

Week ending 21 March 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	32
Summarised incident total	16

Summarised incidents

Incident type	Summary	Recommendations to industry
Serious injury SinNot-2018/00428	A worker cleaning a washery sump was hit in the face with mud/slurry from a hose under pressure. The worker suffered a fractured eye socket.	Mine operators and contract companies should review the use of non-genuine hoses, nozzles and fittings. Mine operators and contract companies should also review the training their workers have received in relation to the potential hazards associated with blockages in pressurised systems.
Dangerous incident SinNot-2018/00426	A worker was cleaning the under body of an excavator with a 3000 psi high pressure water gun. While repositioning himself, the gun trigger was inadvertently activated, spraying the worker just above the right knee. The worker climbed down and walked to the back of the machine where he went into shock and fainted. There was no fluid injection involved.	Mine operators and contract companies should review their procedures for the use of high pressure cleaning systems. This should include the potential hazards associated with not isolating an energy source before moving and always keeping nozzle directed away from persons. Refer to SA14-03 Fluid injection from high pressure water cleaning and SA18-03 Two workers suffer

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<p>Dangerous incident SinNot-2018/00423</p>	<p>A troop carrier rolled away from a lighting plant park-up area. The vehicle travelled about 200 metres before hitting a centre dividing bund at an intersection and then rolled over. No one was in the vehicle. The operator reported that the vehicle was parked fundamentally stable, the park brake applied and the vehicle was shut down.</p>	<p><u>serious high pressure fluid injection injuries in separate incidents.</u></p> <p>Mine operators should review their training packages associated with “parking fundamentally stable” and the minimum time required to establish this control.</p> <p>The review should also consider the benefit of a light vehicle being parked in gear compared to neutral.</p>
<p>Serious injury SinNot-2018/00422</p>	<p>A worker was standing on the walkway of a mobile jaw crusher spotting for an excavator driver who was loading material into a hopper. The worker saw a possible blockage occurring and moved to look into the crusher. He placed his left hand on the rail, and his right hand on the edge plate of the grizzly. While looking in, a rock rolled off the placed material on the grizzly and struck his right hand. The worker felt a pinch and saw his finger was crushed. He signalled the excavator driver, who stopped the machine. The worker was taken to hospital, where it was decided to amputate the fourth finger on the right hand.</p>	<p>Mine operators and contract companies should review to determine if their procedures and training packages include the potential hazards associated with the placement of body parts on solid objects around moving parts and material.</p>
<p>Dangerous incident SinNot-2018/00417</p>	<p>While a face loader was loading haul trucks, some rocks rolled out of the back of the bucket resulting in one rock hitting the face loader windscreen on the bottom left hand corner (from the operator’s driving position). The rock caused significant damage to the windscreen.</p>	<p>Mine operators should ensure front end loader operators are trained in correct bucket loading practice and techniques.</p>

