Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 21 February 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	45
Summarised incident total	9

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot-2018/00259	A new worker operating a loader was cleaning up under a conveyor belt after receiving verbal instructions from a trainer. While cleaning up, the loader made contact with the conveyor structure causing damage to the loader's windscreen.	Mine operators should review their training procedures for new starters and the detailed instructions and procedures that are provided.
Dangerous incident SinNot-2018/00256	A front-end loader was building a ramp on a surface ROM pad. While reversing, the loader's front wheels lost traction and it slid off the ramp. The loader came to rest at an angle of approximately 35 degrees. There were no injuries and the scene was preserved.	Mine operators should review their stockpile ramp design and construction to ensure there is sufficient width and grade to achieve safe access.
Dangerous incident SinNot-2018/00252	The operator of a dump truck detected a hot tyre-like smell. After the tyre fitter checked all tyres with a heat gun the smell remained. The mobile plant fitter was about to check the machine when flames rose approximately one metre from the engine bay. The operator shut down the machine and activated the fire suppression. When the	Good maintenance practices are essential to preventing fires on mobile plant. Heat shields and lagging designed to prevent combustible materials from contacting very hot surfaces must be regularly inspected and maintained.

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	operator exited the dump truck a water cart extinguished the rest of the fire.	Maintenance practices should also include securing loose combustible items such as rubber door seals to prevent contact with hot surfaces.
Dangerous incident SinNot-2018/00248	A worker was taking a sample from a cyclone unit on an exploration drill rig when a noise was heard. The unit cap struck the worker after it was ejected from a small air receiver mounted at the rear of the drill rig.	Mine operators should conduct thorough service and inspection activities prior to returning equipment to service. Service points and connections subject to vibration of compressed air systems should be checked and installed in accordance with manufacturers recommendations, such as torque specifications, lubrication, thread locking and sealing compounds.
Dangerous incident SinNot-2018/00242	While undertaking the process of removing water, the operator of a load haul dump loader (LHD) suffered a laceration to their nose after the reservoir cap was ejected under pressure.	Mine operators should make repairs in accordance with OEM recommendations or make alterations only under an appropriate engineering change management system. Repairs not made to original specification can introduce hazards previously engineered out.
Dangerous incident SinNot-2018/00232	The night shift operator of a haul truck identified a number of alarms sounding in the driver's cabin during the commencement of their shift. To reset the truck the operator went to the main isolator located on the bumper, adjacent to the position of the number one wheel. As the operator de-energised the truck it rolled approximately one metre away	Mine operators should reinforce the importance of correct parking procedures with operators of heavy mobile plant and equipment to ensure they are fundamentally stable, and that park brakes are applied.

