Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 14 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.

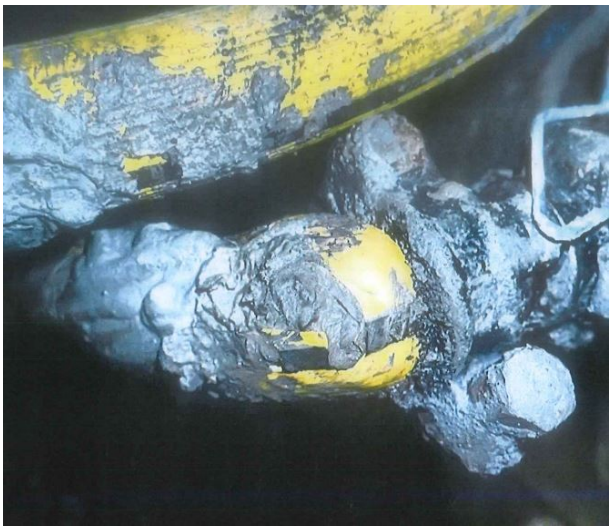
At a glance

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

Type	Number
Reportable incident total	39
Summarised incident total	5

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot-2018/01898	A dump truck and a dozer collided at a dump tip head in an open cut coal mine. The dozer was on the off driver's side of the truck. The dozer's rollover protection canopy and access ladder were damaged and a tyre was deflated. 	A S195 notice was issued to the mine arising from this incident. Tip heads must be designed and maintained to enable safe dumping and interaction between plant. Workers must be trained in dump procedures that must include positive communication requirements. The monitoring and verification of compliance with dump procedures must be routinely conducted by statutory officials. Please review the safety bulletin on positive communications SB18-06

Dangerous incident SinNot-2018/01894	A falling monorail beam hit a worker on the shoulder. On a maintenance day, a conveyor drive gearbox was being changed out. The gearbox was being moved along a monorail. When the trolley crossed a join between segments, the monorail uncoupled. The beam fell about one metre and hit a worker on the shoulder, grazing his back.	Before using any device for lifting or carrying a load, it must be inspected to confirm it is fit-for-purpose and usable. This applies not only to the lifting device but any other component that carries the weight such as monorail trolleys, beams, beam clamps, eye bolts and rud plates.
Dangerous incident SinNot-2018/01876	A worker was sprayed with grout at an underground coal mine. The workers were in the process of grouting cable bolts when a worker removed his glasses. A pressure hose burst and sprayed the worker with grout. A similar failure was reported at another mine where a worker was not placed at risk. 	Hoses, fittings and attachments used for grouting must be rated to the pump stall pressure. All equipment must be inspected as fit-for-purpose and ready for use before commencing work.
Medical treatment injury SinNot-2018/01874	A worker suffered heat stress while working on a drill rig in an open cut metalliferous mine. The worker was on his second day of the roster working a 12-hour shift. The worker started to suffer muscle cramps so went to the airconditioned cab of the drill rig, where cool water, ice packs and electrolytes were supplied. As the cramps continued to worsen he was then taken to hospital. The worker	The mine's health control plan should include relevant controls for managing exposure to heat and weather conditions. Controls should include task rotation, scheduling of tasks, personal protection equipment and training.

	was admitted for continued treatment with intravenous fluids.	The Resources Regulator is currently undertaking a planned inspection program on heat stress management in the underground metalliferous sector.
Dangerous incident SinNot-2018/01872	An operator suffered an electric shock at an underground coal mine. The worker was hanging a feeder breaker supply cable (1000 volt) to the roof. When touching the cable, he felt a tingling sensation that he suspected was an electric shock. He notified his supervisor and the power was turned off. The operator was brought to the surface, had an ECG and was cleared of injury by an ambulance officer.	Risk assessments and cable management procedures must consider the risks arising from handling and working alongside energised trailing cables.

