Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 21 November 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	30
Summarised incident total	3

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot-2018/01932	A worker suffered an electric shock while assisting a boilermaker. The worker was holding a kickboard in preparation for it to be welded to a walkway. As the boilermaker struck the arc, the worker suffered an electric shock through his gloves in his right hand. At the time of the incident, the worker had his shoulder up against the steel building support. The boilermaker had the earth return on the opposite side to the worker holding the work piece. The worker was assessed by ambulance officers and cleared, then was sent to hospital following site procedures. He was later released and returned to site fit for work.	The risk of electric shock from welding processes is widely overlooked by workers completing these tasks. Task-specific procedures should detail controls to eliminate the risk of electric shock to both the boilermakers and workers, who are assisting them. Mines should review their welding electric shock mitigation controls and verify that the relevant workers, including contractors, have a thorough understanding of the required controls.
Dangerous incident SinNot-2018/01916	A worker was injured while trying to stop a runaway vehicle in an underground metalliferous mine. The worker parked a truck and got out of the vehicle. The truck moved forward unexpectedly. The worker	When accessories are fitted to a vehicle (such as bull bars, custom trays/bodies, fire suppression systems, vehicle loading cranes) the

	tried to get back into the truck but was pinned between the door of the truck and the wall of the mine. The worker suffered injuries to the foot and ankle. An investigation identified that the truck was overloaded at the time. 	load carrying capacity is reduced. This should be clearly marked on the vehicle and communicated to operators. When determining locations for parking vehicles at log on points and tag boards, areas on grades such as drifts or declines, should be avoided.
Serious injury SinNot-2018/01913	A worker was injured when poly pipe hit him. The poly pipe was being lifted and dragged into position using excavators. After moving three pipes, the fourth pipe being moved hit the worker. The worker's knee and shoulder were injured when he fell to the ground. 	When poly pipe is being moved, the stored energy and potential for sudden release (spring back) must be taken into account in task procedures. Clear and defined 'no-go' zones must be developed to protect workers from sudden releases of energy. SA09-10 Directional boring fatality details an incident in which pipe recoil resulted in a worker being killed.

Resources Regulator recent publications

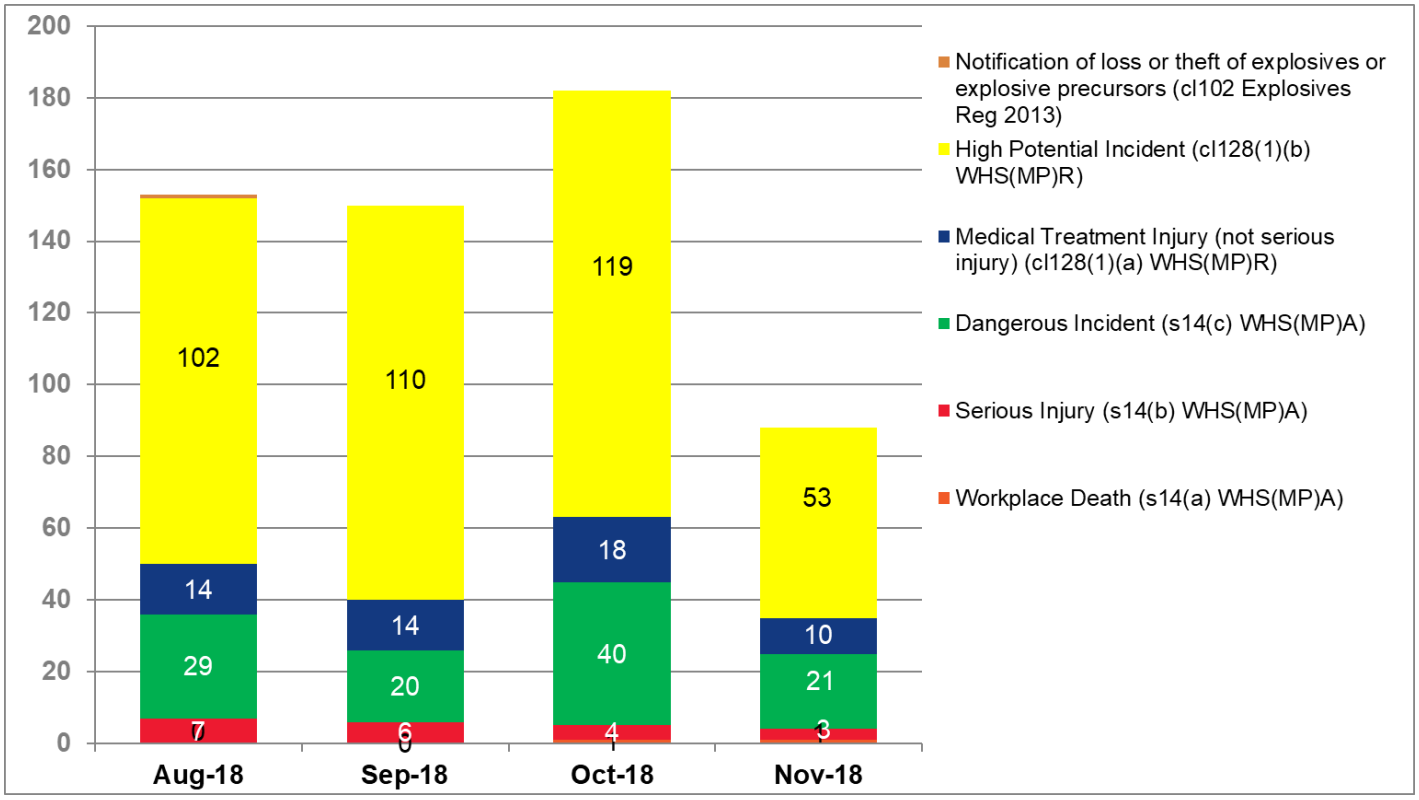
→ Investigation report – Report into the death of Stephen Norman at Rix's Creek Coal Mine on 13 December 2016

