

# WEEKLY INCIDENT SUMMARY

Week ending Friday 15 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 | 38     |
| Summarised incident total | 6      |

## Summarised incidents

| INCIDENT TYPE                   | SUMMARY   | RECOMMENDATIONS TO INDUSTRY   |
|---------------------------------|---|---|
| Serious injury<br>IncNot0036036 | <p>When changing a section of conveyor belt, a worker was using a chain block with a scissor clamp on the side of a belt when the clamp slipped off and hit him below the eye socket. The scissor clamp had very little tension on it and let go when tension was applied to the chain.</p>  | <p>Pre-task job safety assessments should be undertaken before the start of any task.</p> |

Fatality  
IncNot0036060

At an open-cut coal mine, the operator of a push-dozer was found unconscious in his vehicle. Ambulance officers attended and the operator was pronounced deceased a short time later.

This incident is the subject of a major investigation and further information will be published at a later date.

Dangerous incident  
IncNot0036032

While driving a haul truck up a ramp at an open cut coal mine, the driver tried to reduce the brightness level of the modular system display screen. The driver eased off the accelerator to the point where the truck began to roll backwards.

The driver did not notice the truck was rolling backwards. A second truck coming up the ramp moved across the ramp to avoid a collision but the trucks collided. The impact occurred at low speed (about 10kph).

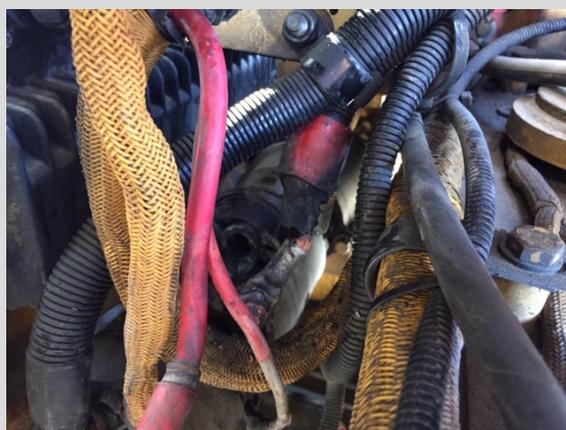
The driver of the truck that rolled back had been operating the truck for the entire shift.

Mine operators are reminded that the machine operator cabs are work areas and that driver ergonomics are important. Mine operators should review machine operators' cabs to ensure items that could distract operators while in operation are minimised. Operators should also instruct drivers to stop in designated safe areas to make any adjustments to equipment.



Dangerous incident  
IncNot0036040

An electrical fire occurred on an agitator truck when the starter motor solenoid failed to disengage. The continuously running starter motor and/or electrical contacts shorted out, causing heat and insulation on nearby cables to melt and ignite. The fire was extinguished when the operator activated the automatic fire suppression system.



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 \(October 2019\)](#).

Dangerous incident  
IncNot0036063

Two mechanical tradesmen were commissioning a pump at a washery, had adjusted the gland packing and pumped grease into the gland and bearings. The temperature of the pump was about 50 degrees Celsius, so the workers set up an airline to cool the pump while the gland seals bedded in. As one worker was reaching to the top of the pump barrel to secure the airline, there was a loud 'pop' and one of the grease lines failed. The loose end of the hose hit the worker on the forearm, causing a bruise and swelling. The worker was taken to hospital and was cleared of fluid injection injuries.

An escape of pressurised fluid in the workplace represents a failure of a risk control to a major hazard (pressurised fluids) that may cause a 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](#)

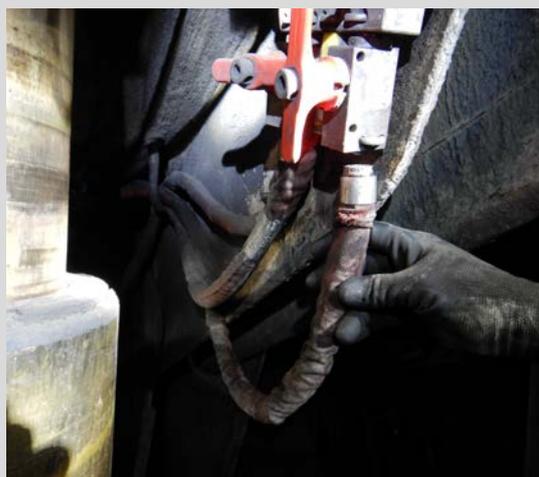
[MDG-41-Fluid-power-systems](#)

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



Dangerous incident  
IncNot0036064

A fourth-year apprentice, working under indirect supervision was function testing longwall shields as part of the longwall commissioning process. While he was function testing a shield, there was a release of fluid from a broken base lift hose. The broken hose had been identified earlier and an out-of-service tag had been fitted. It was later confirmed that the apprentice had not suffered a fluid injection.



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, correct use and understanding of out of service tags procedures and energy dissipation are critical risk controls 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](#)

**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

|                              |  |
|------------------------------|--|
| <b>CM9 reference</b>         | DOC19/1013081                                    |
| <b>Mine safety reference</b> | ISR19-45   |
| <b>Date published</b>        | 22 November 2019                                 |
| <b>Approved by</b>           | Chief Inspector<br>Office of the Chief Inspector |