

WEEKLY INCIDENT SUMMARY

Week ending Friday 8 November 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	37
Summarised incident total	7

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0035968	<p>An empty dump truck was being driven down a mine decline when the operator felt vibration in the drive train. He stopped the truck to investigate and saw a fire on the drive shaft. The fire was put out with a hand-held extinguisher. No injuries were reported.</p> 	<p>Our position on fires on mobile plant is that all fires on mobile plant are avoidable and preventable.</p> <p>Mine operators should be aware of our expectations with regard to fires on mobile plant as outlined in the recently published position paper Presenting fires on mobile plant.</p>

Dangerous incident
IncNot0035970

About 2 am while driving an empty haul truck down a ramp, the driver had to shut down the truck due to a critical engine alarm.

While the driver was in the process of parking up and shutting down, an orange flash was seen coming from the left rear of the truck. The driver heard a tyre deflating. The driver exited the cabin and attempted to lower the boarding ladder, however it would not operate.

The driver re-entered the cabin which was full of smoke.

The driver activated the fire suppression system and left the cabin. With some difficulty, due to poor visibility, the driver was able to descend the emergency ladder to the ground. The fire was extinguished by site water trucks.

The driver was taken to hospital for assessment as a precaution.



Our position on fires on mobile plant is that all fires on mobile plant are avoidable and preventable.

Mine operators should be aware of our expectations with regard to fires on mobile plant as outlined in the recently published position paper [Preventing fires on mobile plant.](#)

Mine operators should also review training packages for heavy plant to ensure they include the application of emergency escape procedures.

Dangerous incident
IncNot0035963

During blasting operations, a 50 millimetre piece of fly rock landed on the roof of an adjacent building outside the exclusion zone.

Persons conducting business or undertakings (PCBUs) should be aware of clauses 26 and 31 and Schedule 2 of the Work Health and Safety (Mines and Petroleum Sites) Regulation 2014.

Mine operators are reminded that appropriate systems must be in place to review and audit the explosives control plan and blasting work practices to ensure that

High potential incident

IncNot0035985

A drill operator was retrieving a production drill from the surface workshop after a service. To tram the machine from the workshop bay, the operator removed the barricade tape at the entrance and went back to the cabin of the machine. While the drill operator was preparing to begin tramping, a fitter parked a light vehicle in front of the drill without the drill operator's knowledge and walked away. The light vehicle was not visible from the cabin of the drill as the machine was in the tramping position with the boom and carousel raised. The drill operator moved the drill forward, colliding with the parked light vehicle.



exclusion zone requirements are adequate. See our publications:

[SA05-16 Blast control – flyrock incident](#)

[IIR17-08 Dangerous incident during blasting](#)

The risk of collision when vision is restricted is well documented and reasonably foreseeable. Suitable risk controls such as cameras and vehicle escorts should be used when tramping large items of plant with restricted visibility around mine sites.

When dealing with the risk of a collision involving mobile plant, the hierarchy of controls should be followed. Systems such as collision detection and avoidance systems, visual aids and segregation should be implemented before relying on procedural controls.

Dangerous incident

IncNot0035992

During the commissioning of a single point isolation valve (SPIV) at the maingate, the SPIV lever broke from the main manifold resulting in the operator's right forearm being covered in solsenic fluid.

It was identified that the bolts failed.

An escape of pressurised fluid in the workplace represents a failure of a risk control to a major hazard (pressurised fluids) that may cause serious or fatal injury. Mine operators are reminded that effective isolation and energy

dissipation is a critical risk control when working on high pressure fluid systems.

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](#)

[MDG-41-Fluid-power-systems](#)

[MDG-40 Guideline for hazardous energy control](#)

Dangerous incident
IncNot0035997

A light vehicle was driving up a rehabilitated slope towards a contour drain. The depth of the contour drain was not visible from the driver's seat with a drop-off on the other side of about one metre. When the vehicle crested the contour drain, it continued over the edge and overturned.

Four people were in the vehicle at the time. There were no injuries.



Vehicle operators must remain vigilant of the risk of rollovers and should be reminded of the importance of wearing seatbelts. When planning tasks and travel paths, supervisors must consider roll over hazards.

Dangerous incident A dredge on a river caught on fire in the engine
IncNot0036010 compartment.
The dredge operator followed the fire procedure, closed all the hatches and used a fire extinguisher to put out the fire.
The operator was not injured.



Our position on fires on mobile plant is that all fires on mobile plant are avoidable and preventable.

Mine operators should be aware of our expectations with regard to fires on mobile plant as outlined in the recently published position paper [Preventing fires on mobile plant](#).

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 (November 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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