

WEEKLY INCIDENT SUMMARY

Week ending Friday 10 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	41
Summarised incident total	3

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0036444	<p>A CAT 775D service truck was descending a ramp at a surface coal mine that was recently watered. The truck began to slide for about 50 metres, then gripped on the dry line of the ramp, resulting in the truck overturning on to the driver's side. The operator was not injured.</p> 	<p>All personnel who operate rubber-tyred, heavy mining equipment should be trained on driving techniques in wet conditions.</p> <p>Management plans and procedures should identify ramp and cresting speed limits.</p> <p>The recommendations from <u>Safety Bulletin SB18-09 - Overwatering of roads leads to vehicle incidents</u> should be reviewed and fully implemented.</p>

Dangerous incident
IncNot0036443

At a surface coal mine, a drill operator driving a light vehicle stopped and got out to talk to an operator in another light vehicle. The drill operator's vehicle started to roll away and he attempted to open the door to get back in. The operator became caught between the two vehicles and was spun three times between the trays. The vehicle rolled about 50 metres, over a bund and down a 4-metre slope and continued another 15 metres before stopping.

The operator reported he was distracted at the time and could not recall applying the park brake before getting out of the vehicle.

Although the operator was not seriously injured, he suffered some scratches on his back from hitting the trays and was fortunate to have not suffered more serious injuries.



Management plans and vehicle operating procedures invariably specify a requirement for vehicles to be parked fundamentally stable.

The circumstances of this incident highlights why this is so, and why mine operators should continually reinforce the importance of complying with safe work procedures.

Dangerous incident
IncNot0036461

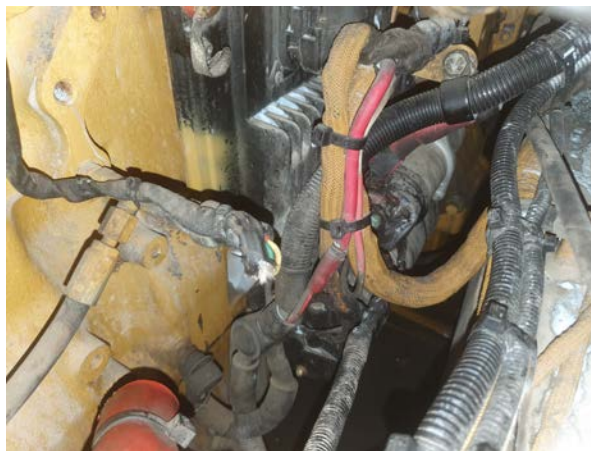
A fire occurred on a loaded concrete agitator at an underground metalliferous mine. The operator had set up to spray cement in the decline when he saw a fire at the front of the agitator.

When modifying equipment, mine operators must conduct adequate change management to ensure any new risks are identified and additional controls are implemented as

The cause of the fire was determined to be water ingress into the starter motor. Previous modifications allowed water (which is regularly used to clean the machine) to get into the engine bay and subsequently the starter motor.

The fire was extinguished by the onboard fire suppression system and a hand-held extinguisher.

required. In this case, modification of the engine covers (to address another risk) allowed excessive water into the engine bay.



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	<p>Metal/non-metal mine fatality</p> <p>A mobile maintenance mechanic was driving on a pit haulage road on 5 November 2019 when the service truck he was operating left the road, hit a berm and flipped onto its side, ejecting the miner. The worker died at the scene.</p> <p>Details</p>
	International (other, non-fatal)
MinEX NZ	<p>Truck rollover during tipping</p> <p>As a subcontractor was delivering a truck and trailer load of rock to a site, he tipped the load and jack-knifed the trailer to tip the truck at the edge of a drop-</p>

off. The driver then engaged the power TA to lift the truck hoist, while also engaging the clutch. As he released the clutch, the truck jerked and jumped backwards, resulting in him losing control and traction.

The driver removed his seatbelt and jumped clear as the truck rolled backwards over the face.

[Details](#)

Our recent investigation releases

- [IIR20-01 Underground mine worker contracts mixed dust pneumoconiosis](#)
- [IIR20-02 Maules Creek Mine – dozer and light vehicle collision](#)

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 2020.

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 (January 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	DOC20/17814
Mine safety reference	ISR20-02
Date published	17 January 2020
Approved by	Chief Inspector Office of the Chief Inspector