

6 Week ending 6 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	41
Summarised incident total	6

Summarised incidents

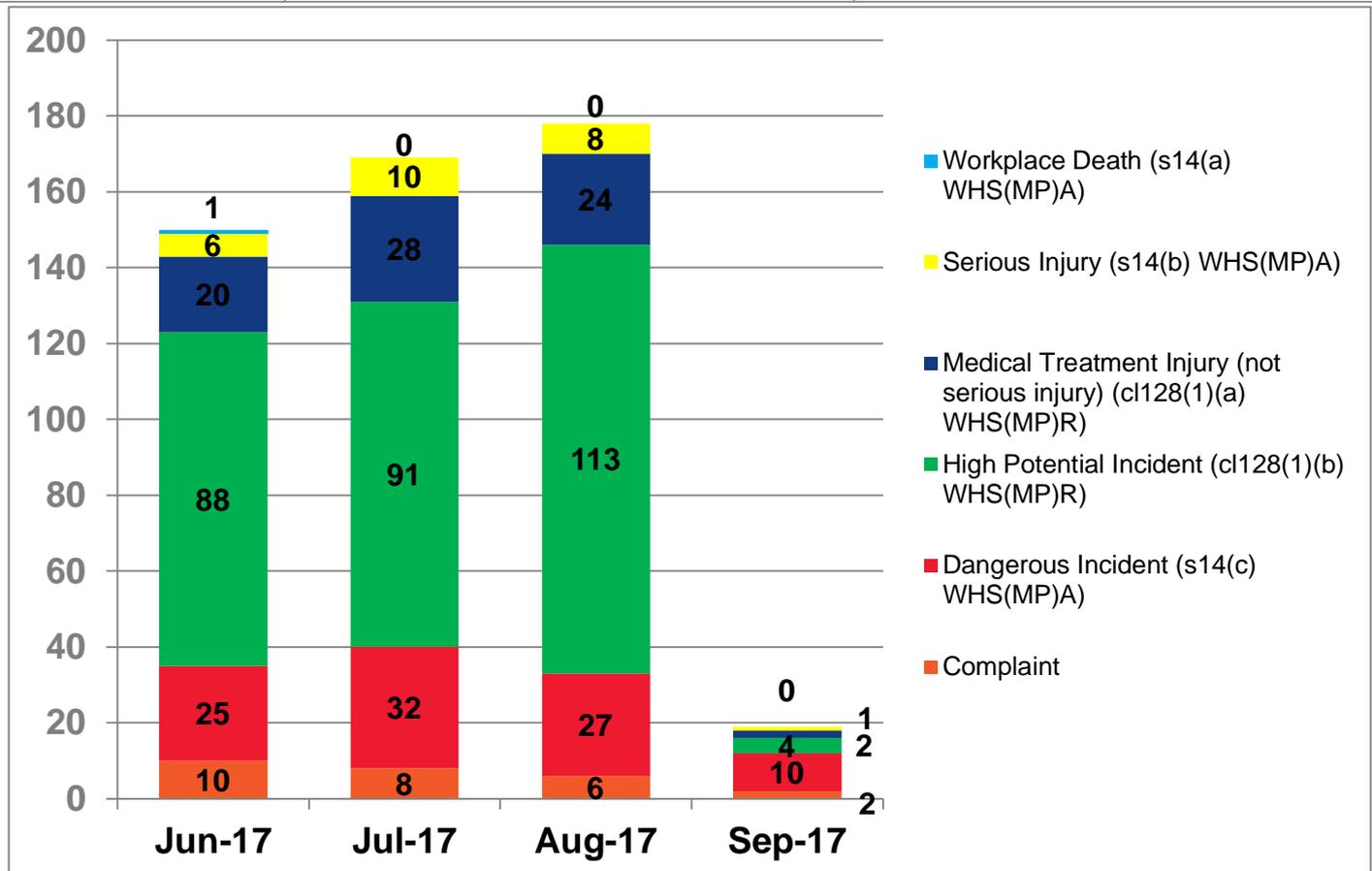
Incident type	Summary	Recommendations to industry
Dangerous incident SinNot 2017/01416	While in the process of returning to a clay pit, a dump truck veered off the road and onto a safety bund.	<p>Some factors that may affect operator vision and / or ability to control a vehicle include:</p> <ul style="list-style-type: none"> • fog, sunlight, storms, dust or environmental factors • fatigue • slippery road condition after being watered • obstructions that affect lines of sight. <p>Mine operators should consider these items in their principal hazard management plans for roads and other vehicle operating areas, along with fit-for-purpose barriers such as bunding or windrows to prevent uncontrolled vehicles going over embankments.</p> <p>Drivers should be reminded to correct speeds, and select and use appropriate equipment and retarders when descending.</p>
Dangerous incident SinNot 2017/01412	Two fitters were fault finding on a tilt bucket issue on a 45 tonne excavator. While attempting to remove a counter balance valve, the cartridge ejected at velocity over the heads of the fitters and sprayed one of the fitters with oil.	Mine operators must identify the risks associated with working on hydraulic systems, hoses, rams and associated components. This should include the risk of people being struck by projectiles or pressurised fluid as a result of residual

