REPORTABLE INCIDENTS | WHS MINES LEGISLATION

# Weekly incident summary

**24 August 2016**

*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.*

**To report an incident call 1300 814 609 24 hours a day, 7 days a week**

## Reportable incidents total: 37 Summarised Incidents: 12

**Summarised Incidents –** incidents of note for which operators should consider the comments provided and determine if action needs to be taken.

| Incident type | Summary | Comment to industry |
|---|---|---|
| Dangerous incident<br>SinNot 2016/00244 | A truck had loaded from the reject bin and driven away, when it became evident the bin door had not opened and closed in the required 8 second cycle time, but had closed after 50 seconds. Contents of the bin were discharged onto the ground. Root cause was pin coming out of hydraulic cylinder. | Mines should review their bin door arrangements and make sure the bin maintenance schedule is appropriate to identify and address such potential failures. |
| Dangerous incident<br>SinNot 2016/00243 | Truck driver tried to raise the access ladder however it jammed part way. The driver attempted to free the ladder by pulling it, which subsequently moved, jamming the driver's left leg, resulting in bruising. Problem with ladder had been reported but not actioned. | Mines should review their defect management systems such that defects with potential for harm are appropriately actioned. Mines should assess human factors around acceptance of defective equipment. |
| Complaint<br>SInNot-2016/00241 | A report of bullying and harassment behaviour towards contract (labour hire) workers has been received by the department. | This matter is under investigation. Mine operators and labour hire companies should define and reinforce appropriate behaviours in the workplace. See our website for more information www.resourcesandenergy.nsw.gov.au/miners-and-explorers/safety-and-health/topics/bullying-in-the-workplace |
| Dangerous incident<br>SInNot- | Operator of dump truck noticed smell while at dump site. Operator drove to maintenance park up at go line to investigate. Operator identified fire in | Mines should review their hose management systems for vehicles especially for hoses which, if they failed, would spray onto hot surfaces and become a fire hazard. |

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|---|---|---|
| 2016/00240 | engine bay and used combination of on board fire system and hand-held extinguishers to extinguish fire. Source appears to be engine coolant sprayed onto hot turbos (burst hose). | |
| Dangerous incident<br>SInNot-2016/00222 | Tyre fitter was attending to a bubble on the side wall of a tyre on a haul truck, when the side wall failed, releasing the internal pressure. No injuries. | Mines should review procedures for this type of tyre failure including the means used to de-pressurise the tyre without placing people at risk. Where tyre maintenance is performed by contractors, these learnings should be included in the relevant contract SWP. |
| Dangerous incident<br>SInNot-2016/00218 | Two trucks were heading to a dump. A dozer was on the dump directing traffic. The dozer directed the lead truck to a point requiring the truck to reverse. The operator decided not to re-circle back to that point. The second truck was on the dump and stopped. The first truck reversed into the stopped truck. It hit the truck in a T-bone fashion at the front end of the stopped truck. | Mines should review their inter-vehicle communication protocols, especially where multiple vehicles are involved in close proximity. |
| Dangerous incident<br>SInNot-2016/00252 | A small fire occurred in the engine bay of a 996 shovel. It was caused by a broken bolt in the flanged joint of a steel hydraulic pipe. | Accepting that there is a hierarchy of control measures in place to mitigate risk to the vehicle driver, the number of reported engine bay fires at mines shows that the measures to prevent fires breaking out in the first place are inadequate. It is possible to eliminate engine bay fires altogether through better design, engineering and maintenance practices. |
| Dangerous incident<br>SInNot-2016/00246 | During an air pipe extension, the operators noticed that an isolation valve was fouling on the end of line manifold. They loosened the bolts between the manifold and valve and between the valve and pipe range in order to rotate the valve. This was done without isolation. The valve and manifold were blown off the pipe range and an operator was struck in the face by the compressed air and debris. He was cleared of major injury. | Mines should reinforce correct isolation for all tasks. A simple design change to the manifold could have prevented the possibility of the valve fouling on the manifold. |
| Dangerous incident<br>SInNot-2016/00229 | An electrician was working on a shuttle car. There was a loop in the cable on the reel that he has attempted to remove by driving the car a short distance. He drove back to the original location. He stuck his hand into the area to check to see if the loop was still there and suffered a shock to the hand. | Mines should reinforce to workforce that handling cable with power on in positions such as this is a poor practice. Mines should identify circumstances where handling energised cables is not acceptable and manage accordingly. |

