Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 28 March 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	35
Summarised incident total	5

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot-2018/00448	A light vehicle was on a vehicle hoist in a workshop. It was parked in neutral and had wheel chocks applied. The hoist was raised to about 1.5 m for fitters to work on the wheels. They tried to lift the vehicle and found the lifting jack didn't work, so the fitters then cycled the power to the hoist. When power was reapplied the rear left-hand side of the hoist started to creep down (about 300 mm). The fitter operating the hoist was at the front of the hoist. The other fitters tried to stop the unplanned movement. The vehicle didn't move on the hoist because of the wheel chocks, but a fitter was within 3 m of the side of the hoist that lowered.	Mine operators should review and keep no standing zones around plant updated whenever new plant comes to a site. A review of both electrical and mechanical maintenance programs should also be undertaken.
Dangerous incident SinNot-2018/00438	A drill rig was tramming up a ramp for a blast evacuation when a hydraulic hose ruptured. A trail of leaking oil was on the ground until the drill rig stopped due to a low oil level trip. The operator investigated the problem and	When a fire occurs, mine operators must conduct a thorough investigation by a competent person to determine the: → fuel source and heat sources

Incident type	Summary	Recommendations to industry
	saw a flame around the exhaust area. The exhaust and turbo had heat wrapping. The operator activated the fire suppression system manually and used a dry powder fire extinguisher to extinguish the fire. A water cart was called but not used.	→ surface temperature value → cause of the fire → controls to prevent re-occurrence such as reducing engine component surface temperatures and segregating fuel sources from areas of high temperature, and fire safety inspections → training of workers to identify fire risks such as fuels or oil leaks or worn hoses → review of the fire risk assessment for the item of plant. Mine operators should report the issue to the original equipment manufacturer.
Dangerous incident SinNot-2018/00437	A coal burst was reported on a longwall face. No injuries were reported, however a worker was reported to be in the vicinity of where the event occurred. About 20 kg of coal product was ejected into the walkway. A section 195 notice was placed on the mine prohibiting longwall operations.	Mine operators should review how hazards on site are assessed as being a principal hazard. A principal hazard management plan should follow the hierarchy of controls and follow the legislative requirements.
Serious injury SinNot-2018/00431	A surface drill was being packed up. At the time, there were stilsons attached to a cylinder that had no device to stop them falling over. They fell onto a control panel and the operator's left middle finger. He continued operating the machine and reported it 10 minutes later. He was taken to hospital and diagnosed with a compound fracture to the finger.	Mine operators should review how their workforce are trained in personal risk assessments, especially in the recognition of potential hazards and the hierarchy of controls. Mine operators should review what methods are in place for supervisors to confirm compliance.

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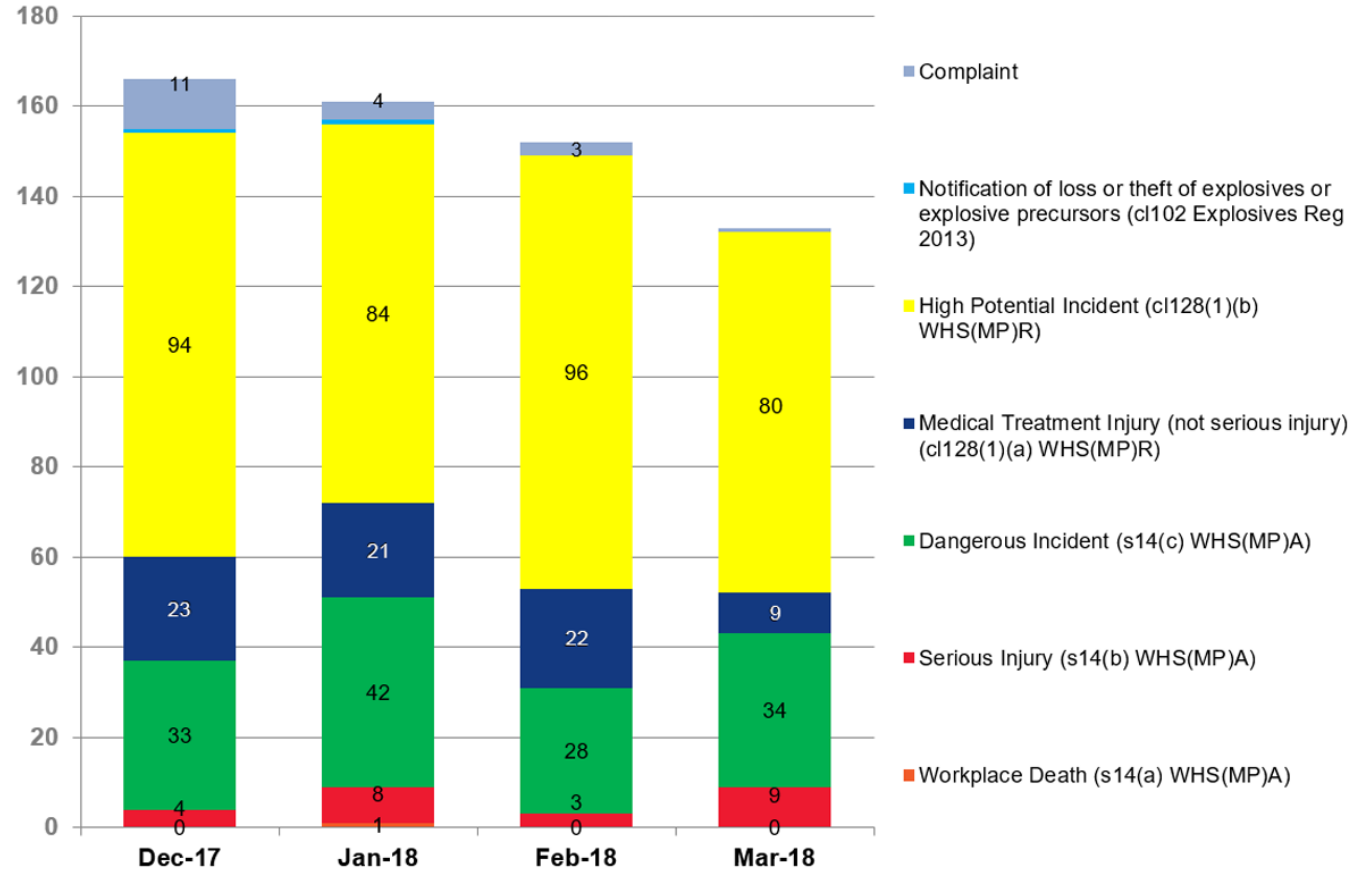
Serious injury SinNot-2018/00429	A fitter suffered an injury to his right hand, including a broken wrist and possible tendon damage when a transport cradle associated with a downhole hammer rig fell. The rig had been transported to site and was being unloaded and set up for use. The fitter had removed a pin from the transport cradle and was standing the cradle up when the cradle fell and jammed his hand and wrist.	Mine operators should review what is in place to assess the hazards associated with a potential change in conditions due to vibration and shaking after loads have been transported any distance.

Number of incident notifications, by commencement month and incident type



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.

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.

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