Week ending 6 December 2017

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.

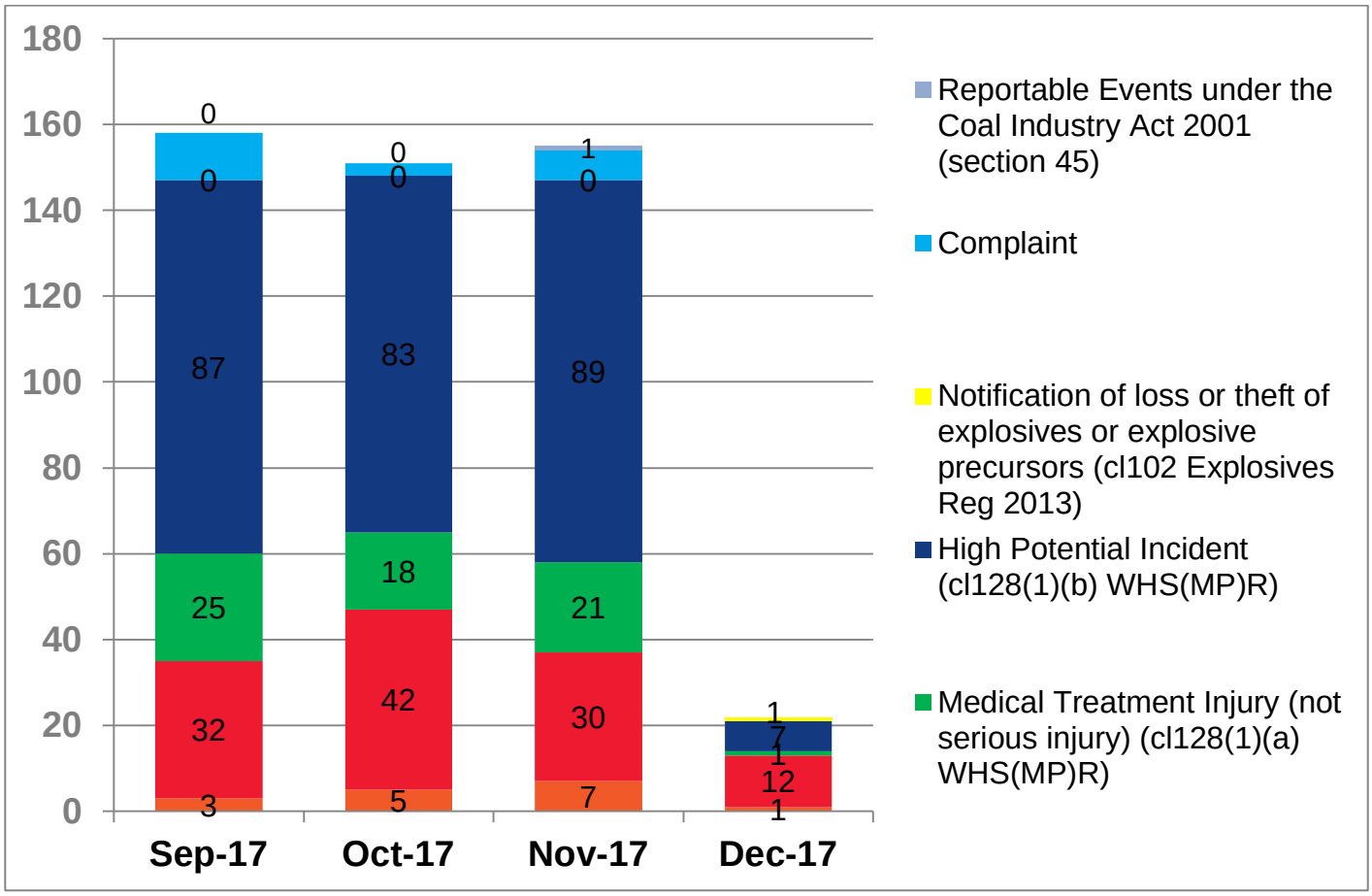
Type	Number
Reportable incident total	40
Summarised incident total	9

