

WEEKLY INCIDENT SUMMARY

Week ending Friday 13 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	30
Summarised incident total	9

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0035497	<p>A fire occurred on the surface of an underground metalliferous mine when a dump truck exited the portal. The fire suppression was activated which automatically extinguished the fire.</p> <p>The investigation identified that the radiator pump assembly's o-ring in a hose/valve block arrangement failed, causing a mist of hydraulic fluid to be sprayed over a hot engine. The oil made contact with the engine because a cover had been left off. The cause of the o-ring failure was due to incorrect torque applied to the hose/valve block fitting.</p>	<p>Mine operators should review maintenance procedures to ensure that the manufacture's torque settings are applied to fasteners.</p> <p>Mine operators should review maintenance procedures to ensure commissioning checks are carried out by a competent person before the plant is returned to service as fit for purpose.</p>

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
<p>Dangerous incident IncNot0035498</p>	<p>A service truck, at an open cut coal mine, rolled away from where it was parked. The vehicle travelled approximately 50 metres before turning itself around. It continued to travel another 80 metres, coming to rest on a coal windrow on the bench below a loaded and demarcated blast zone.</p> <p>As the vehicle was rolling, a worker ran after the vehicle until the truck came to its finally resting place. The worker turned off the pumps and drove the vehicle out of the demarcated area.</p> 	<p>Mine operators must ensure that all vehicles are parked in suitable areas or designated park up areas.</p> <p>Workers should receive communication regarding:</p> <ul style="list-style-type: none"> • compliance with correct parking procedures • being situationally aware of hazards. <p>Mine operators should consider:</p> <ul style="list-style-type: none"> • audible warning systems and/or visual alarms to warn of the lack of park brake application • interlocking that automatically applies the park brake when the operator leaves the operator's position (i.e. door interlock). • functional testing of park brake application warning systems • the recommendations in safety bulletin SB13-02 Unplanned movements of vehicles - too many near misses.
<p>Dangerous incident IncNot0035534</p>	<p>An opal claim miner fell approximately 12 metres down a mine shaft. This resulted in the miner having to be rescued by emergency services.</p> <p>The worker sustained serious injuries and was taken to hospital by helicopter.</p>	<p>Opal mine operators should consider the recommendations made in the Safety Alert 18-14, which provides recommendations to opal mine operators regarding the risk of injury and falls in opal mines shafts.</p>

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
<p>Dangerous incident IncNot0035514</p>	<p>An outburst occurred at an underground coal mine while trimming the roof and floor in a development panel.</p> <p>Two workers were at the continuous miner preparing to install a sheet of roof mesh following a grunching cycle, when rill material dropped at the face, causing a dust cloud to extend to the miner platforms.</p> <p>The gas reading on the CO2 monitor mounted on the continuous miner went off-scale following the incident.</p> <p>Both workers egressed the machine platforms without incident and were not injured.</p> <p>The continuous miner was pulled back from the face. No road tape was installed approximately 20 metres outbye of the face, for scene preservation.</p> <p>The continuous miner in an adjacent panel was also grunching at the time of the incident and was stood down, pending investigation. No road tape was installed approximately 40 metres outbye of the face.</p>	<p>The mine operator should consider the guidance information located in the targeted intervention program report– Gas outburst risks in longwall mining.</p>
<p>Dangerous incident IncNot0035515</p>	<p>A contract worker suffered an electric shock at an open cut coal mine. The worker was conducting insulation test using a 5 KV tester on a Liebherr 282 haul truck wheel motor.</p> <p>The investigation identified a lack of procedures and training regarding the correct use the 5 KV insulation tester, and that the tester leads were not fit for purpose.</p>	<p>A section 195 notice was issued to the mine prohibiting the use of the 5KV tester until safe work procedures were developed and implement.</p> <p>High voltage test equipment must be operated by a trained and competent person and must be maintained in a fit for purpose condition.</p>

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The worker was taken to hospital for further assessment.



Dangerous incident
IncNot0035517

A load haul dump (LHD) was towing a feeder breaker on a sled into an underground coal mine when a uni-joint on the tailshaft failed.

The tailshaft appeared to have damaged hydraulic hoses within the engine bay, resulting in a fire. The fire suppression system on the LHD was activated, extinguishing the fire in the engine bay.

A secondary fire occurred on one of the engine bay covers, forced open by the failure. The secondary fire was

Fires in underground mining environments can lead to significant risk and catastrophic events.

Mobile equipment should be inspected and maintained to a high standard to reduce the risk of component failure, helping to keep the risk of fires to as low as reasonably practicable.

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	<p>extinguished by the machine operator with a handheld fire extinguisher.</p> <p>No one was injured as a result of the incident.</p> 	

Dangerous Incident
IncNot0035523

A contract worker at a metalliferous mine was drilling a vertical hole into concrete using a hand held 240-volt wet drill. When the worker pressed the trigger of the device, an electric shock was felt.

The worker was taken to hospital for assessment.

The investigation identified that a water collection system, in conjunction with a wet-type industrial vacuum cleaner, is a mandatory requirement for working on ceilings.

Mine operators and contractor managers should ensure that before workers use 240-volt portable tools, they conducted an inspect of the equipment and it is used as per the manufacture’s recommendations.

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
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Dangerous incident
IncNot0035537

An excavator at an open cut coal mine was operating during production when a fire occurred.

The on-board fire suppression system was activated allowing the worker to safely egress the machine without injury.

Further cooling via water cart was required to fully extinguish the fire. The fire occurred in the engine bay of the excavator, with the specific cause still to be determined.



Mine operators must conduct a thorough investigation, by a competent person, to determine the root cause of any fire that occurs on mobile equipment. The investigation should include:

- fuel source and heat sources
- surface temperature value
- cause of the fire
- controls to prevent reoccurrence, such as reducing engine component surface temperatures and segregating fuel sources from areas of high temperature
- training workers 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 equipment manufacturer.

Dangerous incident
IncNot0035538

An underground loader, at an underground metalliferous mine, was in the process of bogging when the operator noticed oil spraying at the

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rear of the machine and flames within the engine compartment.
 The worker manually activated the on-board fire suppression system, which immediately extinguished the fire.
 The worker was able to exit the machine without injury.

standard to reduce the risk of component failure, keeping the risk of fires to as low as reasonable possible.



Note: While most 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 (September 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, Industry and Environment or the user's independent advisor.

DOCUMENT CONTROL

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