

WEEKLY INCIDENT SUMMARY

Week ending 10 May 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	24
Summarised incident total	5

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0034556	A 20 tonne crane rolled over. The crane was travelling while carrying a load and rolled over while attempting to turn. The boom came to rest against an adjacent container. No workers were injured.	When planning travel paths for mobile cranes, the path must be inspected and load charts must be assessed to confirm the crane will remain within safe operating limits.



Dangerous incident
IncNot0034518

A fire occurred on a loader in an underground metalliferous mine. A worker reset a circuit breaker while fault finding, which caused an upstream circuit board to trip, resulting in a short circuit and an electrical fire. The fire was extinguished by a hand-held extinguisher.



When fault finding on electrical circuits, workers must use test equipment to identify possible short circuits. Workers should-not rely on resetting circuit breakers to find faults.

Dangerous incident
IncNot0034536

An unplanned movement occurred on a crane at a processing plant. During scheduled maintenance, the pendant controller was left attached to the crane and exposed to rain. During commissioning, the crane moved towards a worker and struck scaffolding that was erected around the crane. The worker hit the emergency stop on the pendant, but it failed to stop the crane. Another worker successfully stopped the crane by using an emergency stop on a fixed control box.

The cause of the water ingress was due to modifications to the remote by the distributor, which rendered the manufacturer's controls ineffective.

The ingress protection (IP) rating of plant is critical for its safe use and must be maintained. Plant that has been exposed to water or heavy rain must be checked before being used.



Dangerous incident
IncNot0034538

A rigger suffered an electric shock at a dragline overhaul site while cleaning welding equipment. The rigger had difficulty splitting a welding lead coupling and applied extra force. This resulted in the rubber sheath being dislodged and exposing the brass coupling pin that contacted the worker's gloved hand. The exposed pin contacted the surrounding steel, striking an arc.

Welding machines must be isolated when not in use. Workers who are given tasks to clean work areas must be given clear instructions and must confirm that equipment is isolated before commencing work.



Serious incident
IncNot0034559

A worker was injured when a compressed air fitting failed. The worker was hammer drilling on air when the fitting broke and air was released. The worker fell off the work platform. The hoses were restrained and did not hit the worker. Another worker shut down the compressor to stop the flow of air. The worker was transported to hospital, kept overnight for observation and released the following day.

Daily inspections should include compressed air hoses, fittings and whip checks. Compressed air systems should be assessed for the risk of whipping hoses and controls, such as whip checks, should be put in place.



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	<p>Yet another ADT rollover</p> <p>A loaded ADT was travelling down a haul road. As it negotiated a bend in the road, the bin rolled onto its side. Although road conditions and the gradient of the decline may have been factors, the findings from the investigation indicated that speed at this corner was the major contributing factor.</p> <p>Details</p>

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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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (May 2019). However, because of advances in knowledge, users are reminded of the need to ensure that information upon which they rely is up to date and to check currency of the information with the appropriate officer of the NSW Department of Planning and Environment or the user's independent advisor.

DOCUMENT CONTROL

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Approved by	Chief Inspector Office of the Chief Inspector
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