WEEKLY INCIDENT SUMMARY

Week ending Friday 6 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	15
Summarised incident total	3

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0035455	 An electrician was going to a transformer following an overload trip on a supply circuit breaker to a DCB in a development panel when he smelled smoke.	Mine operators should review load flows and protection studies when the operating conditions change, resulting in changes to equipment loadings. Mine operators must review the service life of all circuit breakers considering the operating conditions and clearance of fault conditions.

	The miner had previously tripped on overload multiple times and on this occasion tripped back to the transformer. It appears there was arcing on the circuit breaker, which led to a fire. An electrician used a fire extinguisher to extinguish the fire.	
Dangerous incident IncNot0035463	  A dump truck reversed into a dozer on a tip head. No injuries were reported and only minor damage was reported. The truck had a broken reversing mirror. The dozer was moving at the time.	Mine operators must consider the appropriateness of proximity detection systems to prevent machine interactions. Mine operators should periodically review and retrain workers about understanding positive communication between operators using large equipment. Equipment defects must be reported and systems should be put in place to stand equipment down if it is unsafe to use.
Dangerous incident IncNot0035466		Workers should always verify their isolation by dissipating the energy and testing for dead before starting a task. Mine work authorisation systems should include details of the isolation requirements and provide the required information to allow tasks to be carried out safely.

A large surface diesel fuel tank float level switch failed and during fault finding to investigate the issue, an electrician removed the level switch cover without isolating. The worker reported suffering an electric shock.

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 (fatal)
MSHA	**Mine fatality report (final)** A 25-year-old plant operator, with 21 weeks of experience, drowned on 29 December 2018 at 7.59pm after the suction dredge he was operating sank in an impoundment pond. Details
MSHA	**Mine fatality (alert)** On 15 August 2019, a 44-year-old contract electrician, with 10 weeks of mining experience, was electrocuted when he made contact with 120V cable, while working inside a fire suppression system's electrical panel. Details
	International (other, non-fatal)
MSHA	**Serious accident alert** On 3 June 2019, a railcar exploded when incompatible materials stored inside the car reacted violently. Approximately 20,000 gallons of liquid waste derived fuel derived from hazardous waste, spewed from the railcar for 34 seconds. The eruption sent waste fuel into the air and ripped the manway hatch from the railcar. The hatch came to rest about 340 metres from the railcar. Droplets of the fuel landed on a number buildings, structures and vehicles near the facility. Agitators in several of the fuel tanks were not maintained in functional condition. The facility was blending and storing incoming loads of fuel in railcars. A system of analysis was not in place to ensure compatibility of the blended fuel under the conditions it was stored in. 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.

DOCUMENT CONTROL	
CM9 reference	DOC19/791547
Mine safety reference	ISR19-35
Date published	14 September 2019
Approved by	Chief Inspector Office of the Chief Inspector