NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 17 January 2020

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	30
Summarised incident total	6

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0036465 Underground metalliferous mine	A shotfirer loaded a shot and notified it was ready to be fired. A truck and a loader with their respective drivers were still in the exclusion zone. The shotfirer incorrectly thought both operators were together when the truck came out of the exclusion zone. He removed both of their tags and fired the shot. The loader operator was still within the exclusion zone. There were no injuries or damage. It was identified that the mine was relying on the contractor's blasting procedures, however the contractor's procedures did not include the mine's specific details.	Mine operators must have clear and effective blasting procedures that are specific to individual mines. They should also remind workers that personal tags are only to be removed by the person they are issued to.

Dangerous incident IncNot0036464 Underground metalliferous mine	A haul truck caught fire while travelling up a decline. The cause of the fire was an internal failure in a recently rebuilt engine. A mine investigation identified the tappet cover breather caps were modified from a metal cap that was held in place with a circlip, to a plastic cap held with silastic. This allowed the over-pressured engine oil to make contact with the hot engine. The original equipment manufacturer (OEM) is investigating the engine failure. 	When equipment modifications occur, mine operators must confirm that adequate change management processes are followed. This will ensure that any new risks are identified, and additional controls are implemented to reduce the risk to plant, equipment and workers. Engine breather caps should be checked and confirmed to be suitable, as specified by the OEM.
Dangerous incident IncNot0036471 Surface coal mine	An excavator was loading overburden. The first bucket was taken from an out-sequence location. When the excavator swung back to the face it hit a dozer lift ram. The dozer was cleaning up the dig floor and the operator had assumed that the excavator would not return to the same location. The mine is implementing proximity awareness technology that is being commissioned.	Mine operators should remind all equipment operators of the importance of positive communication across all parts of the mine site. Dozer operators should make positive communications with excavators before entering any excavator swing radius.

Mine operators should consider proximity awareness technologies for high interaction areas.

Dangerous incident

IncNot0036500

Underground metalliferous mine

An underground loader was in a draw point of an extraction drive.

The operator saw smoke coming from the engine area. The operator shutdown the loader. He inspected the engine bay and saw flames coming from the belly plate area. He activated the fire suppression system, which extinguished the fire.

A mine investigation identified that the mine had made a modification to all its loaders to facilitate taking engine oil samples. The failed hose had been clamped in place and was not part of any scheduled service inspection.

The OEM did not approve any modification.

When modifications take place, mine operators should challenge if the modifications are the best option. Consultation with the OEM is suggested when the modification is identified as a life of asset modification. Operators must confirm that adequate change management processes are followed to ensure any new risks are identified and additional controls are implemented.

Any modifications to plant must be added to service schedules so that they are maintained throughout the life of the asset.

Serious injury

IncNot0036504

Underground coal mine

During production on a longwall face, a roof support relay bar became disconnected from the tailgate drive frame because of the failure of the vertical connecting pin.

A mechanical fitter was trying to realign the relay bar clevis by lifting the relay bar with a chain block. The security of the attachment point between the chain block and the relay bar was not verified because the hook was underwater.

The relay bar was then operated by manual hydraulic control in order to realign the vertical pinhole. This caused an additional load on the chain block hook. The hook became disconnected from the relay bar and hit the mechanical fitter's face.

The fitter suffered lacerations and minor fractures to his right cheekbone.

A mine investigation identified there was no safe work procedures (SWP) in place for this task.

Mine operators should review their lifting equipment management plans to ensure all tasks using lifting equipment have appropriate SWPs developed for routine and none-routine tasks.

Mine operators must provide adequate information, training and instructions to protect workers from risks while carrying out lifting tasks.

When repairs and maintenance are being carried out, safe standing zones must be established to account for any failures.

Dangerous incident

IncNot0036508

Underground metalliferous mine

A fitter was attending to a breakdown at an underground plate feeder. He was using a battery-powered grease gun to purge grease lines. When he disconnected the grease gun from the grease nipple there was a high-pressure release from the grease nipple that hit him in his forearm.

The fitter was taken to hospital where it was confirmed that he had suffered a fluid injection injury. The fitter underwent surgery to remove the grease.

The mine removed all the battery grease guns from service until its investigation was completed.

Ensure all employees working with or around equipment with high-pressure hydraulic systems are fully aware of the dangers of fluid injections entering the body and the damage they can cause. Mine operators should develop emergency response procedures for dealing with high-pressure fluid injection.

Pressurised fluid injuries are a failure of a risk control to a major hazard. When equipment is tested or repaired, no standing zones must be implemented to remove workers from the line of fire if a failure occurs.

We have published the following safety alerts, bulletins and guides on this topic:

- SB13-01 Fluid injections result in surgery
- SB12-03 Fluid power isolation failures
- SA06-16 Fatal high-pressure hydraulic injection
- SA09-04 Hydraulic injection near miss

Other publications of interest

The incidents are included for your review. The NSW Resources Regulator does not endorse the findings or recommendations of these incidents. It is your legal duty to exercise due diligence to ensure the business complies with its work health and safety obligations.

PUBLICATION	ISSUE/TOPIC
	International (other non-fatal)
MinEx NZ	**Crush injury while welding** A worker was welding on a grader blade turn circle that was not chocked adequately. The stand failed and the turn circle rotated downwards onto the concrete causing severe crush injuries to his feet. Details
	National (other, non-fatal)
EWPA	**Interference effects using radio transmitters in MEWPS** The purpose of this information sheet is to inform operators and supervisors of the risk associated with using UHF radio transmitters in mobile elevating work platforms (MEWPs) and to provide guidance on the use of such devices. Details

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.

DOCUMENT CONTROL	
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