

## Week ending 17 January 2018

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	49
Summarised incident total	5

### Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot-2018/00034	The operator of a loader noticed flames from the rear of the loader when in the decline. He activated the fire suppression and parked the loader safely. The fire was extinguished with the onboard fire suppression. Initial investigation identified the ignition source was electrical as the fire originated around the battery area.	Mine operators should review their preventative maintenance inspections for electrical cables to prevent shorts and arcing related fires. The review should include: <ul style="list-style-type: none"> <li>→ inspections for cable and sheathing damage</li> <li>→ lifecycle management (age of replacement) for cables.</li> </ul>
Dangerous incident SinNot-2018/00033	An operator of a watercart was on the third and fourth step of the ladder boarding the machine when the ladder began to raise. The operator stepped off the ladder onto the access deck. The operator hit their ankle in the event causing some discomfort, but otherwise was not injured.	Mine operators should: <ul style="list-style-type: none"> <li>→ conduct an audit of retractable ladder systems to ensure they are installed to the ladder manufacturers recommendations</li> <li>→ review operating maintenance, pre-use checks and training information for equipment fitted with retractable ladders</li> </ul>

- review [Safety alert SA14-05 – Mine worker injured after falling from grader access ladder](#).
- [IIR Worker seriously injured in fall from articulated dump truck](#)

Dangerous incident  
SInNot-2018/00031

While tramming in the decline, a haul truck operator noticed a flame coming from the engine bay. The operator immediately shut the machine down and activated the fire suppression system, which extinguished the fire. Upon investigation, it appears a steel fuel line had been rubbing on a structure that had caused a failure of the line.

Mine operators should review their preventive maintenance inspections for fuel lines. The review should include:

- inspections for rubbing and mechanical wear of fuel lines
- lifecycle management (age of replacement) for fuel lines and hydraulic hoses
- mechanical supports are adequate to prevent rubbing of fuel lines.

Dangerous incident  
SinNot-2018/00030

An articulated dump truck park brake failed to hold a truck when it was stopped, about to tip a load. The loaded truck rolled forward about 50 m before striking an earth berm. The cab of the truck remained upright but the body overturned. The operator reported that the truck lost all steering and braking while rolling forward. No one was injured

Mine operators should ensure defect reporting and pre-start inspections are being used effectively to maintain safe operating plant.

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

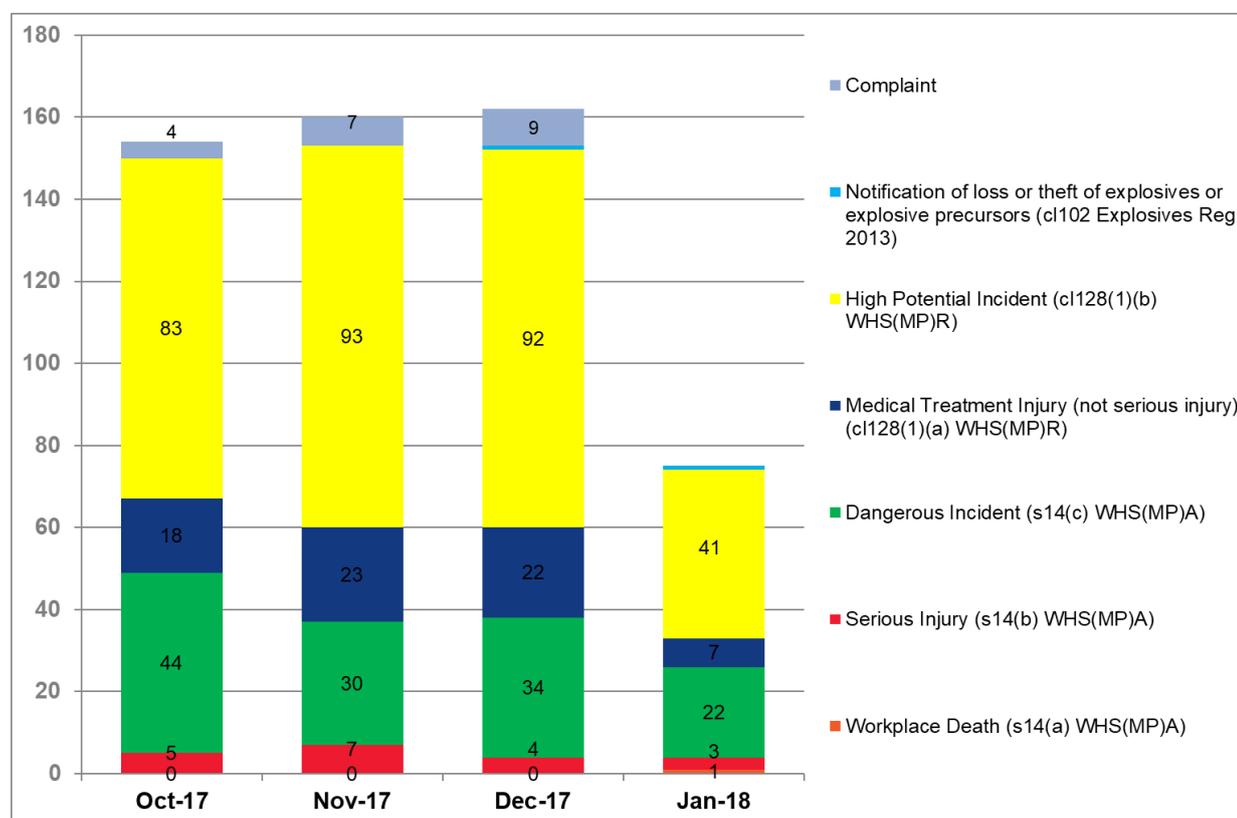
Dangerous incident  
SinNot-2018/00029

After parking a utility vehicle in the lower quarry bench, an operator of a 40 tonne articulated haul truck parked about 1.5 metres from the back of the utility. The operator exited the haul truck and walked to another area of the quarry. When a leading-hand worker was obtaining something from the front of the utility vehicle, the haul truck rolled forward and

Mine operators should review park-up procedures with operators for specific plant with operators. Safety critical systems such as braking and steering systems should be inspected, maintained and tested in accordance with the manufacturer's recommendations.

rested against the rear tailgate of the utility causing minor damage to the tailgate. No injuries occurred.

**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.



## Recent publications

- [Safety Alert: Potentially dangerous mechanical components on opal mine materials handling hoists](#)
- [Safety Bulletin: Mines and preparing for fires](#)
- [MDG 3007 Hydraulic safety](#)
- [MDG 15 Guideline for mobile and transportable plant for use at mines \(other than underground coal mines\)](#)

**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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CM9 reference	CM9 reference
Mine safety reference	ISR 18-02
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