

# WEEKLY INCIDENT SUMMARY

Week ending Friday 29 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	5

## Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0036124	<p>A fire occurred underground on a loaded agitator truck that was travelling down the decline in the mine. The operator reported seeing flames in the area of the rear brakes. The operator parked the machine and put out the fire using a hand held extinguisher. The fire suppression system did not activate as the fire was at the rear axle area, away from the engine bay and fire detection system.</p> <p>The agitator had been pre-use inspected and had recently had a 500-hour service.</p> <p>The root cause of the incident is under further investigation by the mine.</p>	<p>Mines must have a robust system of recommissioning equipment following maintenance, including removing residual rubbish, lubricants and tools.</p> <p>Operators must be reminded of the risks associated with the over use of the service brakes in relation to fires and heat generation in the brake units.</p> <p>Fires in underground mines are a major risk to workers. Mine operators should review the recently published position paper <a href="#">Preventing fires on mobile plant (October 2019)</a>.</p>

Dangerous  
incident  
IncNot0036153

While checking the chain tension on the AFC, at the tail gate of a longwall, a hose to the Porta-power burst. A fitter, who was approximately 30 centimetres away, was hit on the left wrist and hand through his overalls and cut 2 rated gloves.

The mine adds a fluorescent dye to hydraulic oil. When exposed to blue light, the dye glows, indicating the presence of oil. The blue light was used to confirm a fluid injection injury and the worker was transported to hospital. During surgery, the blue light was also used to minimise the extent of the surgery.

The Porta-power had previously been damaged.



All portable tools should be subject to pre-use inspections and used by trained competent persons.

Workers are to be instructed not to use equipment that has been damaged or that could affect safety.

Workers should be reminded to position themselves out of the line of fire when completing tasks that involve high pressures.

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  
IncNot0036159

A fall of ground in the goaf of an underground coal mine caused a wind blast event. No one was injured however, minor damaged occurred to a stopping and the tail gate double doors were blown open, resulting in short circuiting the ventilation. This increased the time to clear the dust from the windblast, exposing workers to a reduced visibility environment.

The mine was operating under a wind blast TARP at the time.

All underground mines that complete secondary extraction must consider the risk of windblast as part of the Ground or Strata Failure PHMP.

Operating TARP's should be in place depending on the amount of roof holding up and the potential for windblast especially prior to initial goaf formation.

Dangerous  
incident  
IncNot0036161

A fully laden dump truck, coming down a ramp, lost control and drifted. The driver turned towards the middle of the road to regain control, where a water truck, which was travelling in the opposite direction

The incident is still under investigation  
Mine site speed limits must be enforced and should consider use of smart technologies that notify

came to a halt. There was no collision or injuries.

Following the incident an inspector attended and identified speed as a major contributing factor.

The start of shift safety briefing topic the day before was ramp speed and a maximum speed of 40kph.

The haul truck had a crest speed of 57kph and it was found that all trucks were travelling at similar speeds.



operators and supervisors when speed limits are exceeded.

Supervisors and managers continually accepting non-compliances to site rules contribute to mineworkers breaching safe systems of work and putting themselves and others at risk.

Speed limits of trucks are in place for a reason and must be complied with.

Dangerous incident

IncNot0036165

An electrical contractor, working within the roof space of a bathhouse, was drilling a hole when the back of his hand contacted an adjacent cable tray causing an electric shock. He was taken to hospital for an ECG.

On investigation a 30mA RCD protecting an air conditioner circuit had tripped and the cable supplying the air conditioning unit had damaged outer insulation.



When working in confined areas like roof spaces where electricity is present, an engineering risk assessment must be completed and all energy sources need to be identified and appropriate isolation controls implemented.

## 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 (fatal)</b>
<b>MSHA</b>	<p><b>Mine fatality alert</b></p> <p>On 5 November 2019, a mobile maintenance mechanic was driving on the pit haulage road when the service truck he was operating left the road, hit a berm, and flipped onto its side, ejecting the miner. The mechanic died at the scene.</p> <p><a href="#">Details</a></p>
<b>MSHA</b>	<p><b>Mine fatality alert</b></p> <p>On 16 November 2019, a contractor spotting for a dump truck stepped directly into the path of a bulldozer. The contractor died at the scene.</p> <p><a href="#">Details</a></p>
	<b>International (other non-fatal)</b>
<b>MinEx NZ</b>	<p><b>Worker falls from conveyor frame</b></p> <p>A worker slipped from a conveyor frame while performing a screen change and fell approximately 2m, contacting guarding and a steel frame (used for hanging hoses) during the fall. The worker sustained a fractured rib and bruising.</p> <p><a href="#">Details</a></p>
<b>MinEx NZ</b>	<p><b>Dangerous access to crusher</b></p> <p>A labour hire worker was trying to shut the bin door over a crusher from the walkway. He had trouble and called for help from the contract engineer via the RT. The contract engineer climbed over the handrail and stood on the brackets supporting the chute and straddled the chute to access the lever to close the bin door. The crusher was operating at the time.</p> <p><a href="#">Details</a></p>
	<b>National (fatal)</b>
<b>NT WorkSafe</b>	<p><b>Securely restrain excavator buckets and attachments before transporting</b></p> <p>In April 2019, a 30-year-old worker was fatally injured while loading an excavator onto a float in the yard of a hire company. At the time of the incident, the</p>

excavator was fitted with a batter bucket carrying two smaller buckets and a single tine ripper. The attachments were not secured before the excavator was maneuvered onto the float for transportation.

[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.

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