

Week ending 9 August 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

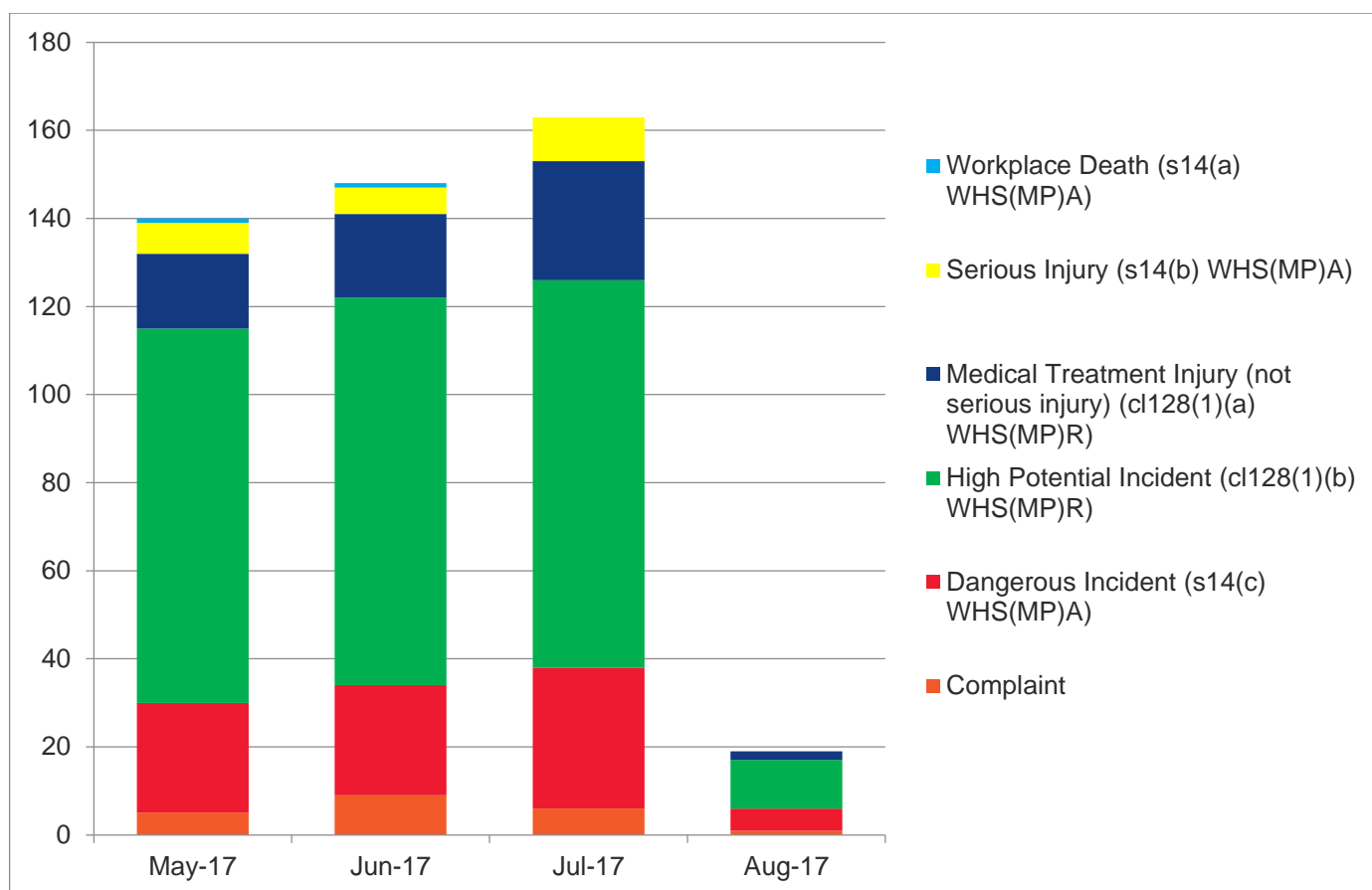
Type	Number
Reportable incident total	48
Summarised incident total	9

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot 2017/01202	A haul truck and a service truck collided at an open cut mine site. The haul truck steps hit the corner of the service truck, breaking them off.	Mine operators are asked to consider: <ul style="list-style-type: none">• collision avoidance and proximity detection systems• fields of vision and use of cameras on large mobile plant• positive communication between vehicles• procedures on parking and isolation of vehicles. Reference should be made to MDG 2007 for guidance on proximity awareness and collision avoidance technologies.

