WEEKLY INCIDENT SUMMARY

Week ending Friday 22 November 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.

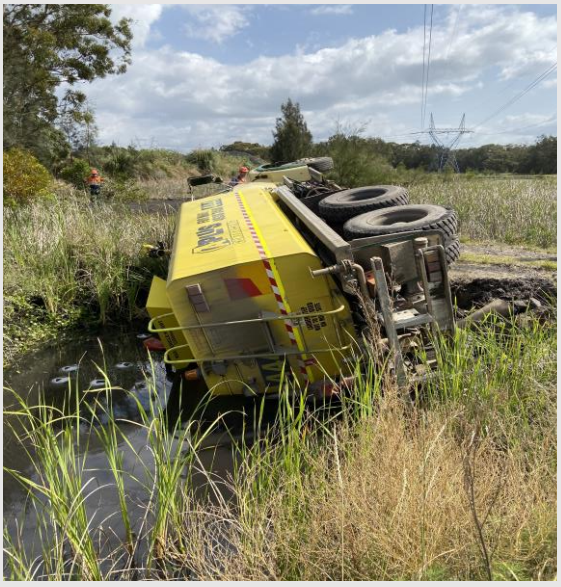
At a glance

High level summary of emerging trends and our recommendations to operators.

TYPE	NUMBER
Reportable incident total	35
Summarised incident total	5

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0036109	A rock fall of about 250 tonnes occurred from the crest of a batter. There was a worker about 20 metres away when the first rocks fell. Just after the worker retreated, the major rock fall happened. 	Operators and supervisors should be trained in geological hazard awareness. Once the cause of any slope failure is determined, mine operators must review their principal hazard management plans (PHMP) and implement effective controls including, but not limited to, catch berms, slope angles, water management and maximum heights.

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0036075	A rigid water cart carrying out dust suppression around surface dams rolled onto its left side when a culvert collapsed. The back of the tank on the left side ended up in about 60 centimetres of water. The driver turned off the truck and escaped through the driver's side window of the truck. 	Principal hazard management plans for roads or other vehicle operating areas should consider factors including: • the impact of road design and characteristics, including grade, camber, surface, radius of curves and intersections for the vehicles using the roadway • the impact of mine design, including banks and steep drops adjacent to vehicle operating areas • having fit-for-purpose barriers in vehicle operating areas to prevent vehicles going over embankments or areas that are not suitable for their size.
Dangerous incident IncNot0036077	An electrician was using a 10kV, high voltage insulation tester to conduct fault finding on a truck in a workshop. While removing a clamp to test the next phase, the electrician brushed against a busbar and suffered an electric shock. As part of the investigation of the mine they have reduced the number of appointed high voltage test personnel and are conducting a full review of the training and assessment package.	High voltage test equipment must be operated by trained and competent workers. Before any contact is made with electrical equipment that has been tested, it must be discharge by appropriate means. This should include the use of a discharge stick.

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	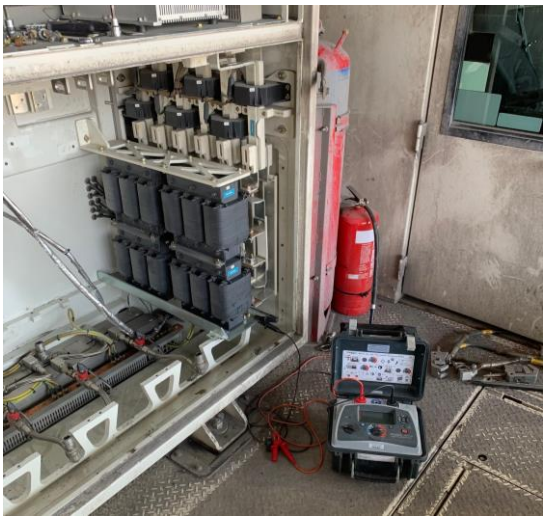	
Dangerous incident IncNot0036106	An electrical fire occurred behind the dashboard of a haul truck. Performance testing was being conducted using an original equipment manufacturer (OEM) provided data logger. The data logger was installed in the dashboard and wrapped in a protective cloth bag. The driver could smell something burning and on inspection of the dashboard, he found the bag smouldering. The OEM investigated the incident and identified that the data logger had moved which resulted in causing a short circuit and the smouldering. The driver extinguished the fire and there were no injuries.	Whenever tests are being conducted to plant, a risk assessment must be completed to identify if any hazards are being introduced. This should be completed as part of the change management process.

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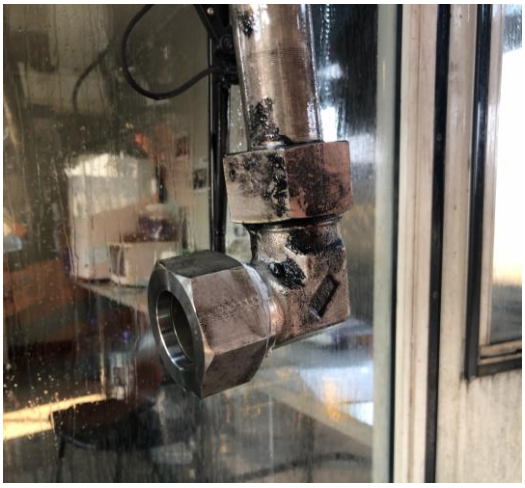
Dangerous incident IncNot0036113	A worker was sprayed with oil from a failed hydraulic fitting. A stainless steel hydraulic pipe had been replaced on a train loader and was undergoing pressure testing when a new fitting on the pipe failed and released fluid that sprayed onto the worker. The worker was cleared of fluid injection injuries. 	An escape of pressurised fluid in the workplace represents a failure of a risk control to a major hazard (pressurised fluids) that may cause a serious or fatal injury. Mine operators are reminded that when equipment is being tested after maintenance and repairs, effective no standing zones are to be put in place that removes workers from the line of fire if a failure was to occur. We have published the following safety alerts, bulletins and guides on this topic: SB13-01 Fluid injections result in surgery SB12-03 Fluid power isolation failures SA06-16 Fatal high-pressure hydraulic injection SA09-04 Hydraulic injection near miss

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
		MDG-41-Fluid-power-systems MDG-40 Guideline for hazardous energy control

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	DOC19/1027493
Mine safety reference	ISR19-46
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