

## Week ending 7 June 2017

This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the Resources Regulator: phone 1300 814 609 24 hours a day, 7 days a week.

### At a glance

Type	Number
Reportable incident total	37
Summarised incident total	5

### Summarised incidents

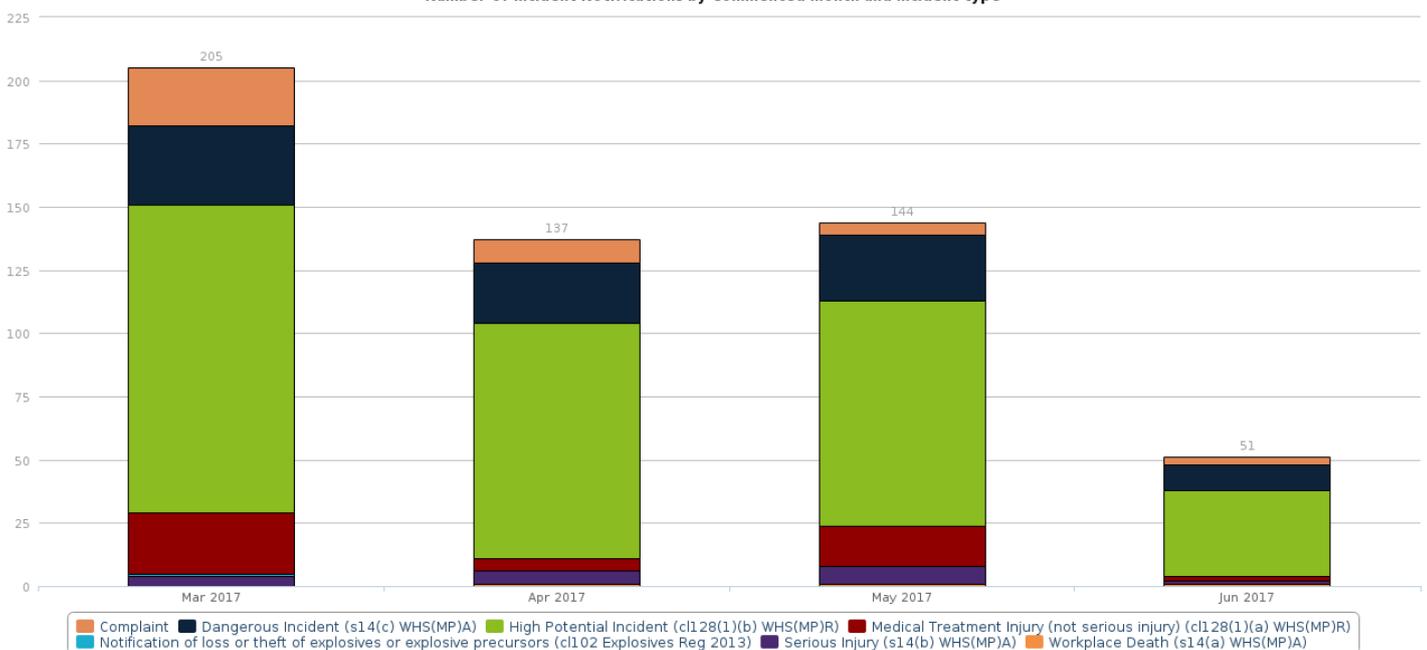
Incident type	Summary	Recommendations to industry
Serious injury SinNot 2017/00852	A rock fell from the back of an underground drive, hitting a worker's hard hat. The rock weighed about 2 kg and appears to have fallen from an area where the strata mesh had been damaged by recent blasting. The worker attended a hospital and was cleared of any major head or neck injury.	<p>Underground operators should ensure workplace inspections are undertaken before starting work in an area. This must include checking:</p> <ul style="list-style-type: none"><li>installed ground support systems for correct installation and any damage to the support systems</li><li>strata mesh for damage, even minor damage, especially where loose rocks can be observed in and around the damaged mesh.</li></ul> <p>Procedures should be implemented to ensure any damaged or incorrectly installed ground support are isolated and repaired to mine design standards before people work or travel under the affected area.</p>

<p>High potential injury SinNot 2017/00845</p>	<p>A personnel transport vehicle hit a pothole in the road. As result of hitting the pothole a worker in the rear of the personnel transport has jarred their back resulting in the worker not being fit for normal duties.</p>	<p>Mines and original equipment manufacturers should consider the recommendations in safety bulletin SB15-06 - <a href="#">Analysis aims to reduce injuries while travelling in vehicles underground</a>.</p> <p>When a person is injured the mine investigation needs to include those items in the safety bulletin SB15-06, <a href="#">Appendix B Fillable questionnaire</a> in their investigation.</p>
<p>Dangerous incident SinNot 2017/00842</p>	<p>Two boats collided at low speed on a dredge pond. The collision occurred when one boat was leaving the jetty and the other was approaching the jetty. The incoming boat did not hear the radio communications from the outgoing boat.</p>	<p>Masters of boats should make sure vessels are safe before embarking on a journey, including ensuring that fully functioning communications and safety equipment is on board.</p> <p>Masters should have knowledge of all local conditions and hazards. Where a risk assessment requires workers to use life jackets while on the water, the master must ensure all workers on board vessels have jackets fitted.</p> <p>Maintaining a proper lookout and safe manageable speeds is essential, particularly in restricted visibility, darkness and restricted zones, in order to avoid collisions.</p> <p>Fire risks should be identified and controlled, and boat masters should fully prepare for emergencies, including understanding and maintaining emergency procedures.</p>
<p>Dangerous incident SinNot 2017/00836</p>	<p>A worker turned off a light switch and felt what she described as a 'sensation' in her hand.</p> <p>The light switch mechanism was in poor condition and was hard to open and close. The light switch cover plate also had cracks and the mechanism was not rated to switch fluoro light circuits.</p>	<p>Where lighting loads are fluorescent, the switching mechanisms should be appropriately rated to the load.</p>
<p>Dangerous incident SinNot 2017/00834</p>	<p>An operator of a haul truck saw flames coming from the truck and manually activated the auto fire suppression system. The flames were suppressed but not extinguished. The emergency</p>	<p>Mines should conduct a thorough investigation of every mobile plant fire. The investigation should be completed before submitting an ancillary form and should include:</p>

	<p>response team (ERT) was activated and hoses connected to two water carts were used by the team to extinguish the fire.</p>	<ol style="list-style-type: none"> <li>1. identification of the cause of the fire</li> <li>2. identification of additional contributing factors</li> <li>3. implementation of effective risk control measures to prevent recurrence of the fire</li> <li>4. consultation with an expert fire investigator.</li> </ol> <p>Fire suppression systems should be designed, installed and maintained in accordance with AS 5602: <i>Refined petroleum products – vehicle bottom loading and vapour recovery</i>.</p> <p>Plant operators should be competent to safely operate plant, use automatic and manual fire control systems, and to implement emergency response procedures in the event of a fire.</p>
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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.

Number of Incident Notifications by Commenced month and Incident type



## Recent incident publications

- investigation information release: [Excavator cabin detaches and falls](#)
- investigation information release: [Fatality at Perilya Southern Operations](#)
- investigation report: [Report into the incident involving a worker at Ulan West Operations on 26 November 2015](#)

You can find all our incident related publications (i.e. safety alerts, safety bulletins, incident information releases, weekly incident summaries and investigation reports) on our website.

### 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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