Other publications of note

Publication	Issue / Topic
	International (fatal)
MSHA	• **Coal mine fatality** On Wednesday, 17 October 2018, a 33-year-old auger helper, with three days of surface mining experience, suffered fatal injuries. He was attempting to move a section of auger steel by using the onboard crane when he was struck in the chest. Details
MSHA	• **Haul truck driver dies from burns** A haul truck driver on night shift died after suffering extensive burns while exiting a haul truck on fire. According to reports from the US Mine Safety Regulator (MSHA), the 60-year-old haul truck operator (with 65 weeks' on the job experience) was transporting spoil to a dump site at the Peabody Bear Run mine, when a dozer operator saw fire on the truck. The dozer operator alerted the haul truck driver and he stopped the truck. While exiting the truck, the haul truck driver was burnt and he was taken to the hospital. Details
	International (other, non-fatal)
MinEx NZ	• **Lifting point failure during dual crane lift** During the dual lift of a 19-ton pre-cast unit, one of the eight lifting points has failed, resulting in the precast unit falling to the ground. The lift was being completed by a crane which was lifting the lead and an all-terrain crane was being used on the tail to rotate the precast until from horizontal to vertical. The load was nearly vertical at the point of failure, with the base of the unit being approximately 1 metre from the ground. An exclusion zone was in place keeping non-authorised personnel out of the area. The closest people were approximately 5 to 6 metres away while the lift was taking place. **Details**

MinEx NZ	• **HIAB tipped during unloading** **Details**
MinEx NZ	• **Light vehicle rollover** While traveling down a haul road towards the portal, the operator of a Landcruiser ute applied the brakes to allow an ADT to exit the portal. On applying the brakes, the ute skidded and the operator took his foot off the brakes to maintain traction. Then on the second application of the brakes, the vehicle failed to slow. The driver then turned into the embankment to stop his runaway vehicle, causing the ute to roll on to the driver's side. **Details**
MinEx NZ	• **Water tanker rollover** A 28,000L water tanker was positioned next to concrete crushing activities. After the water tanker had been filled, a worker observed the front left-hand side jack (jockey wheel) fail and cause the front left-hand side of the tanker to slip. After about five minutes the tanker rolled down the adjacent batter into the scrub. No one was injured. **Details**
	National (other, non-fatal)
WA Mines Dept	• **Structural failure of a corrugated steel water tank** In May 2018, a 600,000-litre raw water tank failed. At the time of failure, the rubber-lined steel constructed tank was near full capacity. The outrush of water affected an operational area of 24,000m², displacing pumping infrastructure, ladders and associated debris. There was no one in the vicinity at the time of failure. Details
MinEx NZ	• **ADT rollover** The operator of an articulated dump truck (Volvo A40) had been accessing a stockpile at a slow speed when he noticed that the rear right-hand side wheel had slipped down a shallow embankment. This resulted in the loaded body rolling onto its right-hand side. No one was injured during the uncontrolled movement. No plant damage and no environmental spill occurred during the event. **Details**

Number of incident notifications, by commencement month and incident type



Note: While most incidents are reported and recorded within a week of the event occurring, some are notified outside this period. All recorded incidents are reviewed by the Resources Regulator's Chief Inspector and senior staff. For more comprehensive statistical data, refer to our annual performance measures reports on www.resourcesregulator.nsw.gov.au.

Disclaimer

The information contained in this publication is based on knowledge and understanding at the time of writing. Users are reminded of the need to ensure that information on which they rely on is up to date. Visit resourcesregulator.nsw.gov.au to view publications, read about causal investigations and emergency responses as well as find your local Resources Regulator office.

Office use only	
CM9 reference	DOC18/896992
Mine safety reference	ISR 18-44
Date published	23 November 2018