

WEEKLY INCIDENT SUMMARY

Week ending 2 May 2019

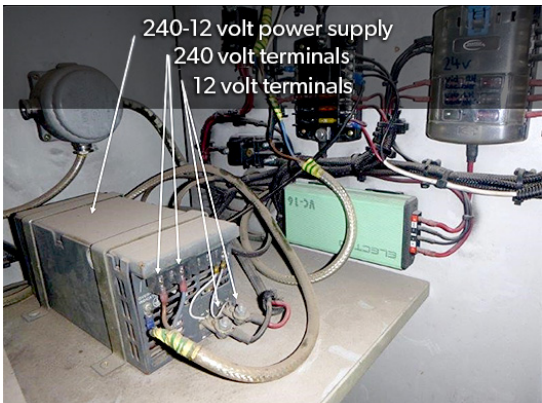
This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the NSW Resources Regulator, phone 1300 814 609, 24 hours a day, 7 days a week.

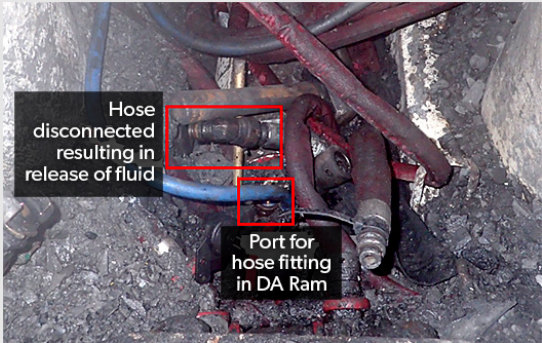
At a glance

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

TYPE	NUMBER
Reportable incident total	21
Summarised incident total	5

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0034469	<p>A fitter suffered an electric shock in an underground metalliferous mine while trying to identify a fault in a tele remote loader hut. The fitter's hand contacted the 240-volt terminals on a power pack.</p> 	<p>Mine operators must ensure only suitably qualified personnel work on electrical apparatus. Isolation and testing for dead are critical to ensure electrical safety. Terminals are to be appropriately labelled and suitably shielded for their environment.</p>

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
<p>Dangerous incident IncNot0034473</p>	<p>A release of under pressure fluid occurred on a longwall face. A fitter was replacing a hydraulic hose on a roof support which had been damaged by stone. The fitter had isolated and dissipated system pressure. When the staple was removed from the hose, it whipped, striking the fitter in the hand. The fluid stream sprayed the fitter, dislodging his hard hat and safety glasses. The fitter was taken to hospital as a precaution and was cleared of injury.</p> 	<p>Where stored pressure can remain in a circuit (such as check valves and load lock valves), appropriate methods must be available to safely dissipate pressure.</p> <p>Mine risk assessment on hydraulic systems must identify and provide effective controls for areas of trapped pressure.</p>

High potential incident
IncNot0034489

A mine reported the gates on a winder at a coal mine opened without the cage being docked. The shift supervisor was investigating a control system fault on the winder when a worker heard the seam level western material gate operate. The worker investigated and found the gates had operated and opened, leaving a fall risk into the shaft sump. The winder cage was parked on the surface at the time. The gates were manually driven closed to make the area safe and the winder tagged out of service.

Mine operators must ensure appropriate controls are implemented to prevent unsafe situations occurring whenever maintenance or fault finding is being undertaken on mine winders.

Seam gates require two independent controls: an electrical interlock and a mechanical gate lock. Routine schedules must be implemented for the proof testing of all primary and secondary safety circuit functions.

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
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Dangerous incident
IncNot0034478

A large fall of ground, measuring approximately 10 metres by 10 metres, occurred in a quarry when a wedge, within a working face, slipped approximately 1 metre. There were no workers at the mine when the event occurred.



All mines with highwalls should complete geotechnical assessments to determine the design of the highwall. All geological and geotechnical issues need to be considered and highwalls designed accordingly.

Dangerous incident
IncNot0034514

A worker in a quarry suffered an electric shock while a fitter was operating a 240-volt winch. While using the winch, the worker's hand contacted a damaged section of the power cord, resulting in an electric shock.



Mine operators must have systems and checks in place for workers to complete pre-use inspections of portable electrical hand tools and monitor worker compliance. Workers must inspect any tools and equipment being used to ensure they are fit for purpose and free from damage.

Other publications of interest

The 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
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International (fatal)

MSHA	<p>Fatal heavy vehicle/light vehicle accident (final report) – Surface, non-metal</p> <p>On 3 November 2018, a 44-year-old supervisor, with three years' experience, was fatally injured when a 150-ton haul truck ran over her parked pickup truck. The incident occurred because the mine operator did not ensure policies, controls or procedures governing traffic control were adhered to.</p> <p>Details</p>
MSHA	<p>Fatal fall of highwall accident (final report) – Surface coal</p> <p>On 11 December 2018, at approximately 2.00 p.m., a 38-year-old surface miner, with 14 years of mining experience, was fatally injured when a large portion of a highwall (approximately 7,000 to 8,000 cubic yards) toppled, crushing the operator's cab of his front-end loader. He was operating the front-end loader to remove blasted material near the base of a 63-foot highwall.</p> <p>Details</p>
MSHA	<p>Fatal machinery accident – Surface coal (CHPP)</p> <p>On 29 November 2018, at approximately 1.00 p.m., a 50-year-old mechanic, with 29 years of mining experience, received a critical injury while examining the hydraulic system on a service truck. The hydraulic system had been modified earlier that day, causing excessive pressure to flow to a fitting. The fitting burst, propelling a temperature sensor into the worker's forehead. The worker died of his injuries on 30 December 2018.</p> <p>Details</p>
MSHA	<p>Worker fatally injured by shuttle car (final report) – Underground coal</p> <p>On 14 January 2019, at approximately 11.00 a.m., a 56-year-old survey crew member, with 30 years of mining experience, was fatally injured when he was struck by a shuttle car traveling to the coal feeder. At the time of the incident, the worker was taking measurements of the mining height as part of his surveying duties.</p> <p>Details</p>

PUBLICATION ISSUE/TOPIC

International (non-fatal)

MinEx NZ

Distraction causes vehicle collision

A dump truck was exiting out of a work area and travelling along the haul road when he noticed an approaching fuelling vehicle. The fuelling vehicle was travelling in the opposite direction, down into the work area he had just left. Both vehicles were now on the same haul road ramp.

The dump truck operator noticed that the fuelling vehicle was heading directly towards him, so he pulled over to the far-left hand side of the ramp and slowly continued travelling up.

Initially, the fuelling truck operator had not noticed he was on the wrong side of the ramp. When the fuelling truck operator tried to correct himself, he was too close to the dump truck and contacted the right-hand front tyre of the dump truck.

The driver of the fuelling truck admitted to being distracted while looking at his iPad in the vehicle.

[Details](#)

MinEx NZ

Rock fall injures worker

A worker approached the side of a mobile crusher to clear away rocks that had fallen onto the catwalk.

The worker had his back to the mobile crusher, which was in operation at the time. A rock fell off the conveyor and hit him on the top of his left shoulder, resulting in serious bruising to his