WEEKLY INCIDENT SUMMARY

Week ending Friday 6 December 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.

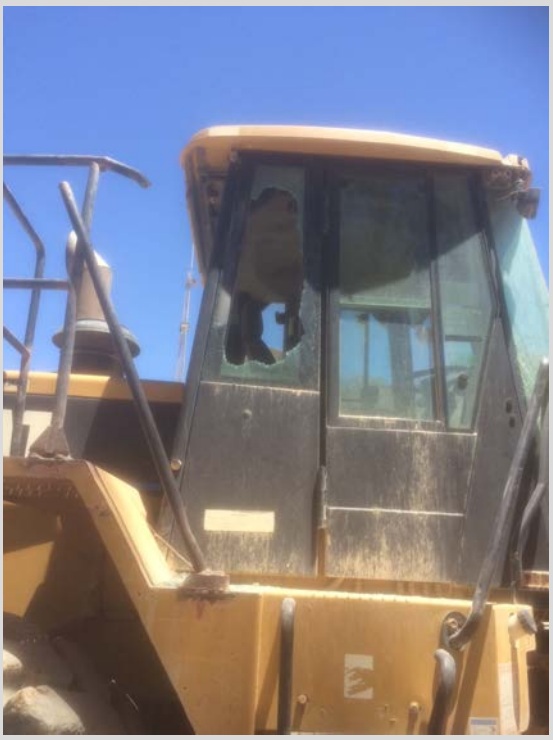
TYPE	NUMBER
Reportable incident total	44
Summarised incident total	6

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0036181	A fire occurred on an underground load haul dump machine (LHD). The fire suppression system was activated, and the flames were extinguished. Three workers retreated to a refuge chamber as a precaution.	When completing emergency exercise planning, mine operators must consider fires on mobile equipment. Fires in underground mines are a significant risk to all workers. The likely position of fires (especially in declines) must be determined and appropriate emergency equipment must be installed in accessible locations including refuge chambers, escapeways, first response and rescue equipment.

Dangerous incident IncNot0036180	At an underground mine, a haul truck was travelling down a decline when it started to slide towards the wall. The truck was stopped without hitting the wall. The operator then started reversing up the decline. A second haul truck came around the corner and was unable to stop before hitting the reversing truck. No positive communications were made by the driver of the reversing truck. No-one was injured in the collision.	Effective communications protocols and procedures should be in place to ensure that positive communication between all operators is achieved. The correct use of these protocols must be monitored on a continual basis by supervisors. Lack of positive communication has been the root cause of many incidents and mine operators must consider higher-order controls including proximity detection. Refer to Safety Bulletin 18-06 Lack of positive communications.

Dangerous incident IncNot0036193	A contractor suffered a laceration to the mouth, one broken tooth and loose teeth after being hit by parts of a breather. The worker had isolated and changed a breather on a large water pipeline. Upon removing the isolation to the breather, a mechanical failure occurred resulting in the worker being hit. 	Mine operators should review how workers and supervisors are trained to recognise the potential hazards associated with all energy sources. When re-energising equipment after repairs and maintenance, operators must consider the potential for premature failure and remove themselves from the line of fire.
Dangerous incident IncNot0036207	A blast was conducted on the floor of a quarry to break up some large rocks. Eight shots were fired at the same time. There was a loader parked up and unoccupied about 200 metres from the blast (in front of the blast). The nearside window of the loader was broken by flyrock from the blast. On further investigation it was found that workers were positioned within the 400 metre exclusion zone, however they were not affected by flyrock. No flyrock fell outside the exclusion zone.	Mine operators are reminded that appropriate systems must be in place to review and audit the explosives control plan and blasting work practices to ensure that exclusion zone requirements are adequate and adhered to. See our publications: SA05-16 Blast control – flyrock incident IIR17-08 Dangerous incident during blasting



Dangerous incident IncNot0036218	A bundle of four polypipes (320 millimetres in diameter and 120 metres long) were being maneuvered by contractors using a wheeled excavator when they lost control. The pipe bundle slid down a batter and over a catch bench where two workers were standing, then continued down a steeper batter to the bottom of the open cut workings, landing in 5-metre deep water. It was estimated that the pipes missed hitting the workers by about 5 metres. 	Mine operators need to ensure that adequate measures, including fit-for-purpose equipment, are in place to prevent unplanned movement of pipes in such circumstances. Safe standing zones are a known control for keeping people out of the line of fire. All potential failures must be identified when determining safe standing zones before starting work. If the task or environment changes, workers must be reminded to stop, reassess the implemented controls and identify any new controls that must be used.
Dangerous incident IncNot0036219	A heavy vehicle operator was parking a truck in a park-up area. In reversing the	When parking up light vehicles in designated areas, vehicles should

truck into position, the operator reversed into a light vehicle that was not fully parked in the designated area. There was no-one in the vehicle at the time, and it was significantly damaged. The park-up bay was congested with several heavy vehicles.

be parked fully within the designated area. If there is inadequate room for the vehicle then it should either be parked in another area, or adequate demarcation put around the vehicle so that it is identifiable to all other road users including heavy vehicle operators. Heavy vehicle and light vehicle park-up areas should be segregated appropriately.

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
National (other, non-fatal)	
DNRME Qld	**Explosives charge vehicle catches fire** An explosives charge vehicle containing explosives, caught fire while at a charged face. When trying to move a charge unit from a heading after charging the face, the charge crew found the machine unserviceable. Details
DMIRS WA	**Management of safe drinking water at mine sites (MSB No 168)** Safe and accessible drinking water (potable water) is important for health and must be supplied to all employees at mining operations in Western Australia. The department has recently been investigating contamination of water supplies with process water or microbial pathogens that have the potential to cause

serious and disabling conditions. Such conditions can lead to severe, debilitating diseases that may cause death in susceptible people.

Details

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	
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