Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 31 October 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	37
Summarised incident total	9

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot-2018/01801	A driller suffered an electric shock. Following electrical trips, area lights were removed from a drill rig on night shift. The day shift driller found a replacement light bar and installed it. The driller went to adjust the lights and suffered an electric shock. An ECG cleared him of any injury. An investigation identified that the light bar had been plugged into the incorrect supply. A 24V DC and 32V AC supply were a common socket and installed next to each other.	Where different voltages are used on equipment/plant they should have unique sockets and plugs to prevent inadvertent use. Mines must have systems in place where plant and equipment is inspected to ensure it is fit for purpose when entering the site. Repairs must only be undertaken by competent tradespeople.

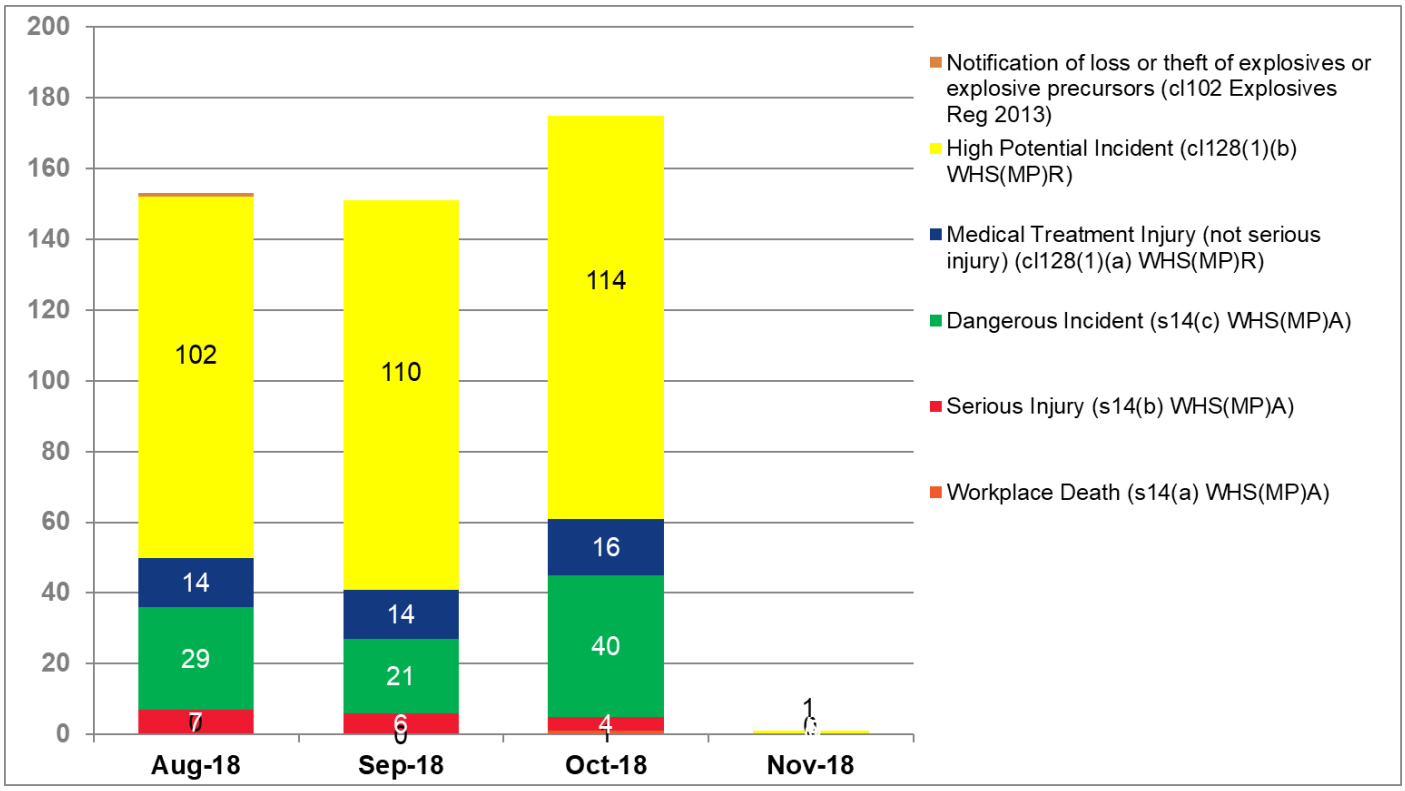
Dangerous incident SinNot-2018/01798	A worker narrowly avoided injury when he was brushed by falling coal. Some rib spall fell against the rib protection, it then broke and a piece fell over the rib guard. 	Rib protection fitted to continuous miners must be designed and operated to match the rib conditions at the mine and forms part of the entire temporary support requirements while installing support.
Serious incident SinNot-2018/01797	A mine worker suffered serious leg injuries at an underground coal mine. The worker was on the AFC installing recovery mesh, when a large piece of stone fell from the top of an adjacent roof support. The operator sustained a gash to his leg and a suspected fracture.	Throughout a longwall move, all different stages of a task must be correctly assessed for potential hazards and appropriate controls put in place. Strata hazards must be assessed in each work area, particularly when roof supports are staggered or operating in poor conditions.

