

# WEEKLY INCIDENT SUMMARY

Week ending Friday 12 June 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 incidents and our comments to operators.

TYPE	NUMBER
Reportable incident total	32
Summarised incident total	3

## Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0037536	A light vehicle collided with a bund, resulting in the driver's lip being injured and requiring five stitches.	It is vital that mines have a robust change management process in place that ensures not only the identification of introduced risk, but the implementation of suitable controls to manage the risk. This includes communicating the changes to all workers who may be impacted by that change.
Open cut construction materials mine 	Over a weekend, a roadway under a conveyor was blocked with an earth bund.  The bund was put in place on one side of the conveyor and bollards with high visibility tape were erected on the other side. The change management process was not followed and the changes were not communicated to staff.  It was dark when the incident occurred.	
Roads or other vehicle operating areas		



Dangerous  
incident  
IncNot0037555  
Underground  
metals

A contract stope charger has removed a guard and was adjusting the hose pusher mechanism on a production charge-up unit when an operator moved the mechanism in the charge basket. The stope charger's fingers were caught in the chain sprocket, resulting in the partial amputation of his index finger and the loss of the tips of his second and third fingers.



Isolation and control of all energy sources from plant is essential when adjustments are being undertaken.

Engineering controls should be implemented to allow regular tasks to be conducted without the need to remove control measures (guards).

Mechanical engineering control plans must set out the control measures for risks associated with moving components on plant.

Dangerous incident  
IncNot0037556  
Open cut coal mine



Fire or explosion

A major hydraulic oil leak occurred on an excavator, resulting in hydraulic oil spraying onto the turbo and catching fire. The apparent cause of the leak was from a broken flange bolt. The automatic fire suppression system activated and the excavator operator used a fire extinguisher to extinguish the remaining flames.



All components within a system including retaining bolts must be identified and appropriate inspection and change out conducted.

When selecting and installing a fire suppression system, the system should cover all likely ignition sources (high temperature areas) so as to extinguish fire in all probable locations.

## 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
	<b>International (fatal)</b>
<b>MSHA</b>	<p><b>Fatality – final report</b> A 46-year-old splitter/chopper with six days of experience at this mine, died on 27 August 2019, from a lightning strike. The worker had stopped splitting and sorting rock and was walking back to a canopy to take shelter when the incident occurred. <a href="#">Details</a></p>
<b>MSHA</b>	<p><b>Mine fatality alert</b> On 1 June 1 2020, a contract truck driver died after falling from the top of his trailer. The worker was given first aid/CPR at the scene and passed away, after being transported to a local hospital. <a href="#">Details</a></p>

**National (other-non-fatal)****DMIRS WA****High pressure water cleaning creates mists and aerosols causing Legionnaires disease: Mines Safety Bulletin No.174**

An underground miner was recently diagnosed with Legionnaires' disease after suffering severe respiratory distress and pneumonia that developed quickly from flu-like symptoms. Despite being young, fit and healthy, the miner required urgent medical intervention in an intensive care unit before he made a full recovery.

High levels of Legionella pneumophila were identified at the underground wash bay where the miner had used high pressure, water blasting equipment to clean heavy machinery during his last roster.

[Details](#)

**DMIRS WA****Integrity of equaliser cables on vehicles hoists: Mines Safety Bulletin No.175**

There have been numerous reports of failed and damaged equaliser cables on vehicle hoists, including those types with two or four posts.

The equaliser cables are typically made using steel wire rope and are used to keep the hoist level during raising and lowering. Over time, equaliser cables can stretch, fray, corrode, crack or break and therefore should be regarded as a wearing component.

[Details](#)

**QMI****Metal shard projectile from excavator track sprocket - Safety Newsflash (Qld.)**

Following an undercarriage track change on an excavator, a metal shard was ejected from the track sprocket. The metal shard travelled 35 metres breaking a side window and entering the cabin of a parked service truck.

[Details](#)

**QMI (coal)****Explosion protected diesel engine exhaust conditioner corrosion - Safety Newsflash (Qld.)**

Internal inspections of several exhaust conditioner inlets have shown reduced integrity over time from corrosion and/or cracking of the internal gussets that support the exhaust inlet pipe.

After the gussets crack, they no longer support the welded connection between the inlet pipe and the lid. The weld in this location, which separates the inlet exhaust gas from the outlet conditioned exhaust gas, can crack from lack of support.

[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.

© State of New South Wales through Regional NSW 2020 You may copy, distribute, display, download and otherwise freely deal with this publication for any purpose, provided that you attribute Regional NSW as the owner. However, you must obtain permission if you wish to charge others for access to the publication (other than at cost); include the publication in advertising or a product for sale; modify the publication; or republish the publication on a website. You may freely link to the publication on a departmental website.

Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (June 2020) and may not be accurate, current or complete. The State of New South Wales (including Regional NSW), the author and the publisher take no responsibility, and will accept no liability, for the accuracy, currency, reliability or correctness of any information included in the document (including material provided by third parties). Readers should make their own inquiries and rely on their own advice when making decisions related to material contained in this publication.

## DOCUMENT CONTROL

<b>CM9 reference</b>	DOC20/465936
<b>Mine safety reference</b>	ISR20-24
<b>Date published</b>	19 June 2020
<b>Approved by</b>	Chief Inspector Office of the Chief Inspector