# Weekly incident summary

NSW RESOURCES REGULATOR

# Week ending 18 April 2018

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 | 50 |
| Summarised incident total | 6 |

## Summarised incidents

| Incident type | Summary | Recommendations to industry |
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| Dangerous incident<br>SinNot-2018/00580 | While lifting a 4-tonne spider cap on a primary crusher, a 10-tonne overhead crane hoist rope failed.<br>  | Lifting procedures must include checks of safety devices fitted to cranes.<br>Workers must follow a site standard or procedure detailing all requirements for bridging, forcing and system impairment including communication to other parties.<br>For routine tasks, procedures should include details of the crane position to achieve a safe lift. |
| Dangerous incident<br>SinNot-2018/00563 | A collision occurred between two haul trucks. One truck reversed into the other. There were no injuries but one truck was damaged. | Mines should review Safety Bulletin SB18-06 Lack of positive communications |

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| Dangerous incident<br>SinNot-2018/00562 | An operator was hit with a stream of hydraulic oil while installing a roof bolt from a continuous miner. The operator was transported to hospital but was cleared of a fluid injection injury. The hose failed due to abrasion from rubbing on another hose.<br>  | Where guarding is in place to protect workers from hydraulic release from moving hoses, the guard should be checked through the complete range of motion to ensure no gaps are present. Mine operators should manage the risk of hydraulic hoses rubbing. |
| Dangerous incident<br>SinNot-2018/00555 | An excavator rolled onto its side while clearing overburden on a bench. The operator suffered minor injuries requiring first aid treatment. The operator was wearing his seatbelt, which reduced the severity of his injuries. | Equipment operators must remain vigilant of the risk of machine roll overs and should be reminded of the importance of wearing seatbelts.<br>When planning tasks and travel paths, supervisors must consider roll over hazards. |

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| Dangerous incident SinNot-2018/00554 | A highwall failed and material spilled over the bund protection and onto the working bench below. This blocked access to part of the pit.<br>While no workers were present in the area where the failure occurred at the time and no equipment was damaged, three workers were temporarily unable to egress the pit due to the access ramp being damaged when the highwall failed.<br>  | A section 195 prohibition notice is in force prohibiting mining operations from taking place in this part of the mine.<br>Review the frequency of assessments of highwall stability and confirm appropriate triggers are included to increase frequency of assessments arising from events such as rain events and shot firing.<br>Mine operators should also review SB17-03 Rocks breach catch bund. |
| Dangerous incident SinNot-2018/00553 | A haul truck ran into a grader while trying to pass it. Positive communications protocols were not followed. No injuries were reported | Digital radio recordings and a review of equipment tracking data provided comprehensive evidence with regard to the |

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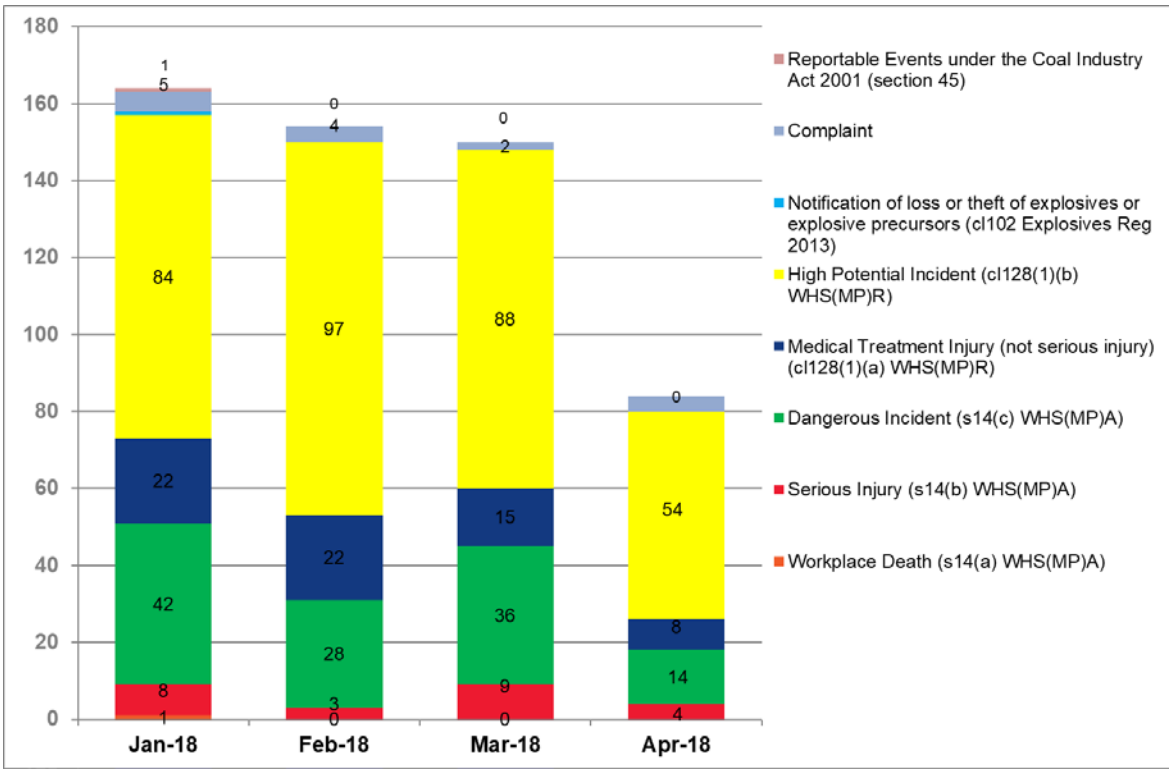
| | but heavy damage was caused to each machine, including a burst tyre.<br>  | sequence of events and the actions of workers operating the equipment involved in the incident.<br>Review the recommendations for positive communications in Safety Bulletin SB18-06. |
| Western Australia<br>Sass 2018/00976 | The Resources Regulator has been made aware of an incident that occurred in Western Australia recently on an elevated work platform (EWP).<br>The telescopic boom “uncontrollably retracted under its own weight approximately 8 metres and stopped on its hard limit”. The unplanned movement occurred due to the failure of two wire rope cables that controlled the boom during the retraction function. An investigation found that the retraction cable mechanism was not maintained to the manufacturer’s specifications, the ropes were not captive in the pulley sheaves and it was evident that one cable had been severed for some time.<br>The retraction cables are inside the telescopic boom section and cannot be inspected visually without disassembly. The detection of rope failure relies on a broken cable indicator system (proximity sensor) to detect excessive movement of the rope as well as a schedule of maintenance and inspections to ensure correct alignment, adjustment and function. | The circumstances of this failure demonstrates the importance of completing maintenance and inspections as specified by the manufacturer. Mines using EWPs must ensure that all maintenance and inspection procedures are completed including those applicable to the concealed rope and sheave mechanisms that control boom retraction. |




**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

- Investigation Information Release: IIR18-02 Serious injury at Werris Creek mine
- Safety Alert: SA18-06 Self rescuer maintenance
- Safety Bulletin: SB18-07 Safe systems of work for mobile plant

**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 | |
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| CM9 reference | CM9 reference |
| Mine safety reference | ISR 18-15 |
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