Weekly incident summary

Planning & Environment
NSW GOVERNMENT Resources Regulator

Week ending 27 September 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.

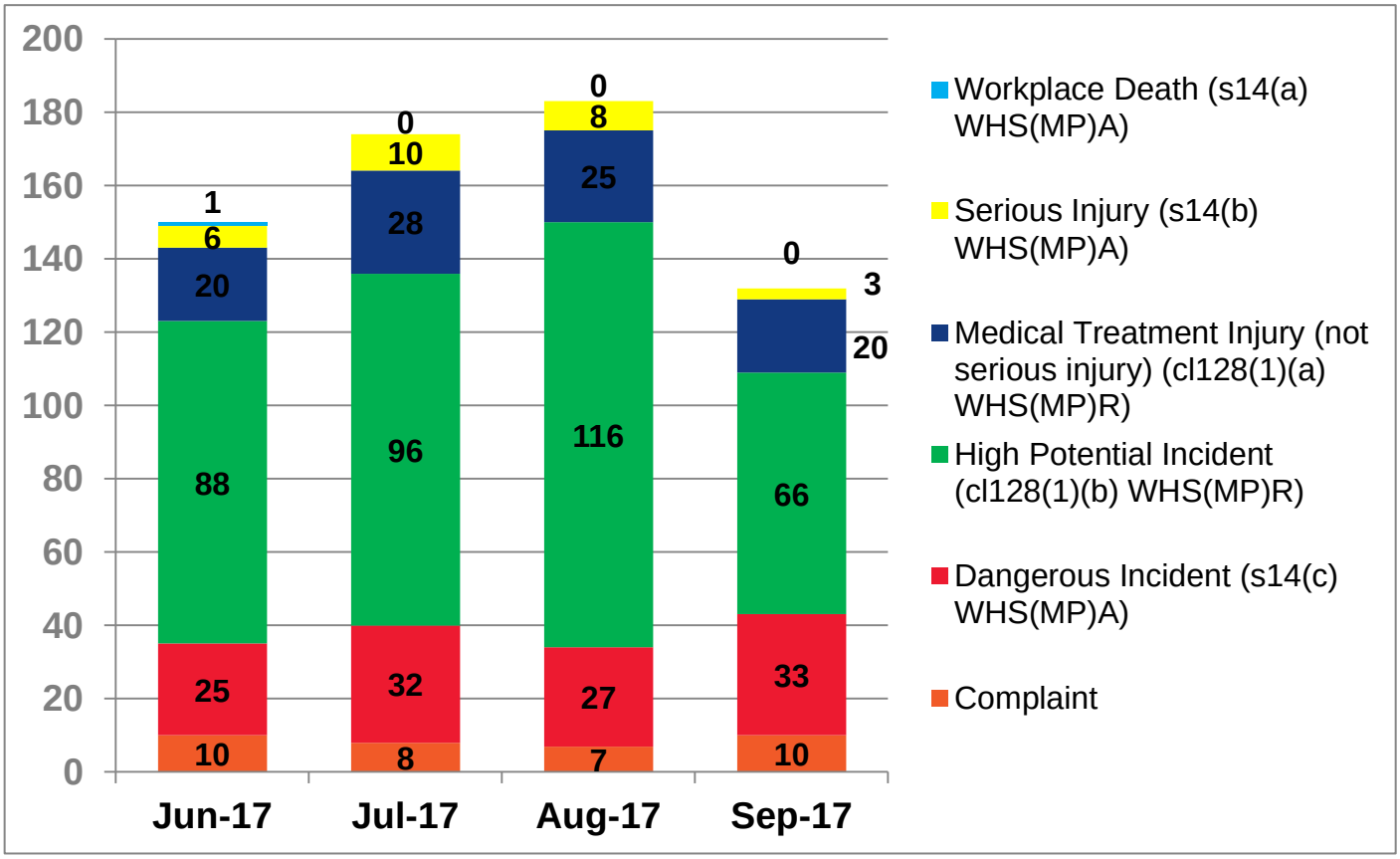
Type	Number
Reportable incident total	50
Summarised incident total	10

Summarised incidents

Incident type	Summary	Recommendations to industry
High potential incident SinNot 2017/01420	A shaft winder at an underground mine tripped. It was initially attributed to a communications fault as a result of a flat battery. In the process of arranging a battery change out, it was identified that 37m of hoist rope was damaged and became knotted and looped on itself. The shaft depth was more than 1000m. An initial investigation found that the cage may have become stuck near the bottom of the shaft and continued to pay out rope.	Mines with winders must have a principal hazard management plan for mine shafts and winding systems. The plan must address control measures for risks associated with mine shafts and winding systems (clause 3, schedule 1 WHS (MPS) Regulation). In developing principal hazard management plans, mines should consider: • the type and adequacy of shaft and winder inspections, including, ropes and attachments, guides to identify damage or areas where a conveyance may bind or become stuck • maintenance requirements in accordance with the original equipment manufacturer's recommendations • testing of safety-related functions in a manner and frequency as required by the designer.

