# December 2023 Incident periodical

Recent High Potential Incidents Risk Controls identified by mine-site investigations Communications

**Queensland Coal Mines Inspectorate** 

Coal Inspectorate



# **Ineffective Risk Controls**

- The last periodical for 2023 is about *ineffective risk controls*.
- Many HPI and accident investigations by mine management are not finding risk controls which will be effective to prevent incidents from happening again.
- Investigation reports are recycling failed administrative risk controls which do not prevent the same sort of incident happening again.
- Mine management must find higher order risk controls that are effective in preventing the incidents from happening again.



## Ineffective seat belts

- A coal mine recently found several vehicles (all Utes) had defective seat belts.
- The seat belts were reported to unlatch while the vehicle was in motion.
- 101 vehicles were inspected at the mine; 6 were identified as having defects with seat belts.
- Seat belts had cracked plastics around the tongue and/or failing tongue integrity.
- Seat belts had latch assembly failures where the seat belt pulled out of the latch when tested.
- The cause of the "unlatching" failures has not been categorically confirmed however evidence suggests dust ingress is a potential contributor.



### Ineffective seat belts



Coal Inspectorate



#### Ineffective seat belts – questions for reflection

- Why are the mine's prestart checks not adequately covering the inspection and function checks of seat belts?
- Why are the field task observations / safety interactions not ensuring compliance to your SHMS, every day on every shift?
- Should site vehicles be audited every day/week/month/ year for seat belt integrity and functionality?
- Who checks the effectiveness of your site maintenance systems for seat belt inspections, on both light and heavy mobile plant?



# Loss of control of dump trucks

- 11 notifications in September reported that coal mine workers had lost control of a dump truck.
- Multiple events occurred at three mines.
- Single events occurred at four mines.
- Every event occurred when the dump truck was travelling downhill.
- Fortunately, all the trucks stayed on their wheels.
- Some trucks did cross into the uphill lane during the loss of control event.



### Loss of control of dump trucks







Coal Inspectorate



# Ineffective administrative risk controls found by mine management

#### N.B. These will not stop it happening again.

- Daily inspection sheets to be completed by supervisors/OCE.
- Appropriate actions to be taken at time of inspection.
- Educate CMW's through toolbox talk.
- Conduct a spot spray trial for down ramps only.
- Reminder to truck operators for first load down a ramp to take it easy on gear selection.
- Retrain truck operator and retest in wet conditions.
- Add in the SOP packs to the new starter training packs so truck operators can read between sessions.
- Create SWI outlining the requirements and responsibilities involved in watering circuits with all water carts.
- Retrain truck operator on low traction training.



# **Collisions at dumps and dig faces**

- 11 collisions were reported during September.
- Most collisions happened on dumps or at dig faces.
- One coal mine worker reported an injury.
- Positive communication between equipment operators was made before some of the collisions occurred and did not prevent it.



### **Collisions at dumps and dig faces**





Coal Inspectorate



# Ineffective administrative risk controls found by mine management

#### N.B. These will not stop it happening again.

- Positive Communications between the vehicle operators.
- Share DZXX and RDYYY incident and learning with mining teams.
- Follow safety compliance protocol with operators involved in DZXX and RDYYY incident.
- Mining equipment to keep headlights on at all times, even while queuing.
- Toolbox on positive communication and site SOP refresher.
- Review truck and dozer operations training package and remove any reference to switching headlights off while waiting in a queue.



## **Concrete drop hole mistake**

- Two concreting jobs were happening on the same day at an underground mine.
- Concrete was being delivered to two different areas underground, using two different concrete drop-holes drilled for the purpose.
- One concrete crew called the delivery driver they had used the day before and said they were ready to take delivery at the bottom of their concrete drop-hole.
- The delivery driver went to the wrong drop-hole and sent the concrete down.
- Fortunately, no-one was under that drop-hole at the time.



# Ineffective administrative risk controls found by mine management

#### N.B. These will not stop it happening again.

- Escort phones to have more effective identification when allocated and comms protocols reviewed.
- Update safe work procedures (SWPs) and create checklist.
- Re-establish drophole familiarisation for surface and underground.
- Update safe work instructions (SWIs) to reflect phone and not DACs.
- Addition of pre-checks.
- Drophole checklist added to procedure.
- Investigate Comms Direct link to UG from Surface for all Dropholes.

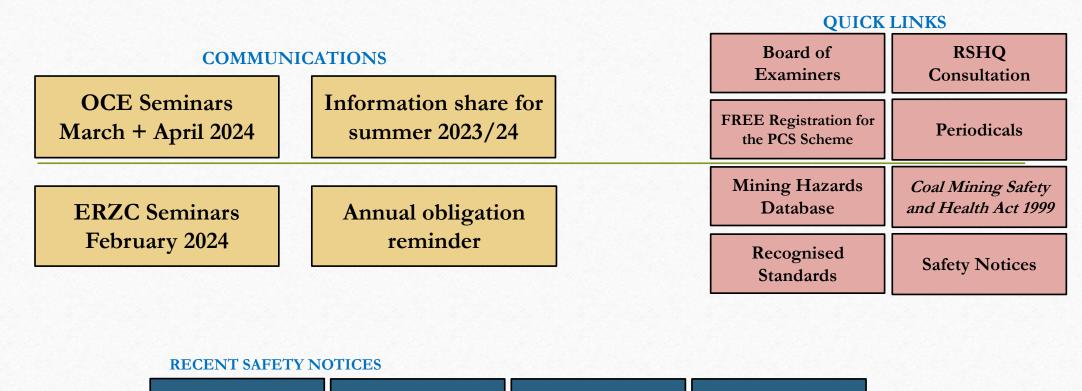


## Medical emergencies at mines

- During September, workers at two mines became unwell during their shift and were taken to hospital.
- Site senior executives are reminded they are obliged to conduct an effective investigation to determine that work-related activity did not cause the medical emergency.
- For example, examining for:
  - exposure of the worker to excessive heat,
  - exposure to chemical agents,
  - situations where the worker may have received a head knock.
- Do not presume that just because it looks like a personal medical matter, no investigation is required.



#### **NOTICE BOARD**



Safety Alert 441 Counterfeit PLC hardwareFluid injected into CMW's skinCMW's foot crushed in scissor lift accidentExc t
---

To subscribe to communications from the Queensland Mines Inspectorate please email <u>QldMinesInspectorate@rshq.qld.gov.au</u>