Weekly incident summary



Week ending 15 November 2017

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

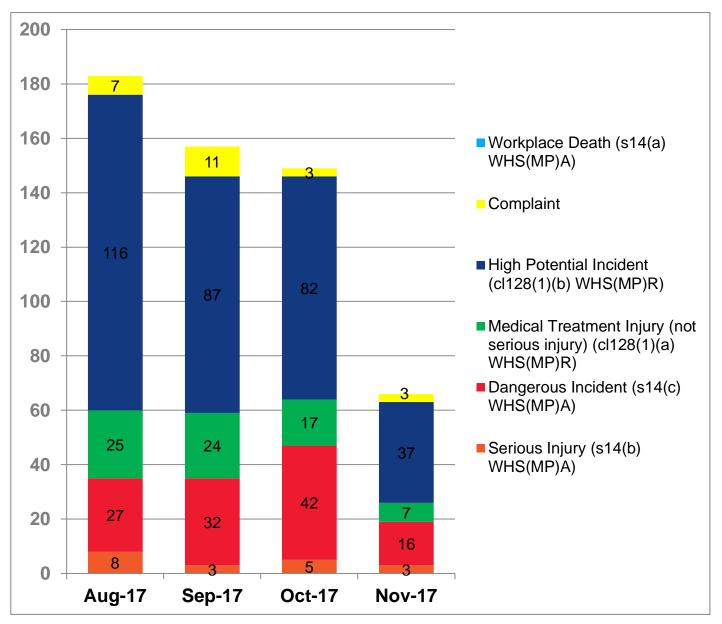
High level summary of emerging trends and our recommendations to operators.

Туре	Number
Reportable incident total	35
Summarised incident total	6

Summarised incidents

Incident type	Summary	Recommendations to industry
	Equipment alert: Manufacturer notice – Kidde fire extinguisher recall Kidde has recalled 134 models of plastic- handled fire extinguishers manufactured between 1973 and the present date. This action is in concert with an alert from the United States Consumer Product Safety Commission. Some extinguishers have been known not to work when needed, others to come apart under pressure - one death has been reported. Some were sold under Kidde's brand, some under the name of other retailers. Access the alert <u>here</u> .	Mines: contact suppliers or www.kidde.com for more information.
Dangerous incident SinNot-2017/01811	The operator of an excavator saw a fire system fault light in the cab. The operator shut down the machine and inspected the engine bay but he could not find anything wrong. The operator called for a maintenance electrician to investigate the fire system. An electrician inspected the right-hand engine and saw a small fire on the turbo. He used a fire extinguisher to extinguish the fire. A water cart was placed on standby, but not used.	Where practicable, hoses should be segregated from hot surfaces using hard barriers. Review the controls in place to prevent onboard fires, especially associated with components with high surface temperatures (e.g. turbos) with the original equipment manufacturer (OEM) Good maintenance practices and housekeeping are essential in preventing the ignition of combustible fluids from hose, pipe and fitting failures. <i>Refer to AS5062:2016 Fire protection for mobile and transportable plant</i>

Dangerous incident SinNot-2017/01795	A small bushfire resulted when overhead powerlines came close together and arced. Movement in the powerlines was attributed to suspected blast overpressure. About 4m ³ of area was burnt out and extinguished with a watercart.	Consider impacts to infrastructure when planning blasts. Electrical infrastructure may require isolation.
Dangerous incident SinNot-2017/01785	During monorail services retraction, a monorail beam separated from a monorail trolley and subsequently two more trolleys fell to the ground. An operator was about 3 m away operating the traction drive using a pendant control.	Review the controls that are in place to prevent monorails from separating. This should include regular inspections of end connections for evidence of overloading or plastic deformation. Inspections also should include correct alignment and support
Dangerous incident SinNot-2017/01781	A 3.3kV back-to-back coupler failed in service on a monorail in B heading. It ejected one of the plugs and there was a visible light and a loud bang. A worker was within 5 m of the failure, another 10 m away and another 25 m away. All three reported ringing in their ears. The two workers closest to the coupler were sent to hospital for treatment.	Electrical protection systems must be designed and configured to detect and clear short circuits, including arc-faults. Review the inspection and maintenance of all electrical couplings depending on the use and environmental factors.
Dangerous incident SinNot-2017/01779	An underground low speed collision between a grader and a LHD was reported. A grader was travelling about 20 km/h in an outbye direction while an LHD sounding its horn began entering the intersection. The bucket of the LHD hit the grader. The bucket of the LHD was bent. No injuries were reported.	Review vehicle transport rules with regard to clear vision, adequate machinery lighting, signs and right of way.
Dangerous Incident SInNot-2017/01763	An OCE step-up supervisor had positioned a lighting plant using a Toyota Hilux ute. After disconnecting the lighting plant, as the vehicle drove away the left front wheel was half dislodged off the axle. A number of wheel nuts were loose and a stud was broken.	All mobile machinery should be regularly inspected and maintained. Review the requirement for wheel stud indicators. All machinery operators have a responsibility to complete a pre-start inspection of a machine.



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.

Recent publications

<u>Consolidated report – structural integrity of coal handling and preparation plants (CHPPs)</u>

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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