

## REPORTABLE INCIDENTS | WHS MINES LEGISLATION

# Weekly incident summary

**9 November 2016**

*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](#).*

To report an incident call **1300 814 609** 24 hours a day, 7 days a week

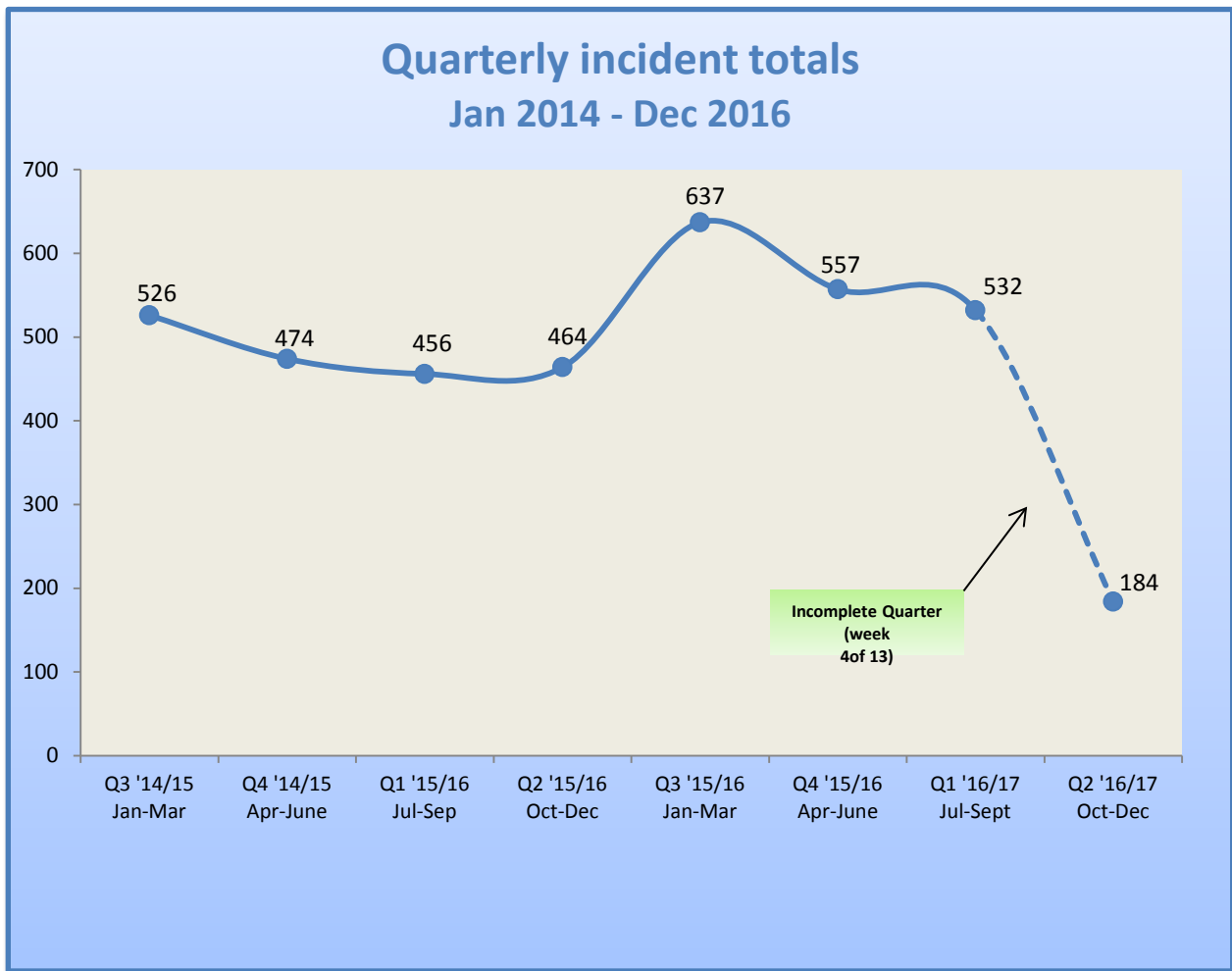
**Reportable incidents total: 45 Summarised incidents: 9**

**Summarised incidents** – incidents of note for which operators should consider the comments provided and determine if action needs to be taken.

Incident type	Summary	Comment to industry
Dangerous incident SInNot 2016/00640	<p>A drum winder was undergoing pre-start (outbye direction selected at the pit bottom). The operator released the controller as the pre-start was completing and the winder was going into run. The winder free-spooled in an inbye direction for a number of metres before the operator dumped the train. The mine engaged the original equipment manufacturer (OEM) of the equipment to assist with the investigation.</p> <p>It was found that the drive motor control program was not configured to maintain the pre-torque state of the motor so as to hold the drum in a static position until the brake was confirmed as having been applied.</p>	<p>It is important to undertake thorough risk assessments and develop functional specifications as part of the design phase of the plant, and ensure that commissioning processes verify that all risk controls identified during design have been implemented and are effective.</p> <p>The importance of control code reviews and audits cannot be understated.</p> <p>It is essential that trained and competent staff maintain the plant.</p> <p>An incident-reporting culture should be actively encouraged. Where a plant is found to be operating outside of normal parameters, it must be reported - as the cause of this incident dated back to the design and implementation phase of the winder.</p>
Dangerous incident SInNot 2016/00715	<p>There was a fire on an Atlas Copco MT60. The fire was extinguished by the operator using a hand-held extinguisher. The operator then manually activated the onboard fire suppression system.</p> <p>A coolant hose ruptured, allowing the coolant to soak into the exhaust lagging. The heat generated from the exhaust ignited the coolant.</p>	<p>Good maintenance practices are essential in preventing the ignition of combustible fluids from hose or pipe failures. Where practicable, hoses should be segregated from hot surfaces using hard barriers along with the use of non-flammable coolants. Consider guidance in Australian Standard 5062:2016, <i>Fire protection for mobile and transportable equipment</i>.</p>

