noticed sparks coming from the engine bay area of a concrete agitator. The truck operator immediately notified the agitator operator, who stopped. The fire was extinguished using a hand-held extinguisher.	Fire risk assessments should be carried out for mobile plant that is operated at mines. The fire risk assessment should consider guidance in *AS 5062:2016 Fire protection for mobile and transportable equipment*. Good maintenance practices are essential in preventing the ignition of combustible fluids from hose or pipe failures. Hoses should be segregated from hot surfaces with the surface being protected. Surface heat must be minimised and fire resistant fluids should be used, where possible.
High potential incident SinNot 2017/01595	When hoisting, a skip trip in the head frame occurred. The skip tipped and the cylinder pushed the skip back into bridle, then the skip descended to the guides. The skip became caught and the winder tripped out. The winder driver heard a	Mines with winders should consider the type and adequacy of shaft and winder inspections, including: • ropes and attachments • guides to identify damage or areas

	bang and stopped to look at what happened. Upon inspection, the cylinder didn't finish pushing the skip into bridle before the bridle descended. The skip wear plates (herring bone liners) allowed rocks and material to build up to the point where rocks jammed the skip door. The push plate became caught on the lip of the chute, jamming the conveyance. The site modified the liners and repositioned the retract cylinder and proximity switch to ensure the skip was pushed and monitored into the bridle once tipped.	where a conveyance may bind or become stuck • maintenance requirements in accordance with the original equipment manufacturer recommendations • testing of safety-related functions in a manner and frequency as required by the designer.
High potential incident SinNot 2017/01619	Ten 3300V phase condition indicators were sent to a licensed repairer for an overhaul. The licensed repairer advised that all of the phase condition indicators did not meet the requirements of approval MDA Ex.d 1319 in that one of the minimum flamepath dimensions specified on the drawing was not met.	The operators of underground coal mines using this equipment should have all plugs that are approved under MDA Exd 1319 verified as complying with the approvals applicable to these plugs. Documentation showing the actual dimensions, not just pass or fail, should be retained in the verification dossiers for this equipment. Where documentation is not available to show actual flamepath dimensions, plugs approved under this MDA must be removed from service.

Editor's note: In the Weekly Incident Summary for the week ending 4 October 2017, the email sent to subscribers incorrectly said that a mine had not immediately reported an incident involving a near-miss between a light vehicle and a heavy vehicle to the regulator. This was a copy transfer error on the email version only. The mine did notify the regulator of the incident mentioned correctly.



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

- IIR17-13 Final investigation report into fatality

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RM8 reference	PUB17/727
Mine safety reference	ISR 17-40
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