

# WEEKLY INCIDENT SUMMARY

Week ending Friday 27 September 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 | 47     |
| Summarised incident total | 9      |

## Summarised incidents

| INCIDENT TYPE                       | SUMMARY  | RECOMMENDATIONS TO INDUSTRY  |
|-------------------------------------|--|--|
| Dangerous incident<br>IncNot0035615 | <p>A load haul dump (LHD) machine coupled to a pipe trailer was being used to install pipes in an underground coal mine when an unplanned movement of the trailer occurred. The trailer detached from the LHD and began to roll down the drift.</p> <p>The trailer moved about 3 metres then broke the QDS hoses, causing failsafe brakes to engage, which stopped the trailer. A worker on the outbye end of the pipe trailer, jumped off once it started moving. Another worker, who was on the inbye end, remained on the trailer until it stopped. Neither worker was injured.</p> | <p>Pre-start checks of equipment are an essential part of maintaining fit-for-purpose plant.</p> <p>Unplanned movements of machinery should be accounted for when developing safe standing zones. The risks of unplanned movements should be communicated to all workers during no-go zone training.</p> |



Dangerous incident  
IncNot0035623

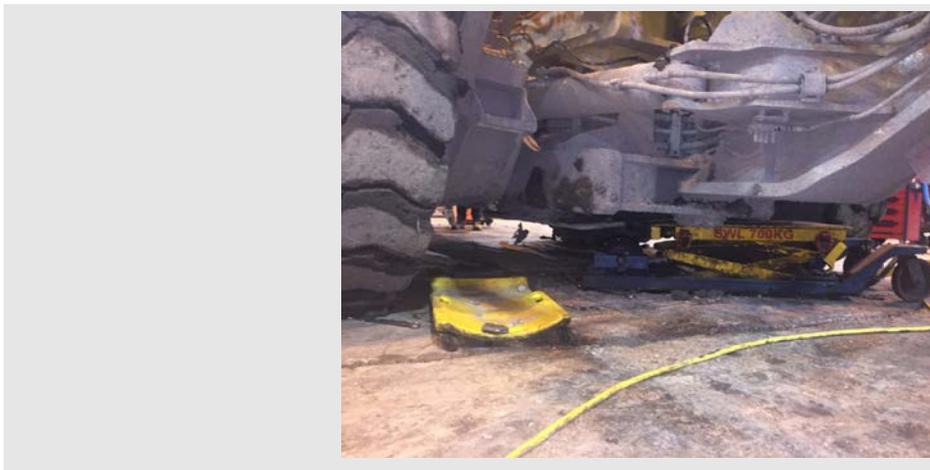
A fitter working on a grader at a surface coal mine was removing the grader's belly guards using a rattle gun. The belly guard weighed at least 100 kilograms. The fitter had not put the trolley jack under the belly plate or removed the retaining bolts. The fitter had two bolts finger-tight, which failed. The belly plate swung down and pinned the fitter's hand between the rattle gun and the ground.

An X-ray confirmed there was no fracture, but the fitter suffered swelling and scratches.

The mine identified that there were no procedures for this task.

Mine operators must provide safe systems of work.

The work methods and controls used must consider the risk of falling material, the positioning of workers, and the use of mechanical aids.



Dangerous incident  
IncNot0035634

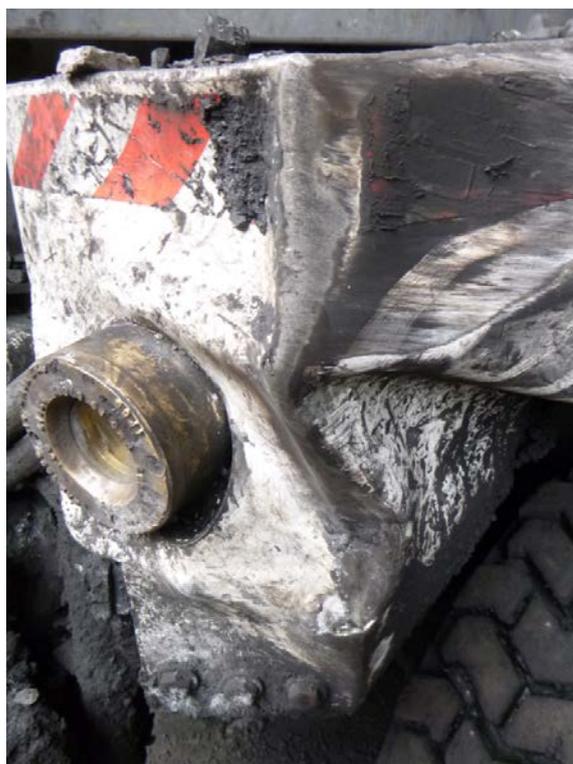
A personnel transport vehicle was travelling out of an underground coal mine when it hit the rib. There were several workers in the vehicle and one worker, who was seated in the rear compartment, suffered a soft tissue injury.

