

WEEKLY INCIDENT SUMMARY

Week ending Friday 1 November 2019

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	43
Summarised incident total	12

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0035947	<p>An excavator was being utilised to dig a trench along a 2 to 3metre high bench adjacent to a tailings dam. When the excavator reached the end of the bench it slid sideways off the bench and came to rest at a 30-degree angle. The operator safely exited the cabin.</p> 	<p>Equipment operators must maintain situational awareness and remain vigilant to manage the risk of machine rollovers. The circumstances of this incident under-pins the importance of wearing seatbelts as a mitigating control. When planning tasks and travel paths, supervisors must consider rollover hazards.</p>

Dangerous incident
IncNot0035890

While using an endless chain block to lower a 4.5 tonne ventilation fan, a chain failed and the fan fell about four metres to the ground. A preliminary investigation suggested one of the endless chains failed at the gooseneck of the hook and had moved about 100 millimetres when it began to fail. This caused the fan to shift and a second chain to break. No-one was injured.



Mine operators should ensure that pre-use inspections are available for workers and are completed for all lifting/lowering equipment tasks.

The rating of all lifting components within a system should consider the worst-case scenario if loads are off balance or get caught on other objects.

Whenever there is a possibility that objects can fall, appropriate no-go zones should be established to protect workers. No-go zones should be clearly communicated and delineated to all workers in the vicinity.

Serious injury
IncNot0035903

A belting contractor was guiding a wire rope back onto a winch drum after replacing conveyor belting when his left hand became caught between the cross frame and a roller set. This resulted in the degloving of his middle finger and damage to another finger.

Mine operators and contract companies should review their procedures to determine if their training includes the potential hazards associated with identifying potential pinch points. Appropriate guarding and rope guides must be used to minimise workers' exposure to pinch points.



Serious injury
IncNot0035904

A fitter suffered rib injuries while working beside a boot end that was being positioned as part of a belt extension. The boot end was connected to a load haul dump (LHD) with a quick detach system (QDS). The boot end moved unexpectedly and hit the fitter.

We have published a safety bulletin (see below) with recommendations relating to boot end relocations. Safe standing zones must be created and communicated to protect workers when working in and around mobile machinery.



Dangerous incident
IncNot0035905

A light vehicle rolled backwards about 30 metres after the operator left the vehicle without applying the handbrake when the vehicle was in neutral.

The principal hazard management plan (PMPH) for roads and/or other vehicle operating areas should include procedures that detail the requirement that mobile equipment is parked fundamentally stable.

Lessons that should be communicated through tool box talks include:

- compliance with correct parking procedures
- being situationally aware of hazards.

Refer to the recommendations in safety bulletin [SB13-02 Unplanned movements of vehicles - too many near misses](#).

Dangerous incident
IncNot0035906

Two vehicles were travelling outbye when an LHD fitted with QDS forks shunted into a cut-through to allow the first vehicle to pass. When the first vehicle passed, the LHD drove out and collided with the second vehicle - shattering the windscreen. The driver of the vehicle suffered hand lacerations.



Effective communications protocols should be in place to ensure that positive communications between all operators is being achieved. Mines should monitor and assess compliance with site positive communication protocols. Refer to safety bulletin [SB18-06 Lack of positive communications](#).

Dangerous incident
IncNot0035925

A 3 kilogram crane pendant trolley fell approximately 5 metres to the ground from an overhead crane. The trolley landed about 3 metres from the crane operator who was attaching a load to the crane hook.

Mine operators should review exclusion zones to ensure failures of pivot points and subsequent falling of equipment are considered. The location of overhead components should consider walkways and work areas below and should be located in such a place as to reduce exposure if there is a failure.



Dangerous incident
IncNot0035927

While working in an overdrive in a development panel at an underground coal mine, a deputy and an electrician were unaware that the surface gas drainage plant had tripped.

After about 20 minutes after the gas plant tripped, the deputy's gas detector alarmed on high carbon dioxide with a reading of 3%. As the deputy and the electrician withdrew from the overdrive, they felt the effects of carbon dioxide (difficulty breathing and dizziness). As they were passing through a syncline (lowest point in the district), the gas detector had a peak reading of 5% carbon dioxide. The deputy and electrician were assessed and cleared of any injuries.