Dangerous Incident SInNot-2017/01509 Dangerous Incident SInNot-2017/01541	While running in drill rods on a drill rig in an underground metal mine, a driller saw a flame appear, then disappear out of the drill rod. The flame was about 30cm, bright orange and lasted for about 30 seconds. The gas monitor was not alarming. The incident was not reported until a few days after the event because the drillers and supervisor were not aware of the reporting requirements of clause 179(b) regarding a fire in the underground parts of a mine. During re-entry in a cross cut in an underground metal mine, a shift boss found a burned ventilation bag. This was reported to the foreman. The mine has not been able to identify the cause of the fire and the regulator directed the mine operator to complete further investigation and assessment. The incident was not notified to the regulator until several days after the incident occurred.	Both of these incidents required immediate notification to the regulator. Late reporting of incidents inhibits adequate assessment of potential causal factors and failed or absent control measures. Mine operators should have a documented process for notifiable incident responses and investigations. Mine operators should ensure all supervisors and workers are trained to identify and notify incidents when a notifiable incident occurs. Mines and petroleum sites must promptly notify the regulator when an incident occurs. For guidance on reporting refer to the Notification of incident and injury guide.
Dangerous Incident SInNot-2017/01507 Dangerous Incident SInNot-2017/01530	An operator of a dump truck noticed smoke coming from an engine compartment. The operator stopped the truck and activated the fire suppression system. The operator used a hand-held extinguisher to extinguish the fire. An underground truck was on the surface pit ramp when there was a fire in the engine bay.	Fire risks assessment should be carried out for mobile plant that is operated at the mine. 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.
Dangerous Incident SInNot-2017/01513	An articulated water cart tanker was reported as having rolled over. The truck cab remained upright.	A number of articulated dump truck roll overs have occurred at mines recently. Mine operators should refer to the recommendations in safety bulletin SB17-01 Industry reports more truck rollover incidents.
Dangerous Incident SInNot-2017/01520	A fully loaded dump truck lost control on a haul road with the truck's front wheels going through a windrow. The windrow stopped the truck from going over a 10m drop-off to a small berm and a further 30m to the pit floor. The truck operator said he lost control while avoiding a kangaroo. The incident occurred at night with roadway conditions reported as good.	Mines should ensure windrows are installed and are of sufficient height to arrest mobile plant if it becomes uncontrollable. Factors that may affect operator vision and/or ability to control a vehicle include: • fog, sunlight, storms or dust

		• fatigue • slippery road conditions • obstructions that affect lines of sight. • wildlife. Mine operators should consider these Matters in their principal hazard management plans for roads and other vehicle operating areas, along with fit-for purpose barriers such as bunding and windrows to prevent vehicles going over embankments. Vehicle operators should be reminded to travel at speeds suitable for conditions.
Dangerous incident SinNot – 2017/01521	Falling rocks damaged the cabin of a loader while the operator was cleaning up the working face. The operator was uninjured.	Machine operators should inspect their work area to identify hazards that have the potential to fall or roll onto equipment, in this case falling rocks. MDG 15 Mobile and transportable equipment recommends all cabin windows be fitted with safety glass. MDG 15 guidelines should be consulted with respect to the use of roll-over protective structures and falling object protective structures.
Dangerous Incident SInNot-2017/01525	The operator of a 75 tonne excavator requested an articulated water cart to wash down the front windscreen of his excavator. The water cart started the wash down. The excavator had its boom and stick in the air. The excavator operator lowered the bucket to assist the wash down, but in the process of lowering the bucket hit the cab of the articulated water cart.	Positive communication is essential. Mines should consider human and organisational factors when developing their principal hazard management plans for roads and other vehicle operating areas.
Dangerous Incident SInNot-2017/01549	A heavy vehicle interaction near-miss was reported to the regulator. Two large mining haul trucks avoided a low speed collision at a T-intersection when the haul truck coming from the right failed to give away to the haul truck on the left (as per the site transport rules). The speed limit at the intersection is 20km/h and the haul trucks stopped without making contact (about 8m between them). The incident occurred at night, the weather conditions were fine and the intersection was not lit.	The incident highlights the importance of having an effective risk management program in relation to the interaction of light and heavy vehicles at surface 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 is followed. Mine should review the report and associated recommendations in Ravensworth open cut investigation report of a fatality that occurred in November 2013 – Heavy and light vehicle interaction.



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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