WEEKLY INCIDENT SUMMARY

Week ending Friday 25 October 2019

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	34
Summarised incident total	6

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0035855	A grader driver was using a hydraulic platform to lower himself to the ground when the hydraulics failed and the platform fell. The driver hit his ribs on the hand rail. He was taken to hospital. 	In relation to hydraulic systems and equipment, mine operators should ensure: • case drains and return lines are installed as per the design drawings • workers have adequate information, training and competencies for the task • commissioning activities and checks for maximum working pressure, relief settings, flows are completed.

Dangerous incident IncNot0035854	A load haul dump (LHD) operator parked a vehicle and applied the handbrake to take a temperature reading on the differential when the machine rolled forward. The operator had to jump out of the way but was uninjured.	It is important to park vehicles in a fundamentally stable position whenever workers leave them. There have been numerous incidents reported in which workers have been run over by the machine they were operating.
Dangerous incident IncNot0035856	While installing 8 metre, twin-strand cable bolts, a drill steel contacted a powered 11kV high voltage cable, damaging the cable sheath and wire strands. The power remained on and was subsequently manually isolated. There were no injuries. 	Workers need to maintain awareness when working around energised sources. Areas with high voltage cables are to be clearly delineated. The installation of isolation or hard barriers should be considered before starting work.
Serious injury IncNot0035869	Following relocation of a boot end using a quick detach system (QDS), a conveyor belt tension caused the boot end to retract, pinning a worker underneath.	The NSW Resources Regulator will publish a safety bulletin with recommendations relating to boot end relocations. When completing isolation, workers must isolate all energy sources and dissipate stored energy. Safe standing zones must be created and communicated to protect workers from high risk areas.
Dangerous incident IncNot0035876	While operating a truck in a main decline, a fire began in a rear driveshaft. Initial investigation suggested the rear driveshaft support bearing overheated and caused grease contained in the bearing to catch	The NSW Resources Regulator's position on fires on mobile plant is that *all fires on mobile plant are avoidable and preventable.* Mine operators should be aware of the Regulator's expectations with regard to fires on mobile plant as outlined in the recently

	fire. The bearing was under the tub area and not adjacent to any significant fuel source.	published position paper Preventing fires on mobile plant.
Dangerous Incident IncNot0035881	A diesel powered integrated tool carrier vehicle was driving up an incline when it lost power. The brakes failed to engage, and the machine rolled downhill about 30 metres to the level below. There were no injuries reported.	Mine operators should ensure defect reporting and pre-start inspections are being used effectively to maintain safe operating plant. Safety critical systems such as braking and steering systems should be inspected, maintained and tested in accordance with the manufacturer's recommendations.

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
	National (fatal)
DMIRS	**Trailer tarpaulin cover mechanism failure – Fatality SIR No. 278** On 11 September 2019, the mechanism used to open and close a tarpaulin cover on a triple road train trailer failed while a truck driver was in the process of closing the cover. 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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