Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 15 August 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

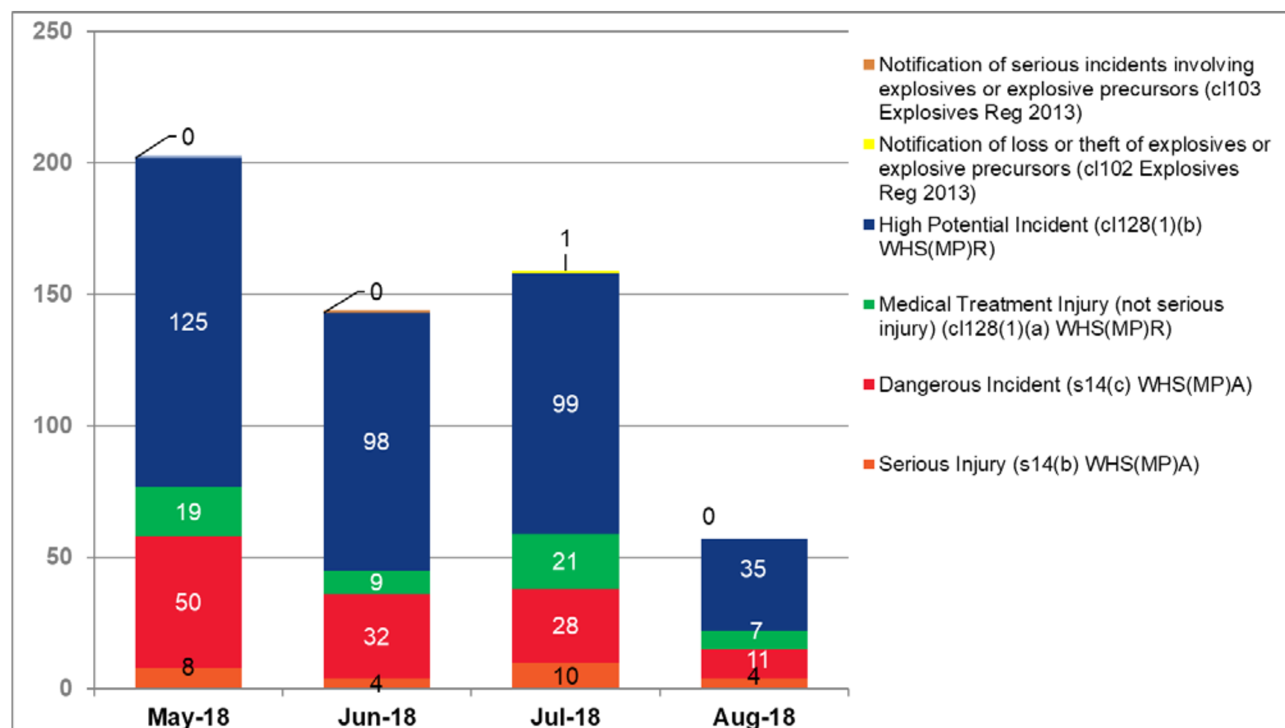
High level summary of emerging trends and our recommendations to operators.

Type	Number
Reportable incident total	22
Summarised incident total	5

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot-2018/01312	An underground coal mine operator identified indicators of spontaneous combustion in the goaf of a longwall panel. The mine has recently completed extraction in the panel and is in the process of relocating equipment to the next block. The mine has responded according to their trigger action response plan.	Mines must consider all ventilation variables when monitoring and managing the risk of spon com. This includes changes in longwall ventilation due to goaf falls, roadway choking and seal strata deterioration. Composition of geological structure (e.g. presence of sulphur) needs to be reviewed when assessing the spon com risk.
Dangerous incident SinNot-2018/01303	A supervisor was sprayed with hydraulic oil from a load haul dump manifold block and transported to hospital where he was cleared of injury. The supervisor was assisting another worker identify the source of an oil leak. When the hydraulics were activated, the oil escaped from a threaded fitting on the manifold block.	The circumstances around this incident are similar to those detailed in SB13-01 Fluid injections result in surgery. This bulletin should be reviewed to confirm the recommendations have been reviewed and actioned.