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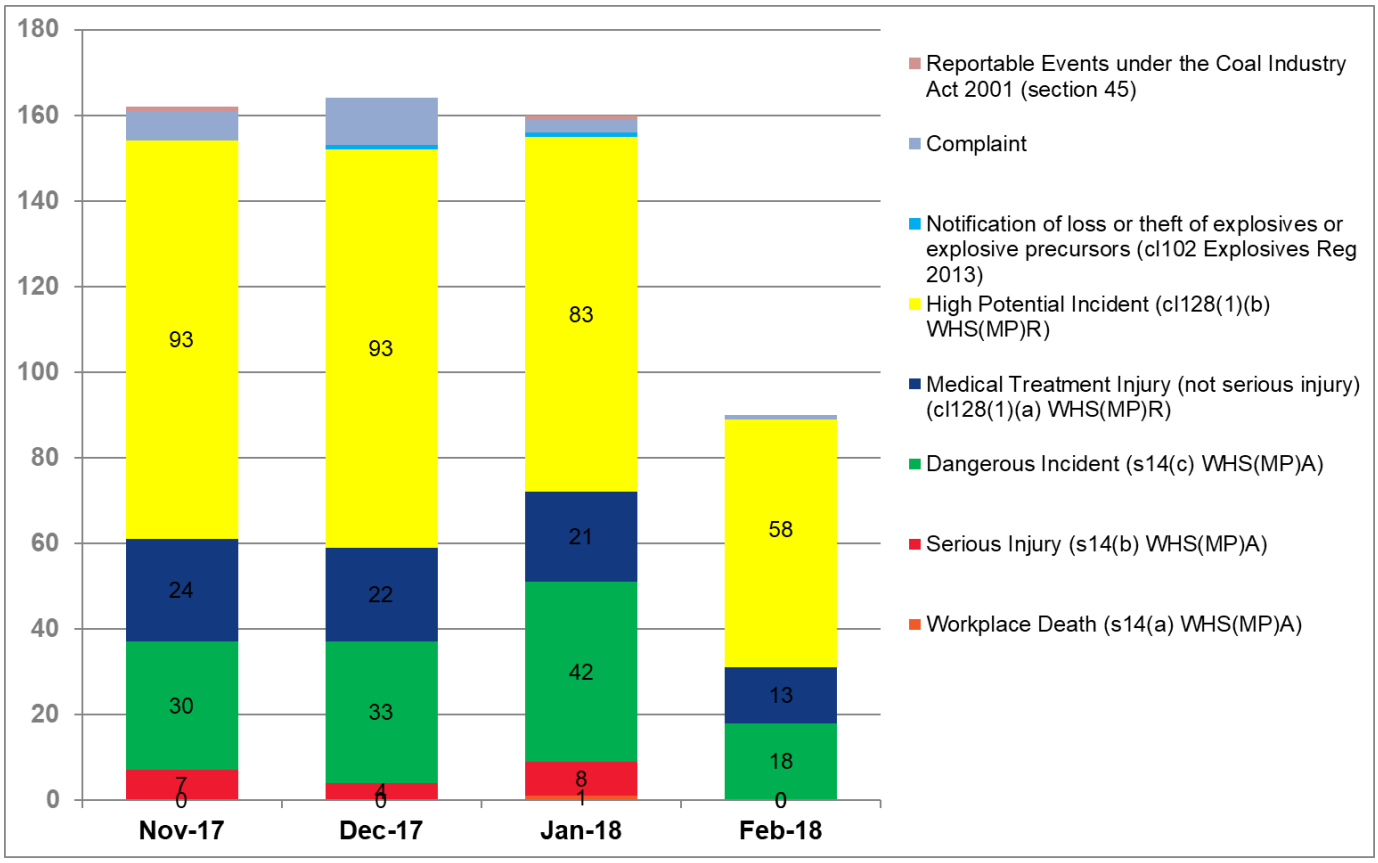
	from the operator's position before coming to rest. No one was injured.	Warning devices such as alarms or interlocks provided to ensure park brakes are applied prior to exiting the vehicle should be regularly tested or inspected to ensure operational effectiveness.
Dangerous incident SinNot-2018/00223	During the process of changing a drill bit, a drill rig operator stepped out of the cab and noticed the dust collector was full. The operator stepped back into the cab and switched from drill mode to raise mask mode. After switching modes the drill rods have spun and a rod has become dislodged, allowing the drill rod to hit and slightly penetrate the cab windscreen. The operator wasn't injured and no other person was in the area.	Mine operators should re-enforce the importance to complete every task as per the procedure in place for the task. Mine operators should highlight that every task takes time. Rushing or taking shortcuts can create unexpected hazards.
Dangerous incident SinNot-2018/00222	A telehandler operated by a sub-contractor was transporting a skip bin containing scrap timber in the coal handling and preparation plant (CHPP) construction area. The telehandler made contact with two concrete footings causing the front left wheel to ride up and over the concrete footings. The contact damaged the bolts and dislodged the skip bin off the forks. No injuries were sustained.	Mine operators should review how hazards communicated to the workforce are correctly controlled in the workplace. Areas of risk in a construction site should be demarcated to ensure people are aware of structures. Mine operators should also review how supervisors ensure compliance with procedures.
Dangerous incident SinNot-2018/00215	A jumbo drill rig was drilling a cable bolt hole when the pivot of the roll over boom collapsed and fell to the floor. No persons were injured.	Effective no-go zones were a critical control in this incident. Mine operators should engage supervisors and workers to uphold compliance with no-go zones.

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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