

WEEKLY INCIDENT SUMMARY

Week ending 26 April 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	37
Summarised incident total	8

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Loss or theft of explosives IncNot0034414	<p>A vacuum truck was used at a mine to remove explosives from two holes that had slumped due to rain. The truck was inspected by the shotfirer and cleaned before leaving the site.</p> <p>Two days later, the same truck was used at another mine. While being cleaned, an explosives GL booster and detonator were found in the wash down bay sump. The booster was identified to have come from the previous mine.</p>	<p>Mine operators should review procedures for cleaning out vacuum trucks to ensure all lines and tanks are free of material that could contain explosive precursors from the blast hole.</p>

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
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Dangerous incident
IncNot0034419

A Jumbo Operator at a metalliferous mine was boring when a pocket of gas was hit. The workers followed site procedures however, they reported not feeling well and having a ‘metallic’ taste in their mouth. The workers were taken to the surface and transported to hospital where they were administered oxygen. They were discharged from hospital the same day.


Mine operators must provide adequate information, training and instruction to workers about monitoring and responding to potential situations when undertaking drilling operations (e.g. the occurrence of toxic gases).


Dangerous incident
IncNot0034428


A Hitachi EH5000 haul truck stopped at an in-pit fuel farm. The operator left the cabin and noticed smoke through gaps in the top deck. The operator walked down the stairs and noticed flames at the left-hand engine bay. He returned to the cabin, called emergency and manually activated the fire suppression system. The fire was extinguished, and the water cart attended the incident.

Failures of turbocharger oil supply lines have been identified as the cause of many mobile plant engine fires. Mine operators must develop and adhere to strict inspection and maintenance standards and practices specific for their site conditions, to prevent loss of oil through oil feed lines and mitigate potential engine fires.



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<p>Dangerous incident IncNot0034429</p>	<p>A fire occurred on a water truck located at the top of a ramp. The operator stopped the truck and activated the fire suppression system. The fire suppression system was unsuccessful in extinguishing the fire. Hand held extinguishers and a water cart were used to extinguish the fire. No one was injured. An escape of fluid onto a hot surface was identified as the cause.</p> 	<p>Loss of hydraulic oil or hydrocarbon fluids is a common cause of fire on mobile plant. Mine operators should identify, evaluate and segregate hot surface temperature ignition sources from potential fuel sources.</p>
<p>Dangerous incident IncNot0034437</p>	<p>Mineworkers reported a burning smell at an underground coal mine. On investigation, burning coal embers were identified, which were ignited by a dislodged roller that was running in fines at a roadway underpass. The heating was cooled and extinguished by a water hose. The dislodged roller was most likely caused by a vehicle contacting the underpass guards.</p>	<p>Mine operators must ensure a minimum clearance to vehicles at underpasses and that conveyor belts run clear of fixed structures and fines in all locations.</p>
<p>Dangerous incident IncNot0034439</p>	<p>The operator of a laden haul truck reported experiencing a micro-sleep while driving the truck down a ramp. The haul truck was seen by another driver to be travelling at excess speed and lose control. The other driver called on the two way and managed to wake the operator. The operator</p>	<p>Mine operators should include worker fatigue monitoring and response technology as a part of fatigue risk analysis.</p>

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	<p>managed to regain control on a flat part of the roadway.</p>	
<p>Dangerous incident IncNot0034443</p>	<p>An underground loader at a metalliferous mine caught on fire due to insulation on a battery lead being worn through. The fire suppression system was automatically activated. The operator then used a fire extinguisher to extinguish the fire.</p> 	<p>Mine operators must ensure auto electrical components on diesel equipment are maintained in a fit for purpose state. Cabling and wiring harnesses should always be secured and routed to keep clear of moving parts and heat sources.</p> <p>Following a fire on mobile plant, once the suspected cause of the fire has been identified, all other equipment of the same type in service at the mine should be inspected as soon as possible to ensure the defect does not exist on these other machines.</p> <p>Refer to MDG15 for further information.</p>
<p>Dangerous incident IncNot0034460</p>	<p>A coal burst occurred during remote mining on a longwall, causing the shearer and armored face conveyor to trip. Video footage was used to confirm the coal burst. The mine followed site procedures and no injuries occurred as a result of the incident. An investigation is continuing.</p>	<p>Mine operators must complete a geotechnical assessment to determine the correct support requirements taking into account the potential for rock burst as per cl44B(2)(d). Mine operators should firstly determine the risk of rock burst and then the required support to minimise likelihood. Following this assessment, the mine operator should assess appropriate controls including</p>

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		<p>de-stress drilling, hydro-fracking and no-go zones if the risk of rock burst exists. In most instances rock burst and coal burst should be treated as the same risk.</p>

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.

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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (May 2019). 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 Planning and Environment or the user's independent advisor.

DOCUMENT CONTROL

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