Weekly incident summary

Planning & Environment
NSW GOVERNMENT Resources Regulator

Week ending 29 November 2017

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.

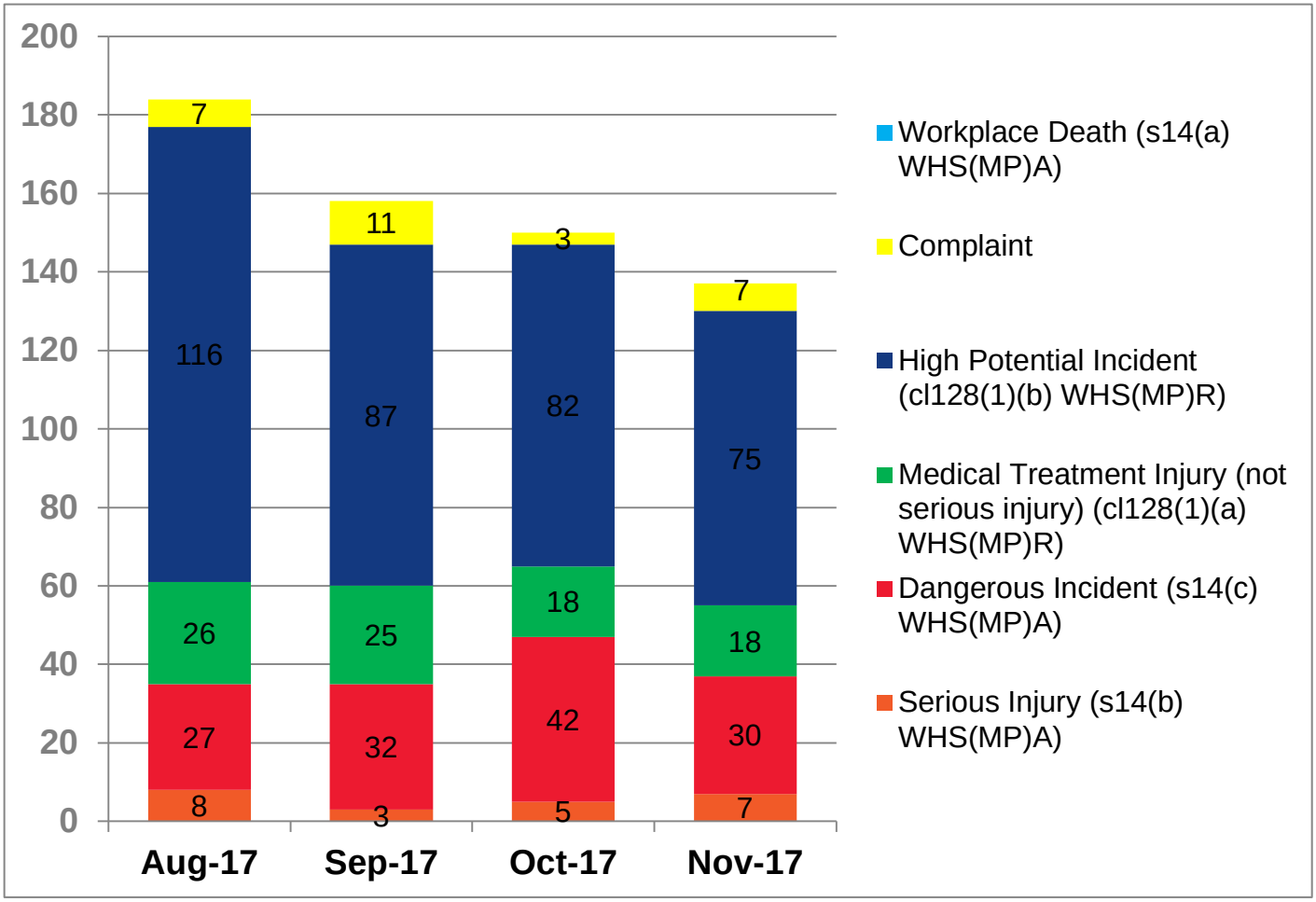
Type	Number
Reportable incident total	39
Summarised incident total	7

