Weekly incident summary



Week ending 25 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.

Туре	Number
Reportable incident total	32
Summarised incident total	8

Summarised incidents

Incident type	Summary	Recommendations to industry
Incident type Dangerous incident SinNot 2017/01696	rous incident An articulated dump truck trailer (body) of	 Hazard: Gravity Risk: Harm to people from falling elevated machine components. Recommendations: Consider the proximity to a stockpile creating uneven ground when truck operators are attempting to tip a load. Use level sensors to alert an operator or prohibit tipping on uneven ground. Ensure tyre pressures are correct and the suspension system is in good condition. Refer to:
		Refer to: SB17-01 Industry reports more truck rollover incidents SA03-01 Articulated dump truck rollovers

Dangarous incident	A mining houl truck operator reportedly	Hazard: valacity/ipartia of vahicles
Dangerous incident SinNot 2017/01695	A mining haul truck operator reportedly lost steering. After trying to turn both ways	Hazard: velocity/inertia of vehicles. Risk: harm to people from the unexpected
SinNot 2017/01695	he applied the brake. The truck ran into a	movement of mobile plant.
	windrow.	Recommendations:
	and the second se	The steering system is a safety critical system that is fundamental to the safe operation of mobile plant.
		 Steering systems should be maintained to achieve the highest degree of reliability over the mobile plant's lifecycle.
		 Steering systems should be maintained in accordance with the original equipment manufacturer's (OEM) information.
		 Assess steering failure risks by considering failure modes of steering systems.
		• Carry out daily prestart safety checks.
		Mobile plant operators should be familiar with emergency procedures.
		Install windrows as a mitigation control.
		Refer to:
		SB10-03 Mobile plant - safety critical
		systems
		SA06-12 <u>Maintenance of safety critical</u> <u>systems - braking, steering and warning</u> <u>systems</u>
Dangerous incident	A mulching machine and water cart were	Hazard: kinetic energy (velocity) of object.
SinNot 2017/01683	clearing scrub and timber. As the water cart returned from refilling and re-entered	Risk: harm to people by being struck by a moving object.
	the work area, a piece of wood about the size of a softball ejected from the mulcher	Recommendations:
and travelled about 30 m be water cart's windscreen at t head height. The result was	and travelled about 30 m before hitting the water cart's windscreen at the operator's head height. The result was a smashed windscreen, with no glass entering the cabin.	• Risks to health or safety at mines must be managed in accordance with clause 9 the Work Health and Safety (Mines and Petroleum Sites) Regulation. The risk assessment should identify hazards associated with the operation of mulchers and identify the controls required to manage the risks.
		• Mulchers should have guards that prevent objects being ejected, as well as preventing people being drawn into the mulcher.
		 Mulchers should only be used on material as specified by the OEM and in accordance with the OEM information

		Refer to:
		SafeWork NSW code <u>Managing the risks</u> of plant in the workplace
Dangerous incident SinNot 2017/01675	<text></text>	 Hazard: gravity. Risk: harm to people from elevated structures falling. Recommendations: Where mobile plant can pass under building infrastructure, height signs must be clearly displayed. Where there is potential contact between the structure and the mobile plant the risk must be well managed. This may include access control systems such as height bars or dangle bars, adequate signage and other warning systems. Truck operators should be trained on site traffic routes. Refer to: SA04-03 Dump truck trays hit overhead structures
Dangerous incident SinNot 2017/01674	On a shift change, a light vehicle carrying five people was travelling along a haul road towards an intersection near a crib hut. Travelling in the opposite direction was a mine haul truck. The haul truck turned into the crib hut, which was across the path of the vehicle. The light vehicle driver did not identify the haul truck was intending to turn. The light vehicle driver braked and skidded, resulting in a near miss. The haul truck operator also braked, coming to a stop.	 Hazard: velocity/inertia of vehicles. Risk: harm to people from collision between heavy vehicles and light vehicles. Recommendations: This incident highlights the importance of having an effective risk management program in relation to the interaction of light and heavy vehicles at mine sites. It is also a timely reminder to ensure that workers are adequately trained and that the requirements of the roads or other vehicle operating areas principal hazard management plan are followed. There should always be positive communications. Light vehicles should give way to heavy vehicles. Vehicle operators should be reminded of the risks of distractions while driving.

		 Consider using proximity detection and collision avoidance systems on light vehicles and heavy vehicles. Consider separation of light vehicles and heavy vehicles on haul roads, where possible. Refer to: Investigation into a fatal collision at Ravensworth open cut mine on 30 November 2013
Dangerous incident SinNot 2017/01669	A mining dump truck was spotting to a dozer and reversed into the rear right hand side of the dozer damaging a light bracket.	 Hazard: velocity/inertia of vehicles. Risk: harm to people from collision between mobile plant. Recommendations: When mobile plant is operating in
		 When mobile plant is operating in close proximity, operators should remain in continual communication and maintain an awareness of the other's position. Workers should be trained in sitespecific procedures. Regular site safety observations should be performed by supervisors to ensure compliance with site procedures. The use of cameras may assist operators by alarming encroachments. When reversing mobile plant, operator should check down both the left and
Dangerous incident SinNot 2017/01668	In an underground metal mine, a diamond drill rig was coring a new hole that was right on top of a resin bolt. While drilling, the drill offsider saw a flash which was thought to be a gas fire. He yelled out to the drill operator, the operator stopped drilling and the offsider pointed the water hoses to the hole. The driller then contacted the supervisor. The supervisor came and looked at the hole. At no point did the gas alarm go off with the gas monitor about 1 m from the hole.	 right sides. Hazard: chemical reaction Risk: harm to people from a flammable gas fire/explosion. Recommendations: Review procedures for drilling into a hard strata where there is potential for gas. Review should consider 'wet hole' drill as a control for reducing the drill tip temperature. Drill operator training should include any detected gas comes from a reservoir of an unknown quantity A gas fire underground is a dangerous incident - it requires scene preservation and immediate notification. For guidance on reporting

	refer to the notification of incident and injury guide.
Dangerous incident SinNot 2017/01665	An empty mining haul truck was descending a ramp after rain, and the operator lost control of the truck. The truck skidded into the potential path of a loaded haul truck. The two trucks stopped approximately 12 m apart.
200	speeds suitable for the conditions.
180	■ Workplace Death (s14(a) WHS(MP)A)
160	Complaint
120 - 97 100 -	116 ■ High Potential Incident (cl128(1)(b) WHS(MP)R) 86 ■ High Potential Incident
80	56 Medical Treatment Injury (not serious injury) (cl128(1)(a) WHS(MP)R)
60 28	Dangerous Incident (s14(c) WHS(MP)A)
40	23 24 14 White(whit)(t) 8 3 4
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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

- WHS undertaking Coal & Allied (NSW) Pty Ltd
- Fact sheet fire and explosion risks in underground metalliferous mines
- Inspector roles advertised
- Updated 2017 Examinations Calendar

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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