Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 12 September 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

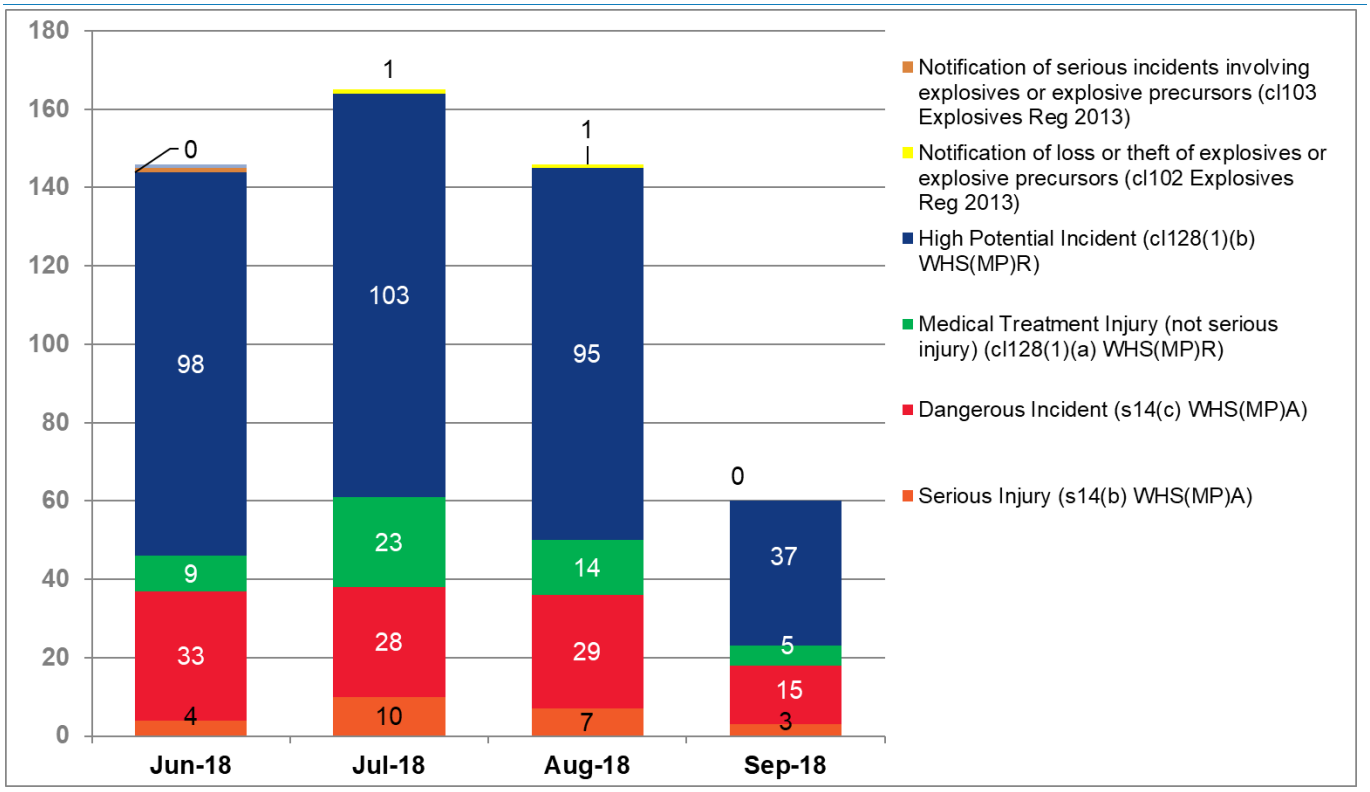
High level summary of emerging trends and our recommendations to operators.

Type	Number
Reportable incident total	31
Summarised incident total	4

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot-2018/01478	Two workers were trapped when a winder malfunctioned. The mine initiated an emergency recovery in accordance with their emergency management plan. The workers were rescued eight hours later.	A causal investigation is underway. Rescue of workers from a winder must be included as part of the emergency response plan for mines with winders.
High potential incident SinNot-2018/01474	A gas exceedance occurred in a development panel when gas levels reached 2.5%.	When mining in geologically disturbed areas, further controls and a heightened awareness of increasing gas make needs to be considered. Sources of increase gas make include floor breaking, proximity of gas drainage holes and geological structure intersection. Controls considered should include borehole management, increasing ventilation and the use of venturis.

