Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 11 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.

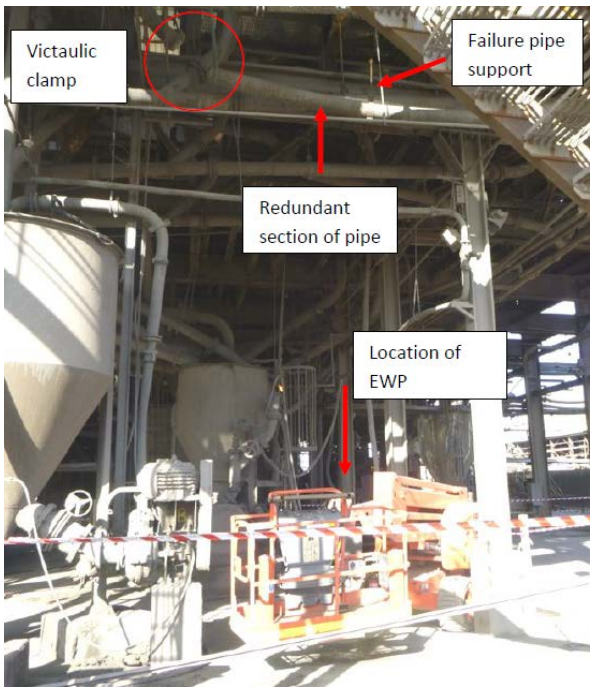
At a glance

High level summary of emerging trends and our recommendations to operators.

Type	Number
Reportable incident total	22
Summarised incident total	7

Summarised incidents

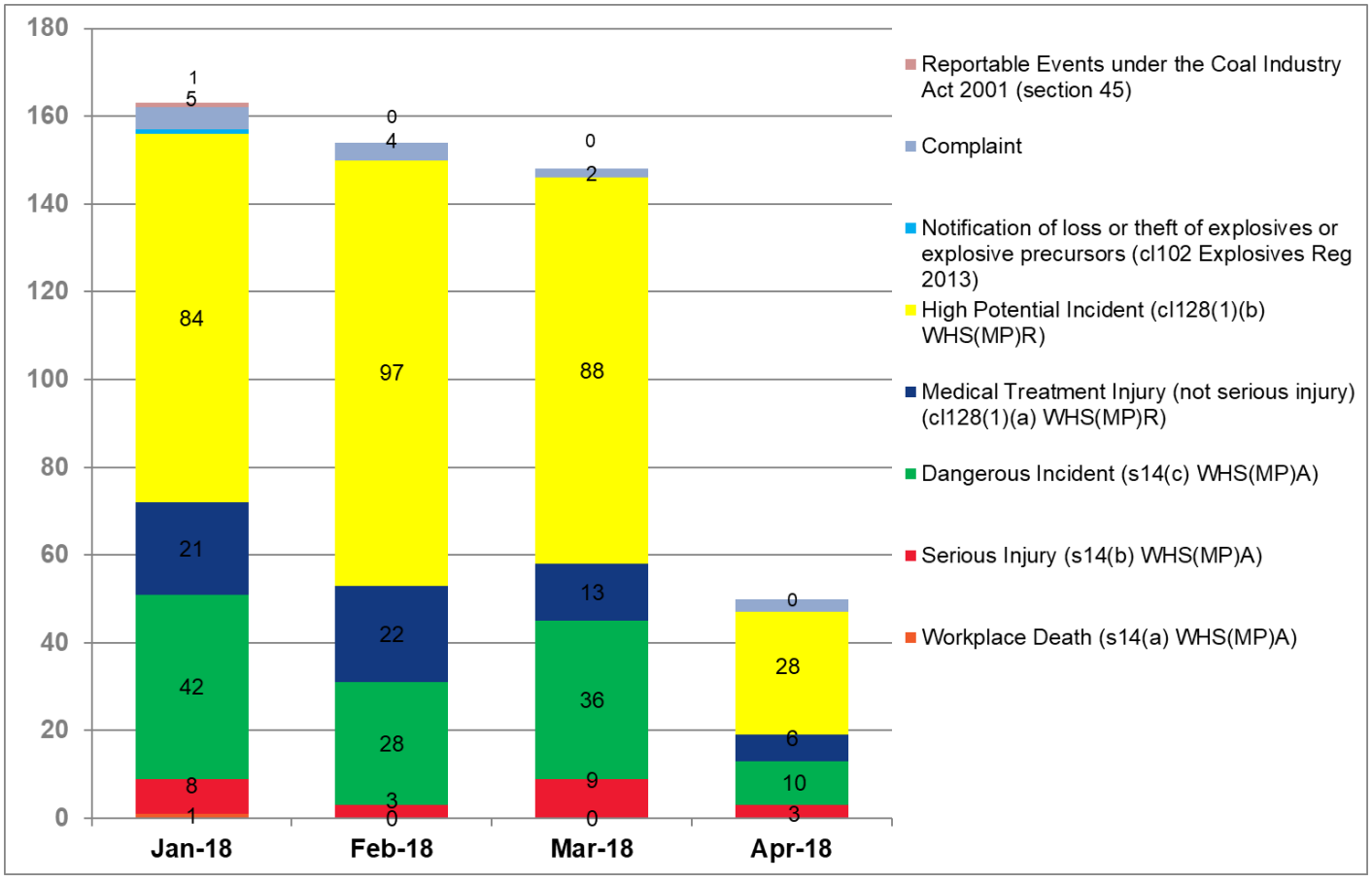
Incident type	Summary	Recommendations to industry
Serious injury SinNot-2018/00521	A worker's finger was crushed when he attempted to dislodge a rock on a conveyor belt.	Equipment should be provided to workers that is correct for each given task.
Dangerous incident SinNot-2018/00528	A collision occurred between a slow-moving haul truck that was passing a stationary grader between the right-hand side of both machines. Seeing the collision about to occur, the grader operator tried to make radio contact with the truck driver, who was on a different channel. No injuries were reported. 	Effective communications protocols and procedures should be in place to ensure that positive communication between all operators is be achieved, and the proper use by equipment operators of these protocols is monitored on a continuous basis. Recently, there numerous incidents have been reported to the regulator where a lack of positive communication between operators has occurred. Monitor and assess compliance with site positive communication protocols. Refer to Safety Bulletin 18-06 Lack of positive communications.