<p>Dangerous incident SinNot 2017/01200</p>	<p>A fire was reported on the maingate corner around shields 1-2 of Longwall 107 (described as smoke and glowing embers). The incident occurred as the shearer was cutting into the maingate (shearer stopped with drum opposite #4 shield).</p> <p>The fire was extinguished - hoses were run out and the area was wet down. The cause and exact location of the fire was unknown at the time of reporting.</p> <p>Several blunt picks were observed on the maingate drum, and that drum sprays automatically turned off when entering the maingate.</p>	<p>One possible cause is heating friction between the shearer picks and changing geological conditions. To mitigate the potential of frictional heating ensure that:</p> <ul style="list-style-type: none"> • picks are not worn and carbide tips are intact and conduct more regular checks when conditions change • water sprays are functional without blockage • there is adequate ventilation.
<p>Dangerous incident SinNot 2017/01224</p>	<p>A worker suffered a suspected electric shock from a conveyor. There were multiple power sources. The worker was taken to hospital for tests.</p>	<p>Mine operators should ensure that safe work method statements and task risk assessments identify the risks associated with using portable electrical equipment in relation to the particular work activities.</p> <p>Where portable electric tools have been modified by the replacement of a supply cord and three-pin plug, the risks associated with this practice including the maintenance of ingress protection rating (IP rating) and mechanical integrity (cord grips) of the equipment should be considered. This is of particular concern where IP56 plugs are fitted to light duty cords.</p> <p>'Introduction to site' processes for portable electrical equipment should be routinely audited to ensure compliance to site standards.</p> <p>Supervisors should review work site activities against mine site requirements associated with the use of portable electrical equipment, including:</p> <ul style="list-style-type: none"> • routing of extension leads • suitability of equipment for task and environment • compliance to site installation standards.
<p>Dangerous incident SinNot 2017/01197</p>	<p>Two workers each suffered an electric shock while using an electric hand tool during poly pipe welding preparation. Investigation has shown the electrical sensation experienced by the operators was due to static build-up in the high density polyethylene (HDPE) pipe flange caused by the cutting bit of the router rotating at up to 22,000rpm.</p>	<p>Where workers are performing work on HDPE pipe including cutting, routing, grinding and welding, mine operators should ensure that:</p> <ul style="list-style-type: none"> • procedures address the risks associated with static generation on HDPE pipes and tools being used • workers are trained in and familiar with the site procedures, particularly those

		<p>for control of static electricity</p> <ul style="list-style-type: none"> • site introduction of electrical equipment intended for use with HDPE pipe work and the associated pre-start checks are performed correctly to ensure the integrity of tools and associated equipment. <p>Refer to AS/NZS 1020:1995 The control of undesirable static electricity</p>	
Dangerous incident SinNot 2017/01187	<p>While driving a 25 tonne Franna crane underground, the operator smelled the brakes. He parked the machine in an off ramp and inspected the wheels. At wheel number two he saw a flickering glow. He used the hand-held fire extinguisher to extinguish the 'fire'. No one was injured. The emergency response team inspected the machine and reported the fire was extinguished. An investigation found that the brake booster had an air leak.</p>	<p>There have been several incidents associated with brake boosters on mobile plant over the past six months.</p> <p>Brake boosters on mobile plant need to be overhauled or replaced at intervals recommended by the original equipment manufacturer.</p> <p>Mines with brake boosters on mobile plant should review their maintenance practices to ensure this occurs.</p>	
High potential incident SinNot 2017/01223	<p>A deputy parked an underground personal transport vehicle to enable him to inspect an area of slumped rib. While he was investigating the rib, a piece of roof approximately 1 m x 0.5 m x 0.1 m fell out between the existing roof support on to passenger side canopy of the vehicle</p>	<p>Mine operators should identify areas where the potential of unsupported rib coal and poorly supported roof may exist, whether in roadways, pillar extraction workings or longwall faces. For identified areas:</p> <ul style="list-style-type: none"> • review the support rules • assess risks and implement controls to avoid danger to the safety of workers from unconfined rib and roof strata. 	
High potential incident SinNot 2017/01196	<p>An operator went to move an LHD and noticed that the machine would propel itself backwards when in the neutral gear. No personnel were within the restricted or no go zones at the time of the incident and as such were not placed at risk.</p>	<p>Consideration for preventing this hazard from occurring include:</p> <ul style="list-style-type: none"> • control system design integrity and validation by OEMs • maintenance is performed in accordance with OEM specifications • compliance with site functional safety management plan to ensure ongoing integrity. 	



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

- **Safety alert:** [Longwall faces – safe access and emergency exits](#)
- **Investigation information release:** [Flyrock incident at open cut coal mine](#)
- **Mine Safety News:** [Resources Regulator compliance priorities](#)

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	
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