

## Week ending 27 June 2018

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	49
Summarised incident total	7

### Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot-2018/01028	<p>A light vehicle rolled after contacting a light vehicle bund. The driver reported having a microsleep while returning to the muster area at the end of night shift. The operator had just had woken up from a fatigue break that was taken in the vehicle.</p> 	<p>The fatigue management procedure should detail the requirements when operators take fatigue breaks in vehicles to manage the risk of subsequent microsleeps.</p> <p>When working in remote areas workers should be in direct communication with supervisors.</p>

Dangerous incident  
SinNot-2018/01023

The windscreen of a loader smashed when a rock hit it. An excavator was operating at the top of a face casting material in a single pass down four benches to the pit floor. The loader then took material to a crusher.

The incident was not reported when it occurred because it was thought not to be a reportable incident.



Work methods and the controls used must consider the risk of falling material and locations of people.

Mines should refer to the recommendations in safety bulletin [SB18-05 Increase in shattered windscreens on mobile plant.](#)

*Work Health and Safety (Mines and Petroleum Sites) Act 2013* section 15 requires mine operators to report incidents. The Resources Regulator website has numerous resources to assist determining what incidents are notifiable and the process. Supervisors should be trained in incident management including notification.

Dangerous incident  
SinNot-2018/00998

An unplanned movement occurred when three longwall roof supports advanced after automation was activated. The automation parameters were incorrectly set for the mining method being used.

A software change management process should be in place to manage software and commissioning processes.

Dangerous incident  
SinNot-2018/00994

A dozer was damaged when it reversed into an excavator bucket. The dozer was ripping the floor for the excavator when it reversed as the excavator commenced loading the bucket. The excavator stopped and the dozer contacted the back of the bucket, damaging the ladder and fuel tank.

Stand-off distances between face equipment must be clearly defined and communicated to workers. Checks and monitoring by supervisors should be routinely carried out.

Dangerous incident  
SinNot-2018/00993

A rubber-tyred dozer was damaged when a rock fell from a highwall. The dozer was working underneath the pre-split high wall conducting clean-up work for the face shovel. A rock fell from the high wall and hit the right-hand side of the dozer. The impact caused

Risk assessments must be conducted establishing appropriate controls for hazards associated with highwalls before working under them.

damage to the electrical systems on the machine, shutting it down and disabling the radio. The operator had to flag down a haul truck operator for assistance.

Workers must remain vigilant and not rely on other workers' inspections when working near highwalls.



Dangerous incident  
SinNot-2018/00982

A large, steel component fell from a truck while being secured. The truck driver was on the opposite side of the vehicle at the time.

Loading and unloading procedures should include the provision for cranes to continue to support a load until it is adequately secured to the truck or sitting stable on the unloading area.

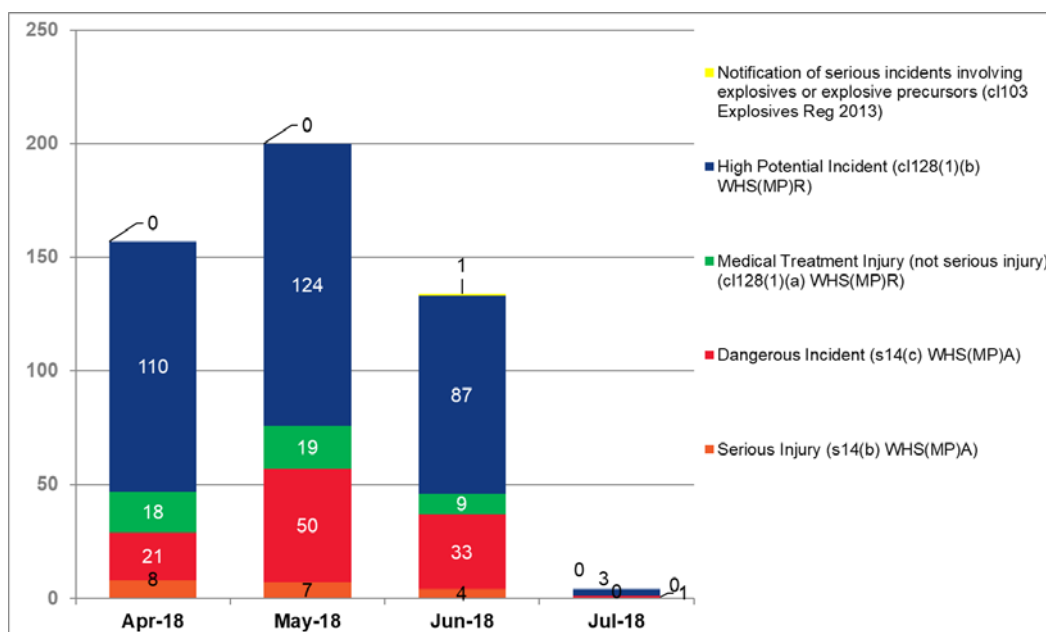


Dangerous incident  
SinNot- 2018/00958

A haul truck was parked up and shutdown due to rain. The operator remained in the cab. After about an hour, the truck rolled forward 30 to 40 metres before the operator was able to stop it. The mine investigation determined that a component in the braking system was installed incorrectly.

Following any works, particularly on safety critical systems, equipment should undergo a form of commissioning to verify the quality and operation of the work performed.

**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.



**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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