

WEEKLY INCIDENT SUMMARY

Week ending Friday 8 January 2021



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. Please note the reportable incident total is recorded for the period 11 December 2020 to 8 Jan 2021

TYPE	NUMBER
Reportable incident total	91
Summarised incident total	8

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0038855 Underground metal mine 	While driving to the surface park up area, approximately 100 metres from the portal, a haul truck's engine caught on fire. The haul truck operator saw the flame coming from the exhaust guard. The fire suppression system initiated, which extinguished the flame. 	The mine identified that the 'O' ring failed, resulting in the spray of hydraulic oil onto the hot engine components. The Resources Regulator has identified a concerning increase in reports of fire on mobile plants. Escape of fluids ignited by hot surfaces has been identified as one of the top two causes, along with electrical wiring faults. For further information and the Regulator's position refer to our website .

Dangerous
incident
IncNot0038873
Open cut coal
mine



A light vehicle being driven by a contractor collided with a barrier on the edge of a mine access road. The barrier intruded into the front passenger side of the vehicle. Statements indicate that the driver may have been distracted by a kangaroo.



Mine operators should ensure light vehicle operators are aware of the hazards in relation to local wildlife.

In addition, mine operators should also ensure that light vehicles are fitted with safety features that provide protection if a crash occurs. Features include crumple zones, airbags, seat belts and active safety assist technologies.

Dangerous
incident
IncNot0038894
Underground
metal mine



An operator activated a self-contained self-rescue unit that was near the end of its life as part of a training exercise. The operator pulled the pin on the SCSR unit to activate the oxygen and the unit ignited. The operator removed the unit from their neck and dropped it to the ground, where it caught on fire. The fire was extinguished, and the operator was not injured.



The cause of this fire has not yet been established. The unit has been sent to the OEM for further testing and analysis.

Mine operators should maintain regular frequent testing of self-rescue units. When excessive failures occur, the entire batch of self-rescuers should be removed from service.

The outcomes of this incident need to be considered when using self-rescuers for training exercises.

Dangerous incident
IncNot0038912
Small mine



A quarry manager witnessed a hole appear in weathered material next to a concrete kerb on an overburden embankment. There was pooling water swirling and gurgling at the location indicating water had accumulated due to a recent rain event. The road was closed to all vehicles and water was redirected. Approximately 45 minutes later a section of the bank slumped out of the hillside

Mine operators must have safe systems of work in place to inspect highwalls, low walls and dumps. These inspections must consider weathering effects, ground water and conditions that affect the stability. Following several incidents where people and equipment have been exposed to significant health and safety risks as a result of highwalls, low walls and dumps failing, the NSW Resources Regulator has published [Safety Bulletin SB20-01 Failure of highwalls, low walls and dumps](#). Operators should take note of the recommendations in this bulletin.

Dangerous incident
IncNot0038925
Underground coal mine

A shuttle car operator was travelling in bye when he hit a pothole. The shuttle car door swung open, then closed on the operator's foot causing a large laceration to his toe. It appears that the door was forced shut by a canch in the roadway next to the rib.

The mine has identified that the shuttle car's anti-slam pin, when raised and the door was shut, did not assist in retaining the door, as it was failing to drop into the designated hole. The mine has notified the OEM. Mine operators should undertake an audit of the door mechanisms of their fleet to ensure they are operating as per specifications. In addition, a road maintenance program should be implemented that includes stopping and fixing deteriorating roads.



Dangerous incident
IncNot0038944
Open cut coal mine

A blast was fired. One piece of flyrock, with an estimated weight of 2 kilograms, has landed adjacent to sentry two position. The sentry cone was positioned 510.6 metres from the blast and the rock landed

Mine operators should have systems in place that prevent designated blast holes from being overloaded. Consideration should be given to:

- establish an inspecting and monitoring process to ensure

at 511.0 metres and approximately 5 metres from the sentry vehicle.



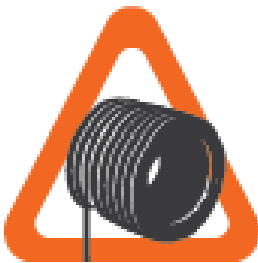
overloaded holes are being identified and procedures are being followed

- ensure quantity and quality of stemming is applied as per the site blast procedures. This should be reviewed and checked by the blast supervisor on site.