		<p>stored (or locked) hydraulic pressure.</p> <p>People should be competent to work on hydraulic systems (including troubleshooting).</p> <p>Hydraulic schematics and original equipment manufacturer OEM maintenance information needs to be available and followed when maintenance is being carried out.</p> <p>Maintenance tasks should have comprehensive procedures for replacing or repairing hydraulic components. Particular attention should be given to effective means to dissipate stored pressure in hydraulic cylinders where valving may hold or lock in pressure for cylinder control. Release of this energy may require specific procedures. Effects of gravity should also be considered.</p> <p>Further information can be found in MDG41 Fluid power system safety</p>
<p>Dangerous incident SinNot 2017/01389</p>	<p>The operator of a roof bolting rig on a continuous miner was sprayed on the back of the knee with hydraulic oil when a hydraulic hose burst. The hose was covered by DAS sleaving. The bend radius of the hose may have been too tight.</p>	<p>Fluid power systems should be designed, installed and maintained while taking into consideration the recommendations in MDG41 Fluid power system safety. Section 7.6 deals with hose management.</p> <p>Preventative measures include:</p> <ul style="list-style-type: none"> • hose rating and design • suitability of hydraulic fittings used to connect hoses to fixed components (such as valve banks and manifolds) • hose bend radius and rubbing • regular hose inspections and training of people doing those inspections. <p>Mitigating measures include:</p> <ul style="list-style-type: none"> • use of guards where possible • hose protection sleeves • ultraviolet sensor dye in oil.
<p>Medical treatment injury SinNot 2017/01413</p>	<p>While drilling polyurethane holes into the longwall face, a 5 m drill steel became bogged horizontally. In attempting to pull the steels free from the face, a sling was connected to the bolt and a pull lift was used to try and pull the stuck bolt out. The pull lift was attached to the sling and the pull lift hook was attached to the</p>	<p>The unintended failure of lifting equipment such as slings, chains, hooks, connectors and chain blocks have caused fatal injuries in the past. Refer to SB09-03 Broken pull chain results in fatality SA04-09 Broken chain connector results in serious injuries</p>

	<p>armoured face conveyor pan spill plate (a vertical steel plate). When the pull lift was tensioned, the chain block hook slipped off the spill plant and struck a worker in the face.</p> <p>The worker received five stitches and dental treatment.</p>	<p>SA04-05 Crane dogger killed unloading trailer</p> <p>Mine operators should remind workers on the use of lifting equipment. The following generally applies:</p> <ul style="list-style-type: none"> • lifting hooks are always put through purpose-made lifting points. Hooking onto a flat steel plate should not be done. • workers using the gear are trained and are competent in its use • equipment is fit for purpose and within current certification • equipment is used in accordance with the relevant Australian Standards and the OEM recommendations • in lifting applications, workers must hold the relevant dogging / rigging licence • lifting equipment that is used for towing should not be used for lifting. <p>Personnel should be trained in the correct use of lifting equipment and correct anchorage.</p> <p>Mine operators should have safe work procedures for unusual tasks, such as freeing stuck drills. Procedures should be followed and specific risk assessments should be performed before starting work.</p>
<p>High potential incident SinNot 2017/01396</p>	<p>A cyanide chemical leak was reported at the leaching tank in the process plant. This was contained in a bunded area that is accessed by few people.</p>	<p>Sites that have this risk should have established management and operating practices for the use of cyanide in their mining activities. These must extend to spillage management protocols.</p> <p>Mines should regularly audit their cyanide environmental monitoring and emergency response programs. Adequate containment facilities and bunding of liquid and solid cyanide containers are necessary to minimise the effects of accidental spillage (consideration must be given to local weather conditions in providing such containments).</p>
<p>High potential incident SinNot 2017/01320</p>	<p>An operator was unable to make the accelerator pedal on a forklift respond despite going through the correct start-up sequence. On about the seventh attempt, the operator noticed that with the seatbelt disconnected in his hand the forklift propelled forward approximately 2 m by</p>	<p>Mobile plant being introduced to a mine should have controls and safety functions checked before the mobile plant is used. The site introduction process should include the recommendations in section 4.5.3 of the mechanical control plan code of practice.</p>

itself. The forklift was stopped through the application of the foot brake.

Where faults are found, the mobile plant should be tagged out of service with the mobile plant owner notified.
The mobile plant should not be used at the mine until a competent person has checked the repairs and verified the plant is safe to use.



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

- [Form: Notification by licence holders of non-compliance of Ex equipment](#)
- [Underground conveyor equipment places workers at serious risk](#)
- [Practising certificates - applications now open](#)
- [Work Health and Safety Regulation 2017 begins](#)

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	
RM8 reference	PUB17/610
Mine safety reference	ISR 17-35
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