

WEEKLY INCIDENT SUMMARY

Week ending Friday 17 May 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.

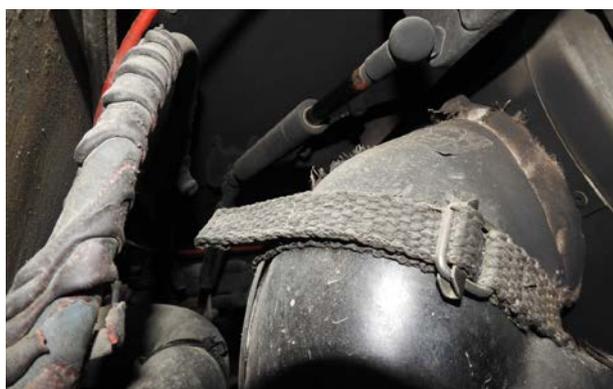
At a glance

High level summary of emerging trends and our recommendations to operators.

| TYPE | NUMBER |
|---------------------------|--------|
| Reportable incident total | 29 |
| Summarised incident total | 3 |

Summarised incidents

| INCIDENT TYPE | SUMMARY | RECOMMENDATIONS TO INDUSTRY |
|-------------------------------------|---|--|
| Dangerous incident IncNot0034587 | A fire occurred on an integrated tool carrier in an underground metalliferous mine. The fire occurred within the turbocharger and was extinguished by the onboard fire suppression system. The cause of the fire has been attributed to a turbocharger oil line failure and is being investigated by the original equipment manufacturer (OEM). | The failure of oil and fuel lines near exhausts and turbo chargers are well known causes of fire. Maintenance systems must account for this when setting inspection frequencies. |



Dangerous incident
IncNot0034595

Early signs of coal oxidation occurred in an underground coal mine.

A longwall superintendent identified a tarry/coal burning smell at the tailgate of a longwall face. Further investigation and bag samples confirmed that the oxidation was not occurring within the goaf. The mine identified the oxidation to be around a bulkhead at the fault-disturbed zone. The mine established an incident management team to manage the situation. The mine pressure grouted the fractured strata with strata binder to reduce air paths, which stopped the oxidation process.

Spontaneous combustion must be addressed as part of the mine's principal hazard management plan. [MDG 1006 Spontaneous Combustion Management](#) must be reviewed to confirm appropriate controls are in place for longwall operation. Setting appropriate TARPs is critical in the early intervention of a spontaneous combustion event and should be set in respect of the testing results.

Dangerous incident
IncNot0034623

A fuel truck rolled away while a worker was on top of the tank in a quarry.

The worker had climbed onboard to dip the tank, when the truck rolled away. The worker jumped from the truck before it came to rest against a barrier. The truck rolled about 150 metres. The driver was not injured.

Mine operators should ensure machines are stable, the parking brake is applied and wheels are chocked before climbing on board to complete inspections or maintenance tasks.



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 |
|--|---|
| International (other non-fatal) | |
| 3M | <p>Fall protection – product notice</p> <p>3M Fall Protection has learned of the possibility of a manufacturing defect in a dorsal D-ring utilised in ExoFit NEX™ harnesses manufactured between January 2016 and December 2018.</p> <p>Details</p> |
| MinEx NZ | <p>Safety alert – Fly rock incident</p> <p>During a blast, fly rock was ejected about 300 metres beyond the exclusion zone and into an area where people were thought to be in the safe zone.</p> <p>Details</p> |
| MSHA | <p>NMN Serious accident alert facility – cement</p> <p>On 7 May 2019, a miner suffered burns to his body when superheated gases carrying hot, fine, alkaline particles were forcefully expelled through an open process vessel door.</p> <p>The worker was on a platform 5 to 6 feet above other miners who were setting off a Cardox charge to free a blockage in the vessel. He opened the door around the same time they set off the charge.</p> <p>Details</p> |
| MinEx NZ | <p>Water cart rollover</p> <p>The operator of an articulated water cart reversed down a ramp with the spray bars turned on. The rear right tyre rode up a rock face about 600 millimetres high and the truck body, with half a tank of water, tipped onto its right-hand side.</p> <p>The operator tried to drive forward while the body was tipping, which caused the cab of the truck to tip to the opposite side. The operator was wearing a seatbelt and was not injured.</p> <p>Details</p> |

National (fatal)

WorkSafe VIC

Worker fatally injured after fall off steel stillage

A male worker has died after falling from a steel stillage that had been raised on the tines of a forklift. While oxy-cutting steel beams, the stillage became unstable and fell from the raised tines of the forklift, landing on the concrete surface about 4.5 metres below.

[Details](#)

National (other, non-fatal)

DMIRS WA

MSB no 164 Wheels detaching from graders

The Government of Western Australia has received reports of potentially serious incidents involving graders, when either a front steering wheel or a driving wheel experienced catastrophic failure of its stub axle, resulting in the wheel suddenly detaching during operation.

[Details](#)

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.

© State of New South Wales through the NSW Department of Planning and Environment 2019.

This publication is copyright. You may download, display, print and reproduce this material in an unaltered form only (retaining this notice) for your personal use or for non-commercial use within your organisation. To copy, adapt, publish, distribute or commercialise any of this publication you will need to seek permission from the NSW Department of Planning and Environment.

Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (May 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

CM9 reference DOC19/428122

Mine safety reference ISR19-19

Date published 24 May 2019

Approved by Chief Inspector
Office of the Chief Inspector