Serious injury SinNot-2018/00520	A worker suffered crush injuries and bruising to his arm when he was removing pipework in an elevated work platform (EWP). The pipe he was undoing suddenly released and fell, hitting his arm against the handrail. A second EWP was required to recover the pipe and release the worker.  	Risk assessments for operation of EWPs should consider the risks associated with a requirement to retrieve or rescue workers from heights. Procedures must be in place, and suitable equipment must be available to facilitate rescue or recovery during working at heights tasks.
Dangerous incident SinNot-2018/00519	A loaded articulated water cart was travelling down a ramp when it began a right-hand turn and lost control and overturned. The operator's cabin was significantly damaged, trapping the operator for some time until he was able to release himself from the vehicle.	This incident is the subject of a major investigation. The Resources Regulator will be undertaking a campaign targeting the safe operation of articulated trucks in mines, with a zero tolerance approach to machine defects, non-compliant access systems, and less than adequate operator training systems. Mine operators should review the effectiveness of controls identified within their safety management systems to manage risks associated with articulated trucks.

Serious injury SinNot-2018/00529	While cutting a shearer stable for maintenance, the tailgate cutting drum of a longwall shearer made contact with a flipper on the roof support. This resulted in a pick tip from the tailgate drum being ejected into a walkway, striking the arm of a worker. The worker required surgery to remove metal fragments embedded in his arm.	Mine operators should review requirements for safe standing zones around operating shearers to protect workers from projectiles, and reinforce these requirements to all workers and supervisors.
Dangerous incident SinNot-2018/00518	A haul truck driver was alerted by a dozer driver that there was a fire visible on the truck. The truck driver stopped, applied the emergency stop and activated the fire suppression system. A hydraulic hose failed spraying oil onto the exhaust system. The fire was localised to an area where a gap in the lagging was identified.	Where lagging is used as a control, gaps, joins and transition points must be assessed for adequacy.

Dangerous incident SinNot-2018/00513	Two haul trucks were passing each other when one operator noticed a flame underneath the other truck. He notified the operator and immediately parked up. The fire was extinguished using a hand-held extinguisher. The centre tail shaft bearing had failed and the heat generated ignited combustible components. 	The lifecycle of components should be managed to minimise the likelihood of failures that could initiate a fire. The Resources Regulator will be initiating a program in open cut mines in the near future examining the impacts of sub-standard maintenance practices on fires on mobile plant.
Dangerous incident SinNot-2018/00510	A surface drill was operating when a small fire occurred. The fire was controlled using a hand-held extinguisher. An investigation identified two hydraulic hoses had rubbed through, releasing hydraulic oil that was atomised and drawn by the fan over the engine. The oil was ignited after making contact with a hot surface at a gap in the lagging near the turbo.	Hose rubbing is a known cause of failure. Mines should enforce the importance of identifying and correcting rub points during maintenance.

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

- SA18-06 Self rescuer maintenance
- SB18-06 Positive communication failures result in collisions
- SB18-05 Shattered windscreens on mobile plant
- SB18-04 Fires on surface drill rigs

Office use only	
CM9 reference	PUB18/169
Mine safety reference	ISR 18-14
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