Dangerous incident SinNot-2018/01793	A live 11kV electrical cable was cut by unknown people at a remote borehole site. This resulted in the safety circuits tripping power to the cable. On investigation, clear signs of arcing/flash could be seen. Other electrical cables were stolen from the site. The incident was reported to police. 	Site security of remote areas should be reviewed. Warning signs and stickers should be fitted to equipment that may be live.
Dangerous incident SinNot-2018/01790	A dump truck was reversing into a dump face when position 5 and 6 tyres went through a windrow. The short wall was about 10 m high. The operator was not injured. The truck was pulled back onto solid ground about 10 m from the edge. 	Dump procedures must specify: → minimum requirements for windrows → how operators are required to approach windrows (e.g. square to windrow) → stopping distances from edges and windrows → windrow height, considering height increases due to incompetent material being dumped or water pooling under dumps.

Dangerous incident SinNot-2018/01789	A mechanical tradesman suffered burns while working on an underground loader (LHD). The LHD had overheated and the tradesman was assessing if a sensor was faulty. When he removed the sensor, he was sprayed with hot coolant. The worker was treated at hospital.	When fault finding, workers need to assess all potential energy sources before starting work. Hot coolant in an engine that was recently operating is reasonably foreseeable and a well understood risk.
Serious injury SinNot-2018/01788	A worker suffered lacerations to the face and head while operating a grader in an open cut mine. A drill rig access track was being repaired when a pressurised 355 mm poly pipe was pierced by the blade. The blast of water picked up loose material and rocks and smashed the side window. The mechanism of injury is still being investigated.  	An investigation has begun and further information will be made available shortly.
Dangerous incident SinNot-2018/01777	A raise-bore cutter head separated from the drill string and fell about 400 m down a shaft. Cuttings from the raise-bore are removed by a tele-remote bogger. The bogger was away from the shaft at the time of the incident.	Components used in raise bore operations must be managed throughout their lifecycle. Inputs such as advance rates, properties of cuttings, condition of removed shaft segments and power demand should be reviewed to assess

		if initial assumptions to develop maintenance plan were correct.
Dangerous incident SinNot-2018/01773	A highwall (about 22 m) partially collapsed in an open cut coal mine. An excavator and a dozer were working in the area. The operators noticed the highwall start to dribble and moved the machines away before the collapse. 	Highwalls must be cleaned back to solid ground to remove material from the wall during excavation. Highwalls must be inspected regularly, particularly following wet weather events.

Publication	Issue / Topic
	International (fatal)
MSHA	• **METAL/NONMETAL MINE FATALITY** – On October 11, 2018, a 26-year old miner with 48 weeks of experience at the mine was fatally injured as a result of falling from on top of a previously cut block of granite. The miner 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/NONMETAL MINE FATALITY** – On October 2, 2018, a 40-year old miner with 20 years of experience 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



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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