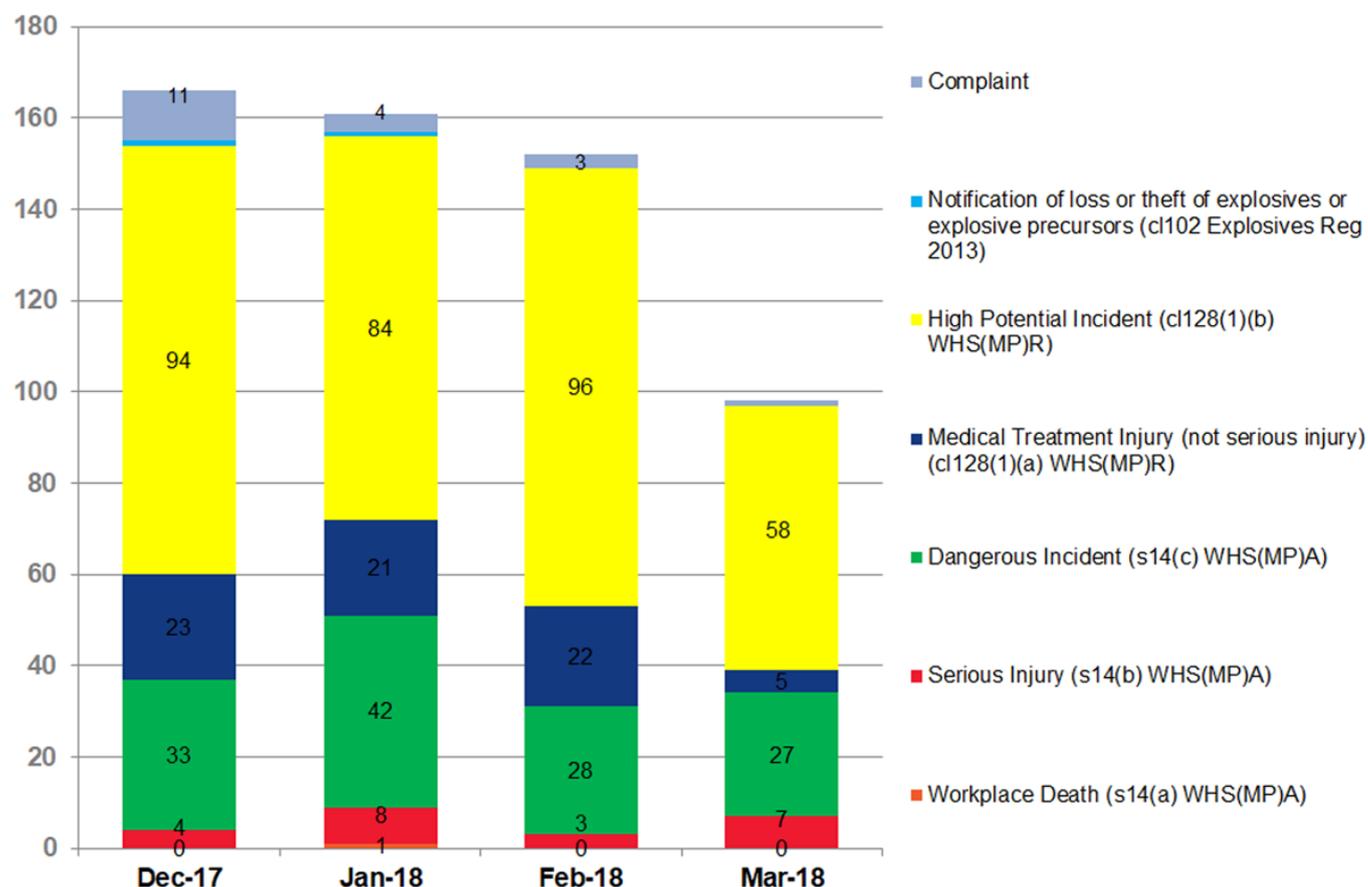
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<p>Dangerous incident SinNot-2018/00410</p>	<p>Haul trucks were parking in a designated park-up area. The trucks had to be reverse parked into each bay before the operators could disembark. Four trucks were parked successfully by driving to the end of the road and performing a U-turn in a clockwise direction before driving back across the entrance of the park-up bays, following the site process. A fifth truck driver did not perform the same U-turn but instead pulled up and reversed the truck in the opposite direction to site process. The driver misjudged the entrance to the target available bay and reversed into the front of a stationary truck occupying a parking spot. The driver on the stationary truck retreated up the access ladder to the cabin to warn the other driver that the truck was going to miss the parking spot but was unable to prevent the collision.</p>	<p>Mine operators should review how their supervisors monitor for compliance with all site procedures. Mine operators should review how often their workers are trained in all site procedures.</p>
<p>Dangerous incident SinNot-2018/00409</p>	<p>During the process of preparing to grout a nitrogen hole drill casing, a casing fell to the floor. The casing hit a bolter handle, breaking it off. An operator was holding the handle at the time and suffered a shoulder injury.</p>	<p>Mine operators should consider hazards from falls due to gravity because of failure of screwed connections or shearing by strata forces of the drill casings. Mine operators should support the casing at the base to prevent lower sections from falling where workers may be in close proximity to the bottom of the casing.</p>
<p>Dangerous incident SinNot-2018/00408</p>	<p>During the process of trimming and supporting after a shot, the roof came in releasing gas. Workers smelled carbon dioxide (CO₂) and the gas monitor on the miner alarmed (1.25% methane). This tripped the miner off. All personnel were in the safe zone at the time. As per the site trigger action</p>	<p>Mine operators should review how the potential hazards associated with shotfiring as a means of remote mining are assessed and controlled. This should include the potential disturbance of additional ground / strata and the effectiveness of removing in situ gas.</p>

