Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 8 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	25
Summarised incident total	5

Summarised incidents

Incident type	Summary	Recommendations to industry
Serious incident IncNot0033801	A worker who was carrying out maintenance activities at the maingate of longwall 425, has suffered a broken leg. The worker was using the shearer haulage to pull a flight bar when the rud link on the shearer failed, hitting the worker on the lower part of the leg.	When conducting any lifting or pulling work, operators must be able to identify correctly rated lifting components before carrying out the work. The total forces applied must be understood and all equipment must be rated accordingly. The mine has been issued a s195 notice prohibiting this activity, and the incident is the subject of further investigation.
Dangerous incident IncNot0033796	At a limestone quarry the shell of a rotating lime kiln was compromised and hot material spilled into the girth gear grease. The grease caught fire and was extinguished. There were no injuries reported.	When assessing the risks associated with fires, mine operators must consider both component and structural failure. Remotely operated automatic fire suppression systems must be considered in all high fire risk environments.

Dangerous incident IncNot0033795	A metalliferous mine reported the unravelling failure of roof in the main decline with about 80 tonnes of fallen material from the left side wall. The failure occurred as an operator in a loader was driving towards the area. The operator reported the incident to the supervisor. No-one was injured.	Where areas of strata deterioration are evident, systems must be put in place to notify all workers, and undertake remediation works as soon as possible. This includes demarcation and temporary support.
Medical treatment injury IncNot0033786	A service crew was working in a decline. They were de-isolating services that they had finished working on when an operator in a basket reported an injured hand. The operator had hold of the basket frame when the basket contacted the rock wall surface. The basket had an internal hand rail. The operator suffered injuries to her right hand. X-rays showed fractures to the fingers.	The transportation of workers in baskets should be considered high risk. This activity should be risk assessed as part of any job and minimised when practical to do so.
Dangerous Incident IncNot0033785	An experienced operator was undertaking work moving a dragline cable using a Merlo 2448. During this work the Merlo overturned. The operator was able to escape from the vehicle. The apparent cause of the rollover was an unexpected cable movement.	Where multiple machines are engaged in a task, all operators must maintain situational awareness and communicate their intentions clearly to other equipment operators involved in the job Machines should not be used for purposes other than what they were designed for without appropriate assessment of the risk. Machine operators need to be reminded that the stability of machines changes as the load height changes.

Other publications of note

These 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
	National
Coal Services	**Prevention of pneumoconiosis in NSW:** Information for workers. This information pack includes an overview of Coal Services's activities in this space in NSW, health monitoring, dust monitoring and mitigation, a longwall dust suppression plan and information on the Standing Dust Committee.
	International (fatal)
MSHA	**Mine fatality –** On 5 January 2019, a 55-year-old contract miner suffered fatal injuries when he was pinned between a pneumatically powered air lock equipment door and the concrete rib barrier near the shaft bottom. **Details**
MSHA	**Metal/non-metal mine fatality** - On 11 October 2018, a 26-year-old miner was fatally injured as a result of falling from the top of a previously cut block of granite. The worker was in the process of separating the cut block of granite from the highwall when the cut block suddenly slid out. The movement caused the miner, who was not wearing fall protection, to lose his balance and fall between the rock and the highwall causing fatal injuries. **Details**
MSHA	**Metal/non-metal mine fatality** – On 2 October 2018, a 40-year old miner was fatally injured when struck by stemming sand ejected from a borehole. While conducting a blasting operation in a new vertical raise, a contract foreman was attempting to clean out a previously blasted vertical borehole with high-pressure air. A sudden release of energy forced stemming sand from the bottom of the borehole, striking the miner. **Details**
MSHA	**Metal/non-metal mine fatality** – On 19 October 2018, a 63-year old quarry manager was fatally injured when he lost control of the haul truck he was driving. The worker was operating a haul truck down a steep grade and travelled through a berm and over a short drop-off. The worker was not wearing a seat belt.

	Details
MSHA	**Mine fatality –** On 14 January 2019, a 56-year-old survey crew member was fatally injured after he was struck by a loaded shuttle car. The victim was measuring the mining height in an entry that was part of the travel-way used by the shuttle car to access the section feeder. Details
MinEx NZ	**Operator hit by moving rail mounted machinery** On 5 June 2014, a precast concrete plant worker received fatal head injuries when he was caught between two rail mounted machines used in the production of concrete goods. The worker was operating an automatic sawing machine on a prestressing line when it was passed by a machine laying out the wires on the adjacent track. He was standing on a working platform, on the stationary sawing machine, while the other machine passed. The gap between the two passing machines was approximately 65 millimeters. The worker appears to have lent forward into the path of the oncoming machine, resulting in fatal crush/shear head injuries. Details
MinEx NZ	**Crushing by crane boom element** When disassembling the crane with a short boom mount (boom head and foot only), the crane operator was crushed by a boom element. Details

International (other, non-fatal)

MinEx NZ	**Dropped spool** A crew was tasked with lifting a 16" spool (approx. 15' in length, weighing approx. 4000 pounds) from ground level to an access platform located 90' high, using an overhead crane. Rigging set up consisted of two 2"x16' nylon slings, two 1-1/8" shackles, two taglines and softeners. Once the spool had reached 90', the crane operator moved the spool over placement point and began lowering it into position. While lowering the spool, one of the slings failed at the choked eye. The spool swung vertically, causing the second sling to fail, resulting in the full length of pipe dropping uncontrolled onto the decking below (approximately 20'). This caused damage to equipment and structure. No individuals were injured. Details
Energy safety Canada in MinEx NZ	**Welder injured when pipe jack collapsed** A welder was injured when the set screw on a heavy-duty tripod pipe jack failed, causing the pipe jack to collapse. The 10 inch pipe spool being worked on rolled off the V-head, forcing all the remaining pipe jacks to shift. The pipe rolled onto the

	welder, pushing him to the ground and crushing his upper body. The welder sustained a broken right shoulder, left arm and broken ribs. **Details**
NZ Safety alert	**Worker falls from truck body** A visiting truck driver was climbing a ladder on the trailer of his truck to put the tarp roller handle into position. The handle did not position correctly and the driver slipped, falling from the bin onto the ground. Injuries sustained included loss of consciousness and bruising to the ribs. The driver's fall was observed by another worker and first response measures were taken. The driver was taken to the medical centre for treatment. **Details**
	National (fatal)
DNRME	**Fatality at Goonyella Riverside Mine, Queensland, on 5 August 2017** On 5 August 2017, an employee of Independent Mining Services was fatally injured while performing maintenance on the outside of an excavator bucket at the Goonyella Riverside Mine. **Details**
DNRME	**Fatality at the Grasstree coal mine, Middlemount, Queensland, on 6 May 2014** On 6 May 2014, a coal mine worker was fatally injured while calibrating gas detectors underground at the Grasstree coal mine. **Details**
DNRME	**Fatality at the Newlands Mine Coal Handling and Preparation Plant on 30 August 2016** On 30 August 2016, a contract worker was fatally injured by a falling deck plate that he and three other workers were in the process of removing. **Details**
	National (other, non-fatal)
DNRME	**Winder brake failure at Osborne Mine, Queensland, on 1 March 2015** On 10 February 2015, there was a high potential incident at the Osborne Mine, resulting in the rope on the fixed winder drum detaching from the skip/cage. **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.

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