Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 12 December 2018

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	40
Summarised incident total	4

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident IncNot0033153	A dozer came into contact with electrical equipment at an open cut coal mine. The dozer backed over a 6.6kV shovel cable and grazed the junction box. Power tripped at the substation. An earth leakage fault was reported against the 6.6kV outlet. 	Electrical infrastructure, whether temporary or permanent, should be delineated. The type of delineation used should be appropriate to the level of risk considering the vehicles and equipment operating in the area.

Serious injury IncNot0033143	A worker suffered a fractured leg when a basket detached from a loader in an underground metalliferous mine. The basket lock-pin disengaged when the operator pressed the wrong button in the cab while attempting to lift the park brake. The basket fell 2 metres from where it was attached to the loader. 	An investigation has commenced. Further information will be released shortly.
Dangerous incident IncNot0033186	An articulated water cart rolled at an open cut coal mine. The water cart was reversing at low speed and turned slightly when the rear wheel rode up onto a dozer rill/windrow, causing the tank to roll onto its side. 	Mines that are operating articulated vehicles, particularly water carts, should review operating parameters (include slope and cross grades). Work areas should be assessed to determine if articulated vehicles are the correct plant for the task.

Dangerous incident IncNot0033198	A worker was sprayed with a cyanide solution at a gold mine processing plant. A fitter was standing adjacent to a pump when the isolation was being removed. A drain valve was left open and a stream of cyanide sprayed out. As it sprayed, the worker tried to move out of the way but he was sprayed on the shoulder and arm. The worker used a safety shower nearby. Full personal protection equipment (PPE) was worn at the time.	When making changes to process equipment, change management processes must be documented, followed and communicated to relevant workers. When positioning drain valves, consideration should be given to the path of any discharge. This is applicable to all fluid and gas types and should consider pressure, flow and substance.

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 Resources Regulator publications

- IIR18-13 Death of worker at Glendell Mine

Other publications of note

Publication	Issue / Topic
	International (fatal)
MSHA	• **METAL/NONMETAL MINE FATALITY** – On June 13, 2018, a 65-year old truck driver was fatally injured when his truck travelled over a berm and into an impoundment of water. Divers recovered the victim in the water. Details • **METAL/NONMETAL MINE FATALITY** – On November 3, 2018, a 44-year-old shift supervisor was killed when a loaded haul truck ran over her pick-up truck at the crusher site. Details

	METAL/NONMETAL MINE FATALITY – On November 11, 2018, a 45-year-old underground technician was killed when the load haul dump (LHD) machine he had been operating underground ran over him. Details
International (other, non-fatal)	
MinEx NZ	A driller failed to notice that a winch wire had become snagged and continued to raise the mast, therefore continuing to increase the tension in the wire until the steel thimble bent, causing the wire and attached hoist plug to release in an uncontrolled manner within close proximity of the driller**.** Details
National (other, non-fatal)	
Qld dept of Mines (DNRM) In MinEX NZ	• Lightning strikes on rubber-tyred heavy vehicles. During lightning storms, heavy, rubber-tyred vehicles should not be recommended as a place of safety. Several incidents have occurred on Australian mine sites in which lightning has struck rubber-tyred vehicles causing tyres to explode, demonstrating the enormous potential for significant harm when this occurs. **Details**
MIRS WA	• There was a near miss in which a latch failed and a gate swung open on a haul truck During April 2018, a worker was exposed to potentially serious injuries when a handrail latch failed, causing a handrail gate to swing open. The truck was in the queue to receive a load when a trainee operator and the trainer stepped out of the cab to hold a discussion. The trainee was leaning over the handrail outside the cab near the emergency ladder when the latch failed. The trainee lost his balance and grabbed the handrail. The trainer reacted immediately and grabbed the trainee's arm to prevent him from falling. The distance to the ground was more than 4 metres. **Details**

Disclaimer

The information contained in this publication is based on knowledge and understanding at the time of writing. However, because of advances in knowledge, users are reminded of the need to ensure that information on which they rely is up to date and to check the currency of the information with the appropriate officer of NSW Department of Planning and Environment or the user's independent advisor.

The following incidents are included for your review, the 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.

Office use only	
CM9 reference	DOC18/969507
Mine safety reference	ISR 18-46
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