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<p>Dangerous incident SinNot-2018/00407</p>	<p>response plan the crew was immediately withdrawn.</p> <p>While operating a bolting rig on a continuous miner, an operator was sprayed with hydraulic oil. The oil came from the drill chuck area. Oil sprayed onto the operator's face and mouth. He was wearing safety glasses at the time. The mine initiated the site oil injection protocol. The worker attended hospital for assessment.</p> <p>The oil release was attributed to a failed bolt providing the clamping force on a directional control valve O-ring seal. On this occasion, covers/guarding diffused the oil spray.</p>	<p>Mine operators should ensure pre-start and maintenance checklists include that covers and guards are installed where they offer protection from failed hydraulic fittings, valves or hoses. Defective or missing covers and guards should be repaired, replaced or effectively managed when reported.</p>
<p>Dangerous incident SinNot-2018/00406</p>	<p>Workers noticed a loss of air pressure from a mobile air compressor and smelled smoke. When they lifted the covers of the compressor, a small flame was found above the starter motor. This was extinguished with a hand-held fire extinguisher, as there was not enough heat to activate the onboard fire suppression. The battery terminal was also found to have been subjected to heat. The battery was removed to prevent further risk.</p>	<p>Mine operators should review how maintenance is scheduled and completed. This should also include defect management.</p>
<p>Serious injury SinNot-2018/00404</p>	<p>During a pre-operational inspection of a haul truck, an operator rolled an ankle while walking over the truck park-up hump. The worker attended hospital for assessment and treatment.</p>	<p>Mine operators should review how park-up areas are accessed and exited.</p> <p>They should also review how supervisors monitor that these walkways are used.</p>
<p>Dangerous incident SinNot-2018/00402</p>	<p>A section of the dam wall for a large tailings storage facility at a metalliferous mine failed, resulting in</p>	<p>There are many publicised cases of tailings dam failures across the world resulting in the escape of tailings materials off site and / or</p>

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	<p>tailings material slumping through the failed section.</p> <p>The slumped material was confined within a second containment facility however some pumping and power infrastructure was damaged as a result of the failure.</p> <p>No workers were exposed to risk at the time of the failure.</p> <p>The mine enacted its emergency response plan. Consequently two residences owned by the mine were evacuated, and a local road was closed, as a precautionary measure.</p> <p>The Resources Regulator, in cooperation with other agencies, is working with the mine operator to ensure stabilisation and recovery works associated with the failure are being undertaken in a safe manner.</p>	<p>significant landform instability issues. Safety consequences range from the displacement of downstream communities through to significant injuries and the death of both mine workers and the public.</p> <p>A cross-agency awareness campaign, facilitated by the Resources Regulator will be conducted across both the coal and metalliferous mining sectors to ensure that titleholders and mine operators are aware of their legislative obligations in relation to tailings management. The campaign will set out the regulator's expectations as well as identify key knowledge gaps that will need to be addressed by industry to promote best practice tailings management.</p>
<p>Dangerous incident SinNot-2018/00401</p>	<p>The operator of a load haul dump vehicle alighted from the machine and noticed it was still moving. The operator re-entered the driver's cabin and initiated the park brake, stopping the machine.</p> <p>The driver had alighted with engine running and without initiating the park brake. It was reported that the operator mistakenly 'assumed the cabin door park brake interlock would operate the park brake'.</p>	<p>Mine operators should communicate with vehicle operators about the importance of following park-up procedures in accordance with manufacturer's recommendations and/or site training. Application of the park brake before exiting the cabin is generally required and door to park brake interlocks should not be relied on for parking.</p>
<p>Dangerous incident SinNot-2018/00400</p>	<p>Two workers were calibrating a weather station and were lowering the mast. The mast has a pivot point (5m off the ground) to allow access to the equipment. One of the supporting wires broke, causing the mast to fall uncontrolled to the ground opposite to where the workers were standing. The weight of the station was 40 to 50 kg.</p>	<p>Mine operators, contract companies and project managers should review the life cycle management of all plant, including potential deterioration due to exposure to weather.</p>

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<p>Dangerous incident SinNot-2018/00399</p>	<p>No- one was injured. The weather station was broken beyond repair.</p> <p>One drill rig was stationary and drilling. A second drill rig was travelling forward to pass the stationary drill rig. Its offside front engine cowling was open. As it passed the stationary drill, it clipped the back-left side of the stationary drill and the cowling was ripped off. No one was injured.</p>	<p>Mine operators and contract companies should review their procedures for the movement of mobile plant. This should include the minimum distance between other mobile plant and structures.</p> <p>They should also review how supervisors monitor for compliance with all site procedures.</p>
<p>Dangerous incident SinNot-2018/00397</p>	<p>Two workers were tasked with towing a lighting plant with a light vehicle. While in the process of hooking up the lighting plant to the light vehicle, the lighting plant's boom was not lowered. The lighting plant rolled over after being towed about 6 m over uneven ground. Both workers were in the light vehicle at the time.</p>	<p>Mine operators and contract companies should review how fitness for work is assessed on site and communicated to the workforce.</p>

Number of incident notifications, by commencement month and incident type



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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