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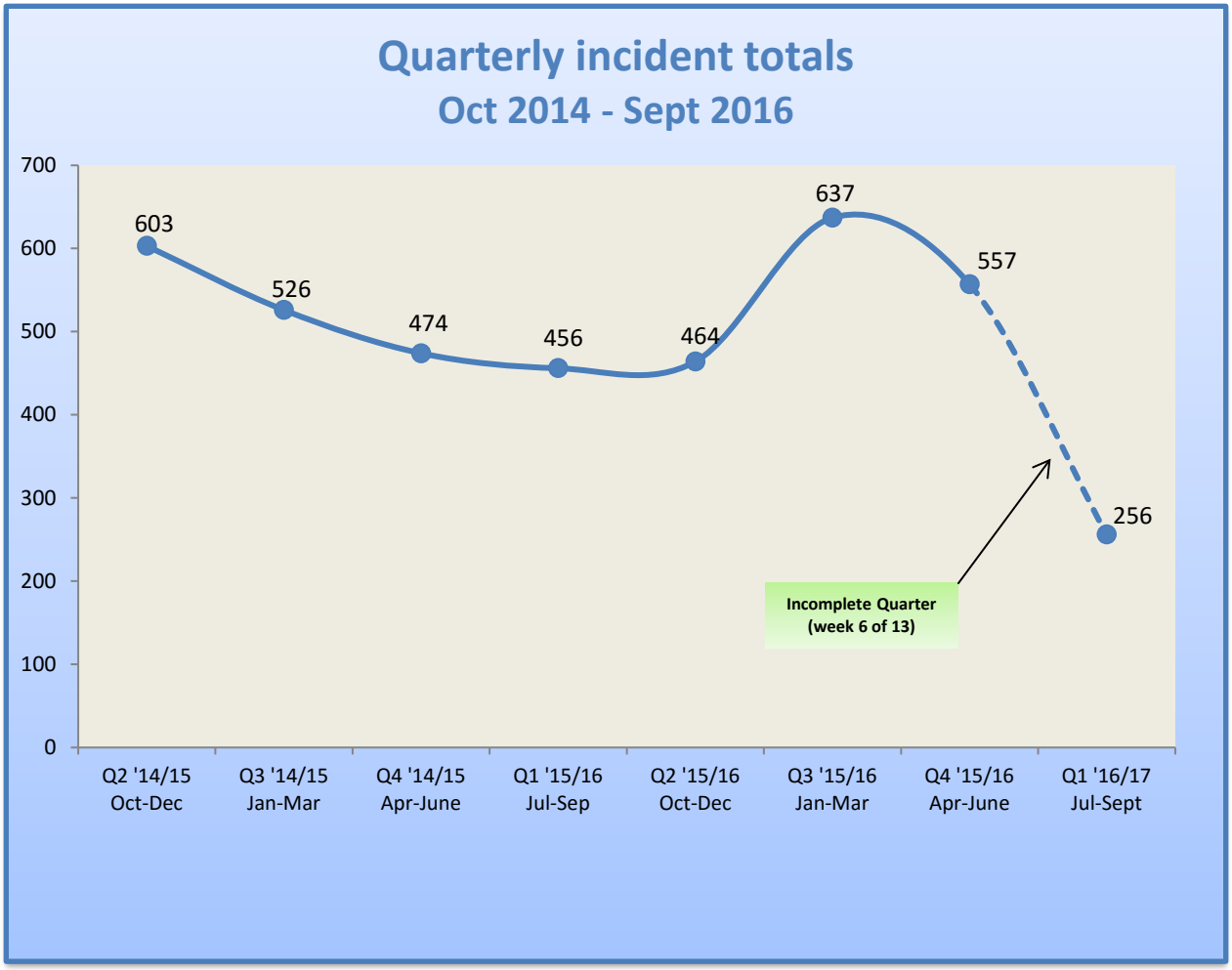
|---|---|---|
| Dangerous incident<br>SInNot-2016/00219 | A fire was detected and extinguished quickly on a conveyor tripper drive unit. The plummer bearing temperature monitoring system indicated heat increasing over a 45 minutes period prior. Further investigations determined the plummer bearing had failed, resulting in a near bye snubber to carry excessive load from the misaligned belting resulting in the snub roller igniting. | Industry should recognise the positive benefits of live monitoring of plant back to a central location (control room). Mines should assess critical component maintenance and monitoring needs. |
| Notification of loss or theft of explosives or explosive precursors<br>SInNot-2016/00247 | A stock reconciliation at a detonator magazine identified that one detonator could not be accounted for. | Explosives management plans should include a procedure that provides details of the quantity and types of explosives and/or detonators that are received and distributed on a mine site. Records should be easily accessible and maintained in a safe place. Mine operators should regularly review and audit the effectiveness of systems used to management the use of explosives. |
| Complaint<br>SInNot-2016/00235 | Dust extraction and other dust mitigation systems while loading quicklime into trucks was reported as inadequate. Workers report eye irritation and dissatisfaction in the response from management when safety matters are reported.<br>PPE was provided. | Investigation of the incident revealed that a quicklime loading sock was in need of modification and caused excessive dust in the work area.<br>Fit-for-purpose PPE was issued to workers but not used consistently.<br>Mine operators should ensure that equipment is maintained to meet design standards.<br>Workers should be trained in the use and maintenance of fit for purpose PPE.<br>Supervision should monitor and enforce the correct use of PPE as per site procedures. |




## Recent incident publications

**No recent incident notifications.**

You can find all our incident related publications (i.e. safety alerts, safety bulletins, incident information releases, weekly incident summaries and investigation reports) on our website.

## Further information

**COAL (NORTH) and EAST METEX**

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