Incident type	Summary	Comment to industry
Dangerous incident SInNot 2016/00713	A dozer was pushing a slot down a 23 degree batter. An object, most likely a rock, smashed through the rear window and cracked the front, right-hand door window. The operator was not injured.	Machine operators should inspect their work area to identify hazards, in this case rocks, with potential to fall/roll onto the machine. MDG15 <i>Mobile and transportable equipment</i> recommends all cabin windows be fitted with safety glass or equivalent.
Dangerous incident SInNot 2016/00712	A fire destroyed a haul truck. An automatic water-based fire suppression system was activated but did not extinguish the fire. While the matter is still under investigation, investigations have determined that the fire may have originated in the engine compartment. Sound attenuation measures made it difficult for the fire crew to access the engine compartment	Mine sites should review mobile plant fire risk assessments in relation to the effects of noise attenuation. The review should consider: <ul style="list-style-type: none"> <li>the ability to access the fire with a water cart</li> <li>emergency response training</li> <li>guidance in AS 5062:2016</li> </ul>
Dangerous incident SInNot 2016/00704	There was an interruption to ventilation due to a power supply problem to main ventilation fans at a shaft site. Fans at another shaft site continued to run as programmed. Underground power dropped. Methane exceedances of up to 4.7% occurred. Workers were not withdrawn to the surface. The department issued a S195 notice to the mine to stop operations and withdraw people from mine.	Mines should identify, through a risk assessment, all events that would require withdrawal of workers from the mine. An uncontrolled circumstance where elevated methane is present and is trending to the explosive range should initiate a controlled withdrawal of people to the surface.  The ventilation control plan must include procedures to be followed in the event of the failure of the main ventilation system including details of the circumstances requiring the safe withdrawal of people from the mine. (cls 62 of the WHS (Mine & Petroleum Sites) Regulation 2014)
Complaint SInNot 2016/00701	The department has received a complaint in which the complainant alleged they has been subjected to bullying and inappropriate conduct.	The complaint is being investigated by the department. Information on bullying and harassment is available on our website at: <a href="http://www.resourcesandenergy.nsw.gov.au/miners-and-explorers/safety-and-health/topics/bullying-in-the-workplace">http://www.resourcesandenergy.nsw.gov.au/miners-and-explorers/safety-and-health/topics/bullying-in-the-workplace</a>  SafeWork Australia also publishes guides to preventing and responding to workplace bullying and a worker's guide to dealing with bullying. See their website for more details: <a href="http://www.safeworkaustralia.gov.au">www.safeworkaustralia.gov.au</a>
Dangerous incident SInNot 2016/00688	A 55 tonne Cat truck was hauling at 950 level when the operator noticed flames coming from under bonnet. He shut down the vehicle, operated the on-board extinguisher and also used a hand extinguisher to extinguish the fire. A hose	<ul style="list-style-type: none"> <li>Good maintenance practices are essential in preventing the ignition of combustible fluids from hose or pipe failures.</li> <li>Where practicable, hoses should be segregated from hot surfaces using hard barriers along with the use of non-</li> </ul>

Incident type	Summary	Comment to industry
	retention bracket came loose, allowing two hoses to rub against each other causing an escape of combustible fluid that contacted a hot surface and ignited.	flammable coolants. <ul style="list-style-type: none"> <li>Consider guidance in AS 5062:2016, Fire protection for mobile and transportable equipment.</li> </ul>
Dangerous incident SInNot 2016/00685	An operator was jump starting a VSI crusher from a loader when the loader lead acid battery caught fire. The operator dropped to the ground and the battery exploded. Nobody was injured.	Lead acid batteries need to be maintained, and in particular the electrolyte levels checked/ maintained where possible. Low electrolyte levels can lead to excessive heating, fire and the explosion of batteries. For this reason, sealed or 'maintenance free' batteries are not always suitable for heavy vehicle applications.  When replacing old batteries, it is important to only use the battery type and capacity as recommended by the original equipment manufacturer.  Fit-for-purpose battery 'jump starting' facilities should be provided and used in preference to jumper leads.  Refer to NSW Safety Bulletin SB16-02 and QLD Mines Safety Bulletin no. 150.
Dangerous incident SInNot 2016/00683	A grader travelling in the underground decline stalled then began to roll away down the ramp. The operator could not stop the grader and turned it into the decline wall to stop it. The grader was damaged but the operator was not injured.  The mine investigation determined that the service brakes failed when the engine stalled, the emergency brake pedal was inoperable and the operator was not trained to use the secondary grader emergency brake activation system.	Mines should ensure that plant safety critical systems, including brakes, are regularly inspected and maintained and are appropriate for the particular mine environment, refer SA06-12 <i>Maintenance of Safety Critical Systems - Braking, Steering &amp; Warning Systems</i> .  Operators should be trained, assessed and competent to use all plant safety critical systems.



## Recent incident publications

### Incident e-alert: [Fatal incident Lightning Ridge underground opal mine](#)

You can find all our incident related publications (i.e. safety alerts, safety bulletins, incident information releases, weekly incident summaries and investigation reports) on our [website](#).

## Further information

Email: [mine.safety@industry.nsw.gov.au](mailto:mine.safety@industry.nsw.gov.au):

### COAL (NORTH) and EAST METEX

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### WEST METEX

#### Orange

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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (November 2016). 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 Industry, Skills and Regional Development or the user's independent advisor.