Dangerous incident

IncNot0038956

Underground coal mine



A drift winder has had an unplanned movement.

Prior to the event, the DC winder motor had been serviced. The electrician entered the man car and intended to travel down the drift (initially in slow/creep speed), however, the man car moved up the drift and at high speed. The movement was stopped automatically by the safety PLC.

Mines with winders must have a principal hazard management plan for mine shafts and winding systems. The plan must address control measures for risks associated with mine shafts and winding systems (clause 3, schedule 1 WHS (MPS) Regulation) In developing principal hazard management plans, mines must ensure components are changed out and replaced with like components.

Dangerous incident

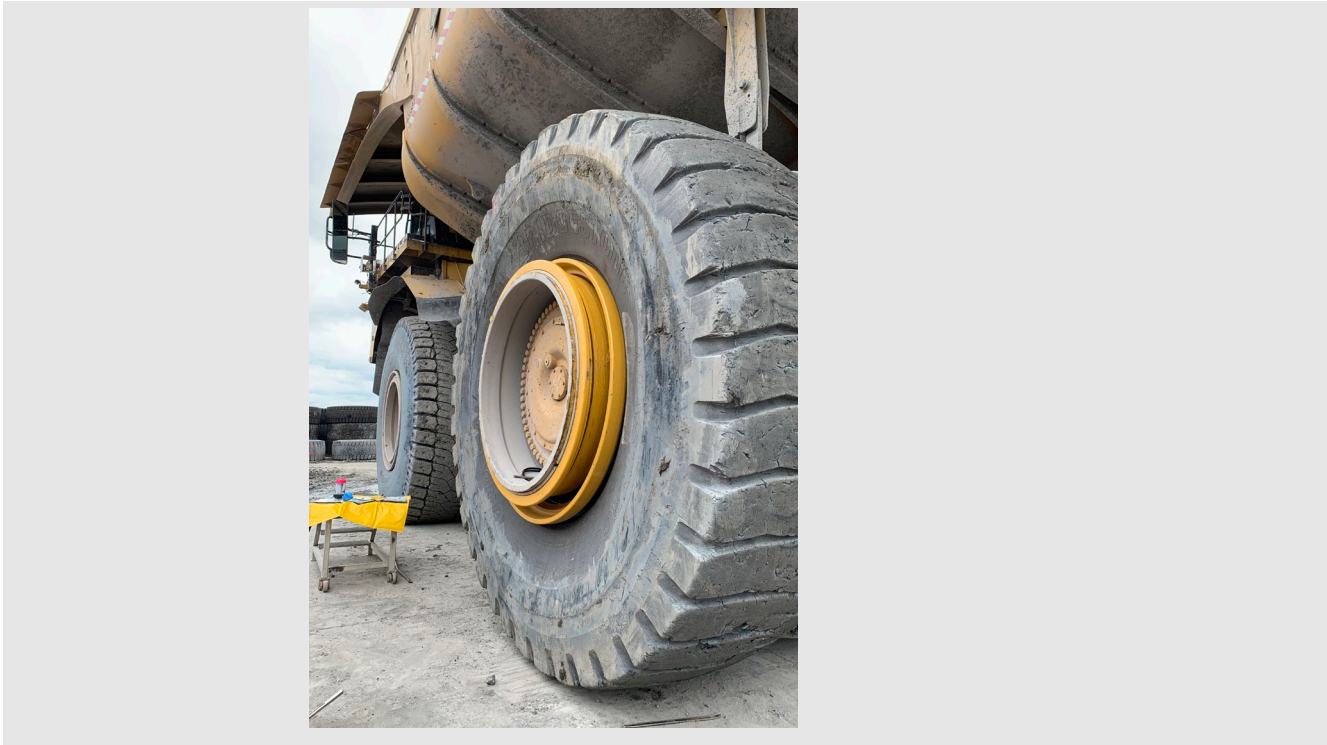
IncNot0038969

Open cut coal mine

A contract tyre fitter was in the process of installing a tyre when the tyre and rim components shifted horizontally and trapped the tyre fitter's fingers between the lock ring and bead seat band.

Mine operators should review their safety management systems for removing and fitting tyres. Mine operators should ensure that:

- potential pinch points associated with the task are identified
- appropriate controls are implemented to eliminate the potential of injury associated with pinch points when removing and fitting tyres
- correct tooling is provided for the job.



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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DOCUMENT CONTROL

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