

WEEKLY INCIDENT SUMMARY

Week ending Friday 31 January 2020

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	24
Summarised incident total	5

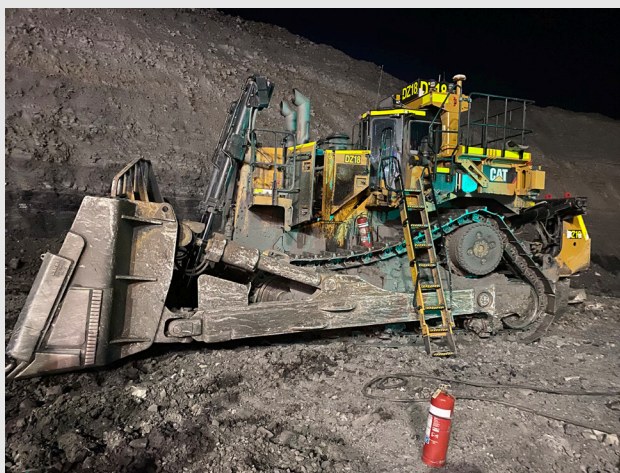
Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0036585 Underground metalliferous mine	<p>An integrated tool carrier (IT) was being used by a charge-up crew when they noticed a flame on the right-hand side of the engine. The onboard fire suppression system was activated manually, which extinguished the fire. The IT was hosed down to extinguish smoldering cladding that was surrounding the exhaust system.</p> <p>The mine's initial investigation identified an overflow or leak in the coolant system that doused the exhaust lagging with coolant. The coolant containing glycol, or similar chemical, can be flammable when dried.</p>	<p>Mine operators must ensure safe maintenance systems of plant. Pre-use inspections should be reviewed to ensure any leaking fluids are identified before the machines are operated.</p> <p>For further information refer to the recently published position paper Preventing fires on mobile plant.</p>

Dangerous incident
IncNot0036586
Surface coal mine

A dozer was working next to the dragline when the driver smelled fumes. The operator pulled the dozer back and saw smoke coming from the engine compartment. The fire was extinguished using a hand-held fire extinguisher.

The mine's initial observation identified that the hydraulic pilot filter came loose, which allowed oil mist to be drawn into the engine compartment and made contact with hot surfaces.



Mine operators must ensure that stringent monitoring and quality control of maintenance and repair activities are undertaken to prevent fires on mobile plant.

Enough time and resourcing must also be allocated for maintenance and repair tasks.

For further information read:

[Preventing fires on mobile plant.](#)

Dangerous incident
IncNot0036629
Surface coal mine

A light vehicle operator drove off an open edge (inactive shovel face) and the vehicle fell about 14 metres. The driver had been conducting blast sentry clearance. A bund across the road leading to the inactive face had been opened-up to allow two drill rigs to tram from the blast area. The bund was not replaced, and no other barricade was put in place to prevent vehicle access to the area. The area had previously been a roadway before being excavated.

The vehicle landed nose first before coming to rest on its roof. The driver exited the vehicle and called the emergency response crew who stabilised the driver until the ambulance arrived. The driver was taken to hospital and cleared of any injuries.

The incident is currently under investigation by the Major Investigation Unit. Information will be published shortly



Dangerous incident
IncNot0036633
Surface coal mine

A slip in a 60 metre highwall resulted in about 2500 cubic metres (m³) of material falling to the ground. The dimensions were about 45 metres high with the maximum extent from the highwall toe of 10-15 metres. A catch windrow was in place under the highwall about 10 metres from the highwall toe. The slip was noticed early enough to remove all workers from the area before the material fell to the ground.



Mine operators must have safe systems of work in place to inspect highwalls. These inspections must consider - weathering effects, ground water and conditions that affect the high wall stability.

Following several incidents where people and equipment have been exposed to significant health and safety risks as a result of highwalls, low walls and dumps failing, the NSW Resources Regulator has published Safety Bulletin [SB20-01 Failure of highwalls, low walls and dumps.](#)

Operators should take note of the recommendations in this bulletin.

Dangerous incident
IncNot0036620
Underground coal
mine

While towing a breaker feeder out of a mine (on a sled) using two load haul dump machines (LHDs), the breaker feeder became stuck on a corner. Workers repositioned slings to pull the feeder further away from the rib then reconfigured them for a straight tow. The lead LHD was parked with the motor running, park brake on and the foot brake applied. When the operator released the foot brake, the machine rolled backwards about 0.5 metres and was stopped by the operator reapplying the foot brake. No workers were at risk and the fault was repeatable.

When towing large equipment underground, the route should be planned to identify tight areas beforehand.

Safety critical systems such as braking and steering systems should be inspected, maintained and tested in accordance with the manufacturer's recommendations.

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)
MinEx NZ	<p>Excavator falls on its side While sorting material on a 1 metre high (approximately) pad, an excavator unbalanced and rolled onto its left side. Details</p>
	National (other, non-fatal)
Worksafe Qld	<p>Crane rope sheave failures – Safety Alert The purpose of this safety alert is to highlight the risk of rope sheave failure on mobile cranes. Details</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 (February 2020). 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	DOC20/79343
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Mine safety reference	ISR20-05
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Date published	7 February 2020
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Approved by	Chief Inspector Office of the Chief Inspector
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