Mine operators must review the adequacy of their trigger action response plans (TARPs) as mining conditions change (such as changes in seam grades, permeability, insitu gas content etc). The potential for gas layering either with carbon dioxide on the floor or methane on the roof needs to be managed reduce the likelihood of accumulations. Examples of methods to manage this include, but are not limited to, increasing ventilation velocities at high/low points and using venturis at these points.

Dangerous incident
IncNot0035929

A drill rig was tramping on a main decline when the engine stalled. When trying to restart it, flames were seen coming from the exhaust of the machine. A hand-held fire extinguisher was used to extinguish the residual flames in the exhaust. No-one was injured.

Our position on fires on mobile plant is that all fires on mobile plant are avoidable and preventable.

Mine operators should be aware of our expectations with regard to fires on mobile plant as outlined in the recently published position



paper [Preventing fires on mobile plant.](#)

Dangerous incident
IncNot0035933

A fire occurred on a water cart truck. The fire appeared to be on a tyre so the area was evacuated in response to the mine's procedures. A preliminary investigation suggested the fire was caused by ignited hydraulic fluid dripping onto the top of the tyre.



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Dangerous incident
IncNot0035940

A haul truck passed onto the opposite side of a haul road to overtake a loader and was approaching a 90-degree corner on the ramp when a light vehicle approached in the opposite direction. By the time the haul truck operator and light vehicle operator realised the situation there was nowhere for either vehicle to go. The light vehicle operator veered to the edge of the windrow and the haul truck operator engaged the emergency brakes but was not able to stop in time. The haul truck passed the light vehicle at low speed with about 4 metres separation between the two vehicles.

Mine operators must continue to remind and enforce compliance with sites' roads rules. There have been fatalities and multiple near misses in relation to heavy and light vehicle interactions and enforcement of transport rules must be a priority of all operators.



Dangerous incident
IncNot0035945

An operator stopped a telehandler on a slope to pick up a load. While manoeuvring the loaded telehandler, the front lifted and the telehandler fell on its side. The operator was wearing a lap sash seat belt.

The load he was transporting consisted of a 6 metre length of steel bracing with a support on top of it.



Equipment operators must maintain situational awareness and remain vigilant of the risk of machine rollovers.

Areas where vehicles are raising a load should be monitored for hazards such as cross grades, uneven ground, soft points and foreign materials.

Our recent safety bulletins

- [SB19-11 Drive shaft failures cause fires](#)
- [SB19-12 Spontaneous combustion of conveyor rubber](#)
- [SB19-13 Workers injured while installing conveyor boot ends](#)
- [SB19-14 Conveyor pulley failures initiate fires](#)
- [SB19-15 Rapid face bolter incidents](#)

Other publications of interest

The incidents are included for your review. The NSW Resources Regulator does not endorse the findings or recommendations of these incidents. It is your legal duty to exercise due diligence to ensure the business complies with its work health and safety obligations.

PUBLICATION	ISSUE/TOPIC
	International (other non-fatal)
MinEx NZ	<p>Fall of axle assembly</p> <p>Two fitters were fitting a 3-tonne front axle assembly onto a loader. A spreader bar was used to allow the correct placement of the two slings on each end of the axle. Once centred, the axle was being lifted off the cribbage when the west side sling dropped, the spreader bar flung around and landed on top of the loader bucket, and the axle dropped onto the cribbing and then slid off onto the floor.</p> <p>Details</p>
	National (other, non-fatal)
DNRME Qld	<p>Qld DNRME incident periodical (October 2019)</p> <p>Key incident data for 2018/19 October in Queensland mining.</p> <p>Details</p>

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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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (November 2019). However, because of advances in knowledge, users are reminded of the need to ensure that information upon which they rely is up to date and to check currency of the information with the appropriate officer of the NSW Department of Planning and Environment or the user's independent advisor.

DOCUMENT CONTROL

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