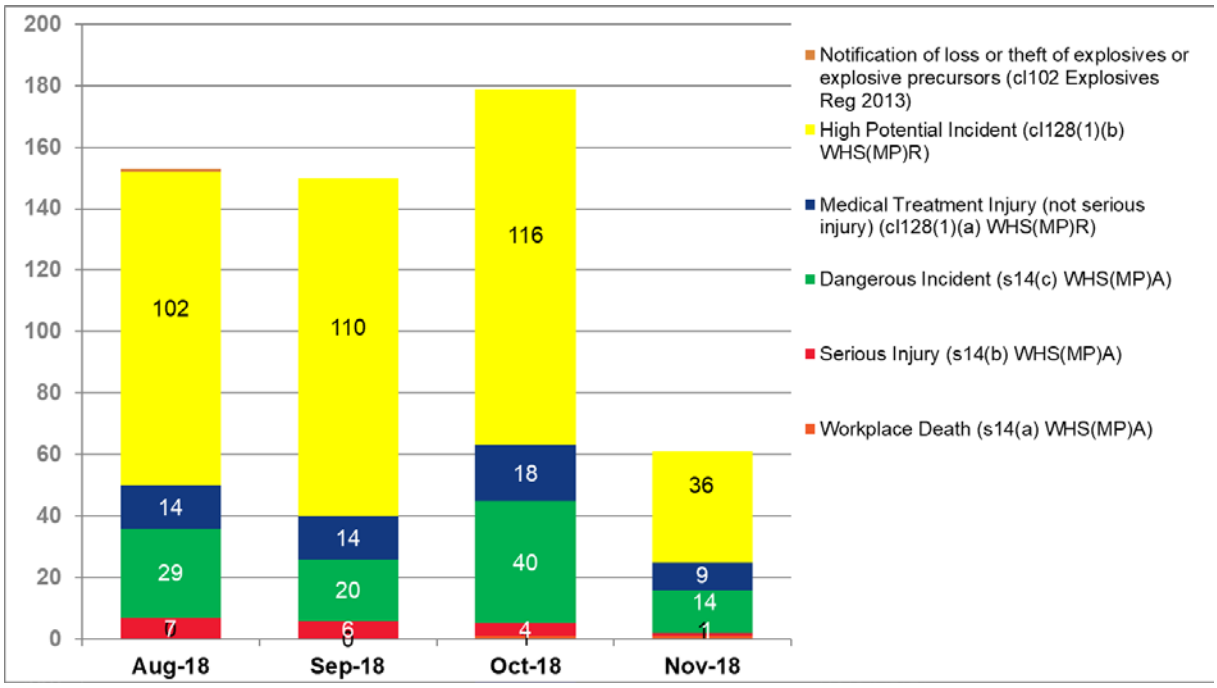
Resources Regulator recent publications

- → IIR18-12 Non-work-related death at open cut coal mine
- → IIR18-12 Worker fatally injured when tyre falls
- → IIR18-10 Grader operator suffers serious head injuries

Other publications of note

Publication	Issue / Topic
	International (fatal)
MinEx NZ	• **Fall arrest fatality** There was a recent fatality in Seattle, WA. When a foreman lost his footing while working from a light-rail concrete girder, falling approximately 33 feet to the ground. The worker was wearing a DBI SALA Nano-Lok fall protection system with a web lanyard. The web lanyard was severed by the edge of the concrete pier cap. **Details**
	National (other, non-fatal)
Qld Mines Department in MinEx	• **Manual fire suppression activation units** An incident occurred at an open cut coal mine where a CMW was unable to activate and remove a fire suppression safety pin during a fire event on a rear dump truck. This was due to an anti-tamper tag being fitted around the activation pin. At another mine, maintenance

	personnel discovered during an inspection the security / safety pin legs crossed over and not allowing the pin to be removed in an event of being activated. **Details**
Komatsu	• **GSN0170 Underground – Uncommanded movement of continuous miner in Australia** A Joy continuous miner in Australia was reported to have experienced unexpected movement where the miner continued to tram an estimated 1 to 1.5 meters in reverse after the dead man button on the remote transmitter was released. Following the incident, the affected miner's fault log was reviewed for faults related to unplanned movements and a complete data download was taken from the miner for review. No obvious issues related to an unplanned movement were identified.



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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