Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 15 February 2019

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.

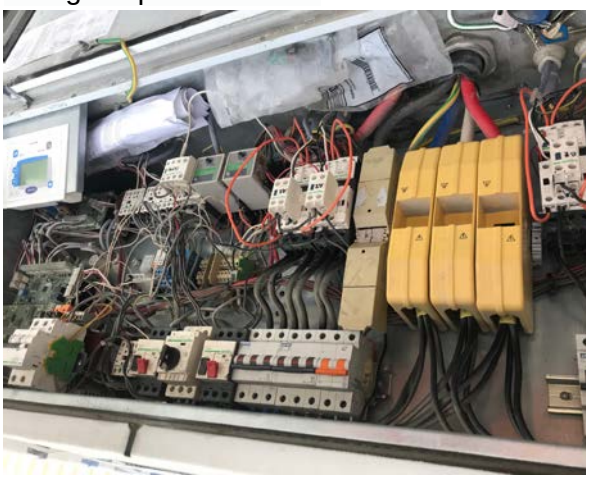
Type	Number
Reportable incident total	35
Summarised incident total	8

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident IncNot0033899	A collision occurred in an underground metalliferous mine. A haul truck was descending the decline when it collided with a rigid body truck travelling up the decline. The rigid truck was pushed two metres as a result of the collision. The driver of the rigid body truck briefly lost consciousness and suffered a head laceration. 	Mine operators must conduct an assessment and identify areas where there is a risk of collision. When developing risk control measures, the hierarchy of controls must be considered. Positive communication requirements must be implemented where a risk of collision remains. The mine was issued with a s195 prohibition notice and the incident is the subject of further investigation.

Dangerous incident IncNot0033897	A roof fall occurred on the longwall installation face at an underground coal mine. The face line had been widened and completed and work had started flitting out the continuous miner. Signs of weighting were first reported on the night shift and the fall occurred during the day shift. 	Underground mines should review the adequacy of their strata monitoring arrangements and associated trigger action response plans (TARPs) to ensure that workers are not exposed to unacceptable risks associated with strata failure.
Dangerous incident IncNot0033889	A light vehicle made heavy contact with the decline wall in an underground metalliferous mine. Maintenance activities had been completed on the vehicle's steering components earlier in the shift. The vehicle was descending in the main access to the mine when the incident occurred. The airbags deployed, and the vehicle was significantly damaged. No-one was injured. 	Maintenance processes must include appropriate checks and tests to verify work. When work is carried out on a safety critical system, appropriate work verification procedures must be in place. The mine was issued with a s191 improvement notice and the incident is the subject of further investigation.

Dangerous incident IncNot0033855	An excavator rolled in an open cut mine. The excavator was working on a 5-metre high stockpile of loose, wet material when the material under the left-hand track gave way. The operator safely exited the machine and reported soreness to his elbow. 	Before starting work, supervisors and equipment operators must inspect and assess the work area to determine hazards, such as material slip. Planning for the work must include identification of hazards, risk assessment and control. The operating environment should be examined to ensure: • the ground beneath the working area is stable and free from faults, fractures and soft areas • there is no moisture or water present in the earth or rock below the equipment • work is not carried out close to the edge or in a zone of influence of an excavation or any previously disturbed ground. All excavators should have a means of egressing the cabin if an incident occurs and the main cabin door cannot be opened. Review Investigation Information Release Fatality at Karuah Quarry
Serious injury IncNot0033848	An operator suffered micro-fractures to the skull after being hit by a drill steel in an underground coal mine. When removing a drill steel from one rig, it slipped from the operator's hands. The drill steel fell into the other drill rig, which had started to auto retract. The drill steel caught under the drill motor and started to bend. It then sprang out, hitting the worker in the side of the head. The worker was taken to hospital, assessed and released. Subsequent x-rays identified the fractures.	Mine workers need to be made aware of the hazards and controls of working around equipment and automated equipment. MDG35.1 Bolting and drilling plant in mines contains information to assist mines in managing the risks of operating drill rigs.
Dangerous incident IncNot0033839	A blast was fired while a worker was within the 500-metre blasting exclusion zone. No injuries or damage were reported.	All workers must be aware of other activities occurring in their work area, particularly when changing work areas.

		Blast controllers must conduct a thorough and extensive sweep of blast exclusion zones before giving approval for a blast to occur. Supervisors must inform all workers of any blasting activities occurring in their work area that may pose a risk to their health and safety. The mine was issued with a s191 improvement notice and the incident is the subject of further investigation.
Dangerous incident IncNot0033837	An electrician suffered an electric shock when he made contact with an 'insulated' wire in the control panel of a chiller unit in a metalliferous mine. The electrician was resetting a circuit breaker when his finger slipped off the operating toggle and brushed against the sheath of the energised cable. A voltage of 240V was measured on the cable insulation. The cables were found to have a conductive outer layer (semicon layer) that was in contact with the live terminals of a downstream contactor. As a result, the outer sheath of the cable was energised at voltages up to 240V AC. 	Where workers are required to access electrical equipment for isolation or resetting protection devices, the equipment must be designed so that the workers cannot inadvertently make contact with energised cables or components or be exposed to a risk of arcing faults that may occur. Cable insulation must be suitable for the intended function. Where cables are fitted with semiconductive sheaths, the cables must be installed and terminated in accordance with manufacturer's recommendations.

Dangerous incident IncNot0033833	While installing a conveyor drive module, the supporting structure failed in a quarry processing plant. As the weight was removed from the crane, the support structure buckled. The site investigation revealed discrepancies between suppliers and contractors in the design and supply of steel work. The mine was issued with a s195 prohibition notice requiring independent structural engineering assessment. 	When multiple parties are involved in the procurement of plant and structures, appropriate controls and checks must be in place to ensure all relevant information is communicated between parties, and all parties involved should understand their scope.

Other publications of note

The incidents are included for your review. The NSW 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.

Publication	Issue / Topic
	International (other, non-fatal)
Worksafe NZ and HSE	**Respiratory Protection Equipment (RPE)** **Worker advice -** Details **RPE selection tool -** Details
	National (other, non-fatal)
DMIRS	**Using excavators as rock breakers** In June 2018, a potentially serious incident involving a 45-tonne excavator fitted with a hydraulic hammer occurred at a mine site. The machine was

WA	being used to break rocks on a stockpile pad when one of the boom supports failed suddenly and catastrophically, causing the boom to slide off its support pin and break through the side window of the operator's cab. Metal mesh installed on the side window of the cab to protect the glass from rock damage prevented the foot of the boom from crashing further into the cab space. The operator escaped with minor cuts from the broken glass. 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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