

WEEKLY INCIDENT SUMMARY

Week ending Friday 27 March 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 | 43 |
| Summarised incident total | 5 |

Summarised incidents

| INCIDENT TYPE | SUMMARY | RECOMMENDATIONS TO INDUSTRY |
|---|---|---|
| Dangerous incident IncNot0037001 Open-cut coal mine  Roads or other vehicle operating areas  | <p>A nose to tail contact has occurred between two haul trucks.</p> <p>One truck turned a corner and stopped, waiting to turn onto a dump access road. The second truck turned the same corner, but did not notice that the truck in front was stationary.</p> <p>The contact occurred at low speed. The hand railing on the rear truck was damaged, but there was no contact with the cabin.</p> | <p>Mine operators must conduct an assessment and identify areas where there is a risk of collision. When developing risk control measures, the hierarchy of controls must be considered.</p> <p>Positive communication requirements must be implemented where a risk of collision remains.</p> <p>Systems such as collision detection and avoidance systems, visual aids and segregation should be implemented before relying on procedural controls.</p> |

Dangerous
Incident
IncNot0037003
Underground coal
mine

A worker received an electric shock from the body of a shuttle car.

The worker had been assisting fitters to repair the flight chains on the shuttle car. He tested the conveyor chains, but left the pump running when he exited the shuttle car.

With one hand on a metal bar he had stuck in the ground for support, the worker touched the boom of the car with his free hand and received what he described as a 'tingle' in both hands.

A series of tests conducted revealed no obvious source of the fault. The fault was resolved following the replacement of the reeling cable. It is suspected that failed earth conductors created an asymmetrical cable fault.

Investigation of electric shock incidents can be very complex, particularly where no obvious insulation failure or equipment damage is present. A thorough investigation must examine all potential failure mechanisms and the integrity of earthing systems at all relevant frequencies, to ensure no latent fault exists that may lead to a reoccurrence.

Dangerous
Incident
IncNot0037018
Quarry



Fire or explosion

A dump truck operator observed oil on the ground under a front-end loader (FEL) and advised the operator. Some 30 seconds later, the excavator operator, who was loading the dump truck, saw flames on the FEL and instructed the operator to get out of the loader. The fire suppression system and a water cart were used to extinguish the flames. The FEL was extensively damaged.

The cause of this fire has not yet been established.

For further information refer to our dedicated website page about [fires on mobile plant](#)

Refer to our position paper: [Fires-on-mobile-plant-position-paper-October-2019](#).



Dangerous
Incident
IncNot0037206
Quarry

A contract worker was removing a hose on an excavator to fit protective sleeving, when residual oil under pressure escaped and hit the worker in the chest.

The worker was transported to hospital for medical assessment and was cleared of any injuries.

Mine workers must be trained and competent in isolation. Correct isolation includes the identification of all energy sources and the complete dissipation of the energy. Training must include all steps in the isolation process.

Workers undertaking isolation procedures on plant should be familiar with the plant’s hydraulic circuit and manufacturer’s guidance for depressurisation of the circuit.

Dangerous
Incident
IncNot0037042
Open-cut coal
mine



Roads or other
vehicle operating
areas

Two light vehicles (LV) came into contact while driving on a designated LV roadway. The roadway was wet and the vehicles were heading towards one another when one began to slide. The second LV took evasive action and mounted a windrow to avoid the oncoming LV, but the sliding vehicle made side contact with the other vehicle. No one was injured.



All mines must consider the hazard of speeding while driving. Vehicles should be operated at a speed that is appropriate to the prevailing conditions.

Engineering controls need to be considered to minimise this risk, including the use of speed monitoring and alarms.

Segregation between vehicles travelling in opposite directions should be considered when developing the principal hazard management plan for roads and other vehicle operating areas.

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