Serious injury SinNot-2018/01297	A worker suffered lacerations, bruising and an injured jaw when he was hit by falling grout tubes. Three workers were installing tubes into a cavity in the roof and when adjusting the alignment of the installed tubes, a join separated dropping the tubes, hitting one worker on the jaw and chest. An investigation identified that no risk management had taken place for the task.	Mines must have in place systems that require appropriate risk management tools to be available for use by workers for tasks. Additionally, supervision arrangements must include checks to ensure risk management tools are in place.
Dangerous incident SinNot-2018/01295	A light vehicle rolled onto its roof while travelling on the surface of an underground coal mine. The driver had previously stopped the vehicle to engage the four-wheel drive function.	Roads should be designed and maintained for all weather conditions. Relying on instructing workers to “drive to the conditions” is a lower order control. The Work Health and Safety Regulation 2011 clause 36 hierarchy of control measures requires the use of substitution, isolation or engineering controls before accepting administrative controls.
Serious injury SinNot-2018/01290	A haul truck driver was admitted to hospital with neck pain after the truck was loaded. The incident was not immediately reported.	The Work Health and Safety (Mines and Petroleum Sites) Regulation 2014 clause 178 Serious injury or illness part (a) requires the immediate treatment as an in-patient as a serious injury requiring immediate notification. The Notification of incident and injury guide provides more detailed information on the types of WHS incidents that must be notified.



Resources Regulator publications

- Safety Bulletin SB18-13 Alternators and IS equipment

Other safety publications of note

International (fatal)	
MSHA	• **METAL/NONMETAL MINE FATALITY** – On July 31, 2018, a 62-year old foreman with 40 years of experience, was fatally injured while dismantling a portable crusher. The front-end loader was placing a 20-foot long steel tube onto the screen feed conveyor. The front-end loader operator lowered the bucket and crushed the victim against the conveyor structure. Access the MNM Fatality Alert here
International (other, non-fatal)	
MSHA	• **MNM Serious Accident Alert** On April 11, 2018, a miner received serious injuries when he was struck by a piece of metal floor grating. A construction supervisor stepped on a section of metal floor grating. that was unsupported and unsecured on one

	edge. The grating, which weighed over 100 lbs, tilted, fell through the opening it was supposed to cover, and struck the miner 25 feet below. Access the MNM Serious Accident Alert here
MSHA	• **MNM Serious Accident Alert** On June 15, 2018, a miner fell from a man basket while exiting an electric shovel. The weldment used to secure the man basket to the shovel failed causing the miner to fall approximately 15 feet to the ground below. The miner was life-flighted to a local hospital. Access the MNM Serious Accident Alert here
MinEx NZ	**Safety device failures found during checks** • **A company has recently experienced several failures of safety devices, which included the following; Stop pull cord control boxes not resetting, Stop pull cords breaking, Alarms and beacons not working, Isolator boxes breaking.** Details
Repco in MinEx NZ	**Repco product recall** • **The main column of the Repco 6000 kg vehicle support stands may fracture rather than bend if a load is dropped on its outer edge. If the column fractures the load may fall causing serious injury or death** Details
MinEx NZ	**Unauthorised entry into quarries** • **Recently we have noticed an increase in near-miss events where members of the public have accessed a site during the workday either by deliberately by-passing the office, or driving onto adjacent private land to access a specific part of the site.** Details
National (other, non-fatal)	
WorkCover QLD in MInEX NZ	**Worker Crushed by slewing crane** • In May 2018, a dogger received serious crush injuries while working on a truck mounted crane. He was packing up the chains of the 60-tonne mobile crane when it slewed, trapping him between the counterweights and a toolbox mounted on the truck. Investigations are continuing. Details
Qld Mines Dept. In MinEX NZ	**Serious injuries with plant and persons falling over edges** • In June 2018 on a surface coal mine, a D11 Dozer travelled over the crest of a highwall while ripping after dark, falling approximately 16 metres onto a lower bench (see Fig.1 below). The dozer also rolled 360 degrees before coming to rest, and the dozer operator was seriously injured. Approximately twelve months prior to this, an identical incident occurred at another surface coal mine. This time during daylight, a D11 Dozer travelled

	over the crest of a highwall while ripping, coming to rest about 10 metres below (see Fig.2). In both cases only good fortune prevented a fatality. Details
WA mines Dept. in MinEX NZ	**Manned loader falling into an open stope** Loader operator fell into an underground void while building a bund. He did not sustain injuries. Details

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.

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.

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