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot-2017/01880	An operator detected smoke while he was using a dozer on a waste dump. He parked the machine and saw a fire. He activated the fire suppression system and called emergency.	Mine operators should ensure: • where practicable, hoses are segregated from hot surfaces using hard barriers • mechanical protection and restraints for fluid conductors (hydraulic hoses or pipes) are inspected for rubbing and abrasion during maintenance inspections • appropriate maintenance practices and housekeeping are implemented to prevent the ignition of combustible fluids from hose, pipe and fitting failures. **Refer to:** *AS5062:2016 Fire protection for mobile and transportable plant*
Dangerous incident SinNot-2017/01876	While drilling an underground exploration hole, a gas flame occurred, which was self-extinguished. The hole was placed onto gas diversion to make it safe. A gas detector located about half a metre above the drill hole did not detect any gas. A second incident occurred that had to be extinguished by the operator.	Mine operators should ensure appropriate controls are in place to: • prevent an ignition source • detect flammable gas • sufficiently dilute flammable gas.

	There were no indications from the drilling return water or from gas meters that gas had been hit and the rig was operating as normal at the time. It is believed that the friction from the spinning rods against the jaws gave sufficient heat to initiate the gas fire.	
Dangerous incident SinNot-2017/01872	During a routine conveyor inspection a deputy identified glowing embers and a small amount of smoke under a trunk conveyor. No naked flames were seen and a collapsed return roller was found to be the source of the heat. There was a small amount of fines below the collapsed roller, which had 500 mm clearance from the floor.	Mine operators should review the: • appropriate time frame for the defect management of belt rollers and for the removal of spillage along a conveyor • consideration of belt roller life cycle through change management when conveyor speeds have increased. There is an increasing trend in the number of fires on underground conveyors. Key issues identified include: • the quality of inspections including inaccessible areas (eg behind guards, off walk side, etc) • the use of fit-for-purpose rollers and idlers for the location • roller management and the defect management system.
Dangerous incident SinNot-2017/01871	The operator of a bulldozer saw flames coming from the left hand side walkway and manually activated the on-board fire suppression system. The fire was extinguished and a water cart was also used to cool the walkway area. There is no visible evidence of equipment damage but all guards and covers were removed. The machine hydraulic tank was reported as empty, which indicated a failed internal hydraulic line as the likely source of the fire.	Mine operators should ensure: • equipment operators are reminded to investigate any oil leaks and effect repairs and clean up to prevent fires from occurring • hydraulic oil level alarms or shutdown systems are considered to prevent significant loss of hydraulic oil that may result in equipment damage or fire.
Dangerous incident SinNot-2017/01856	While in the process of changing a half filled medical oxygen cylinder gas bottle from the back of a truck, it slipped from a person's grasp. The bottle hit the holding crate and broke off the isolation valve. There was a release of gas under pressure that created a lot of dust, but the bottle didn't move. Two workers in the area remained still until the dust cleared.	Mine operators should review their procedures associated with the handling and transporting of pressurised gas cylinders.

Dangerous incident SinNot-2017/01854	Two fitters were removing the main drive shaft from a loader with the bearing attached. While lifting the shaft, the mount and bearing came loose falling one metre and hitting one of the fitters on the leg. The fitter was taken to hospital.	Mine operators and contract companies should review how the assessment of hazards and the introduced controls are done when there is a change in the task that is not covered in the work procedure.



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.

Recent publications

- Causal investigation: Catastrophic engine failure in an underground coal mine
- Investigation report into the serious injury of a mine worker at Sibelco Sand plant on 1 February 2016
- Video in NSW practising certificate system including the maintenance of competence scheme
- Safety bulletin: air quantities for diesel engines in underground coal mines
- Fact sheet: Heat stress in underground metalliferous mines
- Gazettal: Maintenance of competency
- Review of drawpoint management

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Mine safety reference	ISR 17-47
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