Summarised incidents

Incident type	Summary	Recommendations to industry
Serious injury SinNot-2017/01926	A longwall fitter had the top of his left index finger amputated when a maintenance access cover on the top of the longwall crusher fell on his finger.	Mine operators should review how the hazards associated with heavy metal covers are controlled, especially lifting and securing against gravity.
Dangerous incident SinNot-2017/01921	A worker was operating a front end loader on a cross grade with a full bucket that was lifted in the air. This resulted in the front end loader rolling onto its side. The operator was not injured.	Mine operators should review how hazards associated with machines operating on cross grades are assessed and controls are implemented. The assessment should include: • determination of the appropriate machine for the task • maximum cross grades for safe operation of equipment • ensuring that operator training addresses all controls.

Dangerous incident SinNot-2017/01918	A dozer was parked up and the operator was standing on the deck preparing to lower the ladder so he could retrieve earplugs from an approaching grader driver. The approaching grader driver inadvertently accelerated instead of braking and the blade of the grader struck the lower section of the ladder and tore it from the dozer. The dozer driver lost balance and fell from the deck to the ground (about 3 m) and injured his knee.	Mine operators should review their park-up procedures and how supervisors are monitoring compliance with the procedures.
Dangerous incident SinNot-2017/01910	A haul truck was taking waste to the dump when the driver of the following truck saw fluid coming from truck. He advised the driver via two-way radio and then saw what appeared to be a small flame. The flame grew in size to about 40 cm. After more discussions with the truck driver, the onboard fire suppression system was activated to extinguish the flame.	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 Guideline for Mobile and Transportable Equipment for Use in Mines*): • stop the machine safely • shut down all power and the apply park brake • activate the fire suppression system • initiate the mine's emergency response.
Dangerous incident SinNot-2017/01909	An operator was driving an articulated water cart across a windrow as part of the construction process. As he attempted to straddle the windrow he realised his approach was potentially unstable and he tried to reverse out to improve his position. However, the trailer section of the truck rolled over but the cabin remained upright.	Mine operators should review how hazards associated with operating articulated vehicles are assessed and ensure operator training includes these controls, especially associated with movement of water.
Dangerous incident SinNot-2017/01907	During dayshift, workers on the drift conveyor noticed a smell coming from outbye. They investigated and found the source to be hot coal under a roller. When raked out, there was evidence of glowing embers. They did not report this until the end of shift.	Mine operators should review how inspections of conveyors are completed to ensure all parts of the conveyor are compliant. Mine operators should ensure workers notify supervisors of potential hazards in a timely manner.
Dangerous incident SinNot-2017/01906	The operator of a dozer was alerted to a fire on the left hand side of the engine bay by the dragline operator. The dozer operator activated the onboard fire suppression system, which extinguished	Mine operators are reminded to review: • mechanical protection of fluid conductors (hoses) of fuels or oils

	the fire and he left the dozer without incident.	• rubbing and abrasion of cables and fluid conductors • clamps and fixings of cables and fluid conductors • segregation and separation of mechanical services and electric cables and devices • location of and value of maximum surface temperature • location of fire suppression activation points • fire risk assessment • compliance with *Australian Standard 5062:2016 – Fire protection for mobile and transportable equipment*.
Dangerous incident SinNot-2017/01903	During a longwall pump station relocation. a 100 mm diameter flexible water hose with a crimped Victaulic fitting has come apart at the feral. The water hose swung down and hit a worker on the head. He was taken to hospital for treatment. 	Mine operators should ensure hoses and cables are adequately supported to reduce loads on hose end fittings, particularly where suspended over pedestrian accesses. Manufacturers of hose assemblies should review assembly and proof testing procedures as part of their quality systems.
Dangerous incident SinNot-2017/01893	A bearing failed in the troughing set at the front of the longwall mobile boot end resulting in a small grease fire. The fire was quickly extinguished by water.	Mine operators are reminded of the importance of inspections and maintenance of conveyor belts and idlers for the prevention and early detection of fires. Operators should review the effectiveness of: • automatic fire detection systems • condition monitoring programs • inspections for the detection of overheating idlers and rollers. **Refer to:** Mechanical engineering control plan code of practice clause 5.2.1



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.

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