Serious incident SinNot-2018/01446	A worker suffered a broken ankle after falling. The worker was standing on the edge of a conveyor belt after adjusting an item hanging from the conveyor, before slipping to the centre of the conveyor belt.	For planned and routine tasks requiring workers to access points beyond their reach, suitable access methods should be arranged. The risk of slipping on wet conveyor belting is easily foreseeable.
Dangerous incident SinNot-2018/01433	While driving up a decline at an underground metalliferous mine, a light vehicle began revving heavily. The operator released the accelerator and attempted to shut the vehicle down but it continued to rev hard. Flames were seen coming from the front driver's side wheel arch. The driver activated the vehicle's fire suppression system and rolled the vehicle off the decline. Once stopped, the operator lifted the bonnet and used a hand-held fire extinguisher to put out a flame in the engine bay. An inspection identified a failed turbo and catastrophic engine failure. 	Light vehicles must be included when assessing the risk of fires on mobile plant. Component failure where oil can become an uncontrolled fuel source for the engine (such as a turbo failure), should be considered when developing maintenance schedules.


180
160
140
120
100
80
60
40
20
0
Jun-18
Jul-18
Aug-18
Sep-18
0
98
9
33
4
1
103
23
28
10
1
95
14
29
7
0
37
5
15
3
Notification of serious incidents involving explosives or explosive precursors (cl103 Explosives Reg 2013)
Notification of loss or theft of explosives or explosive precursors (cl102 Explosives Reg 2013)
High Potential Incident (cl128(1)(b) WHS(MP)R)
Medical Treatment Injury (not serious injury) (cl128(1)(a) WHS(MP)R)
Dangerous Incident (s14(c) WHS(MP)A)
Serious Injury (s14(b) WHS(MP)A)

Other publications of note

Publication	Issue / Topic
International (other, non-fatal)	
MinEx NZ	• **Worker injures hand when material falls on it** • In order to conduct maintenance, a worker needed to remove guards from the tail drum of a conveyor. There was a lot of spillage built up inside the guard. As the worker removed the second guard all the weight of the spillage material rested on the last bolt to be removed. The worker put his arm underneath the guard to unscrew the bolt using a rattle gun when the bolt came out and the guard dropped on top of his right hand. His hand became swollen and first aid treatment was administered immediately. • **Details**
MSHA in MinEx NZ	• **Miner injured on belt conveyor** • On July 9, 2018, a miner was injured when the belt conveyor he was standing on unexpectedly moved. The miner was standing on the conveyor to repair the crushing plant engine. After being repaired the engine was started, activating belt conveyor movement. The miner was knocked down and conveyed feet-first up to the head pulley. He was then discharged into a feed hopper, six feet below. The miner was able to get to his feet and cling to the inside of the hopper wall's edge. Other miners heard screams for help, shut down the engine and rescued the injured miner from the hopper. • **Details**
MinEx NZ	• **Another ADT body rolls onto its side** • While reversing to tip his load on a stockpile, the driver of an ADT was partially blinded by sunlight and reversed up onto the edge of the stockpile. This made the loaded body unstable and it tipped onto its side. • **Details** •
National (fatal)	
Qld DNRME in MinEx NZ	• **Fatality involving an articulated dump truck** • On Sunday 29 July the operator of an articulated dump truck was working at a quarry with his last load of the day. Moving fully loaded down the access ramp, it appears he lost control of the vehicle. At the bottom of the ramp the vehicle overturned, partially pinning the operator under the cab. He later succumbed to his injuries. • **Details**
WorkCover Qld in MinEx NZ	• **Operator thrown and killed in bulldozer rollover** • In August 2018, a bulldozer operator from Julatten was killed while clearing foliage. It appears the dozer drove onto a log, causing the tracks to lose friction, and it rolled onto a steep slope, throwing him from the cage. Investigations are continuing. •

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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CM9 reference	DOC18/682079
Mine safety reference	ISR 18-35
Date published	21 September 2018