REPORTABLE INCIDENTS | WHS MINES LEGISLATION

Weekly incident summary

22 February 2017

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: 41  Summarised incidents: 4

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

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Summary</th>
<th>Comment to industry</th>
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<tbody>
<tr>
<td>Dangerous incident</td>
<td>A CAT 789 rear dump truck tipped its load and was heading back to the loader empty. There was a bend in the haul road but the truck continued to drive straight. It hit the windrow and turned over on its side. The driver said he was distracted. The driver had completed three to four loads previously on this road. It appears the driver may have had a micro-sleep.</td>
<td>Operations should review the adequacy of controls associated with worker fatigue. Guidance on fatigue can be found on our website. When designing systems of work, consider the risk of fatigue including the use of engineering aids to monitor operator fatigue.</td>
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<tr>
<td>Dangerous incident</td>
<td>There was a fire in the engine bay of a CAI AE55 truck. The trainee driver noticed flames coming from the engine bay. The driver stopped the truck and extinguished the fire with a hand held extinguisher. The driver then hosed the engine down in the area of the turbo to cool it. The on-board automatic fire system did not operate. The driver did not operate the on-board fire suppression system manually. It was later discovered that an o’ring failure allowed hydraulic oil to spray onto the hot turbo.</td>
<td>Good maintenance practices are essential in preventing the ignition of combustible fluids from hose or pipe failures. Consider guidance in Australian Standard 5062:2016 – Fire protection for mobile and transportable equipment. Truck operators should be trained to respond to a fire event (refer to MDG 15): 1. stop the machine safely 2. shut down all power and the apply park brake 3. activate the fire suppression system 4. initiate the mine emergency response.</td>
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<tr>
<td>Dangerous incident</td>
<td>A mine deputy walking the underground conveyor belts noticed a collapsed roller emitting sparks and heating up. A quick response avoided further danger. During the investigation, it was found that many rollers had been tagged for action along</td>
<td>AS/NZS 4024.3611 Safety of machinery, Conveyors – Belt conveyors for bulk material handling is incorporated into the mechanical engineering control plan code. Clause 5.2 states:</td>
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Incident type | Summary | Comment to industry
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the lengthy conveyor system. | 5.2 Idler Management
A system shall be implemented to minimize hazards created by idler failure in accordance with the following:
(a) The system shall allow the position of idlers to be identified for maintenance purposes.
(b) The system shall identify defective idlers.
(c) The system shall determine when defective idlers should be replaced through an appropriate trigger action response plan (TARP). Where failure of the idler creates a risk to people in the event of a fire (E.g. in confined environments), the TARP shall be escalated accordingly.
The system shall provide for the safe replacement of idlers with consideration to:
(i) location and accessibility;
(ii) weight, size, shape;
(iii) tools/systems required for change out (E.g. lifting gear); and
(iv) required personnel and skills

Dangerous incident
SlnNot 2017/002465
A worker was carrying out some welding at the wash plant. When the worker was changing an electrode in the welding hand piece, he reported receiving an electric shock. The worker was taken to Sutherland hospital for an ECG assessment and cleared of any injuries.
Prior to commencing welding, the work area should be assessed for the risk of electric shock. You should consider hazards such as contact with conductive parts, welding in confined spaces, and welding in damp environments and rain.
All welding equipment should be inspected prior to use and properly maintained. Personal protective equipment (PPE) should be dry and in good order. Site welding procedures and hot work permits should be understood and followed.

Recent incident publications
IIR17-01 Light vehicle collides with mine entry gate
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

Email: mine.safety@industry.nsw.gov.au:

COAL (NORTH) and EAST METEX
Maitland
NSW Department of Industry
Mineral Resources
516 High Street, Maitland NSW 2320
(PO Box 344, Hunter Region MC
NSW 2310)
T 1300 814 609

COAL (SOUTH)
Wollongong
NSW Department of Industry
State Government Offices
Level 3, Block F, 84 Crown Street,
Wollongong NSW 2500
(PO Box 674, Wollongong NSW 2520)
T 1300 814 609

WEST METEX
Orange
NSW Department of Industry
161 Kite Street, Orange NSW 2800
(Locked Bag 21, Orange NSW 2800)
T 1300 814 609

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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (February 2017). 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 Industry, Skills and Regional Development or the user’s independent advisor.