There was damage on the front left-hand corner of the vehicle, however it was able to be driven out of the mine.

The driver may have been driving too fast and the road was reported as being slippery.

Mine operators must maintain travel roads in a safe condition and should establish and communicate speed limits when road conditions change.

Drivers should always adjust their speed to suit road conditions.



Dangerous incident  
IncNot0035641

A batch of longwall roof supports started to advance automatically at an underground coal mine. The incident occurred on the fifth shear after the longwall had been recommissioned. When the supports started to advance there were two longwall operators situated within the maingate no standing zone. The mine investigation identified that roof support software had been updated and the supports had operated correctly as per the parameters associated with automation. The software parameter checklist used during commissioning was identified to be incorrect for the software upgrade. There were no injuries.

Mine operators must provide safe systems of work. When any plant is recommissioned, commissioning checklists must be reviewed so that if any changes have taken place the checklists capture these changes.

Dangerous incident  
IncNot0035643

A haul truck was travelling up a ramp at a surface metalliferous mine, when a turbo fire occurred.

The operator could not operate the fire suppression system because an 'R safety clip' was left under the activation button. A water truck travelling behind the haul truck extinguished the fire.

There were no injuries to workers, however there was damage to the vehicle.



When fires occur, mine operators must conduct thorough investigations by a competent person to determine the:

- fuel source and heat sources
- surface temperature value
- cause of the fire
- controls to prevent reoccurrence such as reducing engine component surface temperatures, segregating fuel sources from areas of high temperature and fire safety inspections
- worker training to identify fire risks such as fuels or oil leaks or worn hoses
- review of the fire risk assessment for the item of plant.

Mine operators should report the issue to the original equipment manufacturer.

Serious injury  
IncNot0035647

A worker suffered a medical episode while travelling on a mine access road at the end of his shift at a surface coal mine. The worker's vehicle left the road, travelling about 250 metres over a guide post, tree sapling and a large poly pipe before hitting a large tree.

The impact with the tree did not cause the vehicle airbags to be set off.

The worker could not remember the accident and was taken to hospital by ambulance.

Mine operators should review and consider the findings from reports published by the Regulator in relation to non-work related deaths, for example the [Investigation report into the Bulga Open Cut dump truck collision](#), the [Investigation Information Release into a non-work related death at a mine site in May 2019](#) and also the [Investigation Information Release relating to a fatality that occurred at an open cut coal mine in 2018](#).

Dangerous incident  
IncNot0035656

An underground coal mine worker using a rib bolter was subjected to hydraulic fluid escape. The worker reported feeling a sharp prick to the right index finger. The mine followed its fluid injection protocol and after an initial assessment by paramedics the worker was taken to hospital. It was assessed that it was not a fluid injection.

Hydraulic hose management must include routine inspections of hose routing, protection and guarding.



Serious injury  
IncNot0035659

A worker was installing a relay travel bar on a longwall support on a recovery face at an underground coal mine. A bobcat was being used to lift the relay bar while two workers inserted the travel bar. The relay bar was lowered, crushing the worker's finger under the travel bar. The worker's finger was de-gloved.

Mine operators must have safe work systems in place that identify any risks of injuries before commencing any tasks. The use of suitable equipment to control risks must be considered.



Dangerous incident  
IncNot0035685

A fire destroyed a haul truck at a surface coal mine. The operator applied the fire suppression system and left the truck.

The mine made a call to establish an exclusion zone around the machine to protect other machines and workers from the fire.

There were no injuries, however one of the tyres exploded.



The investigation is ongoing, however good maintenance practices are essential to preventing fires on mobile plant. Heat shields and lagging designed to prevent combustible materials from contacting hot surfaces must be regularly inspected and maintained. Maintenance practices should also include securing loose combustible items to prevent contact with hot surfaces.

## 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   |
|---|---|
| <b>International (other, non-fatal)</b> |   |
| MinEx NZ                                | <p><b>Insulation failure leads to fire risk on excavator</b></p> <p>A hired CAT 345D excavator operating on a quarry stockpile caught fire in the engine compartment. The speed of the fire and smoke meant that the operator had to turn off the excavator and jump clear. No injuries were sustained however the excavator was fire damaged, which was confined to the engine compartment.</p> <p><a href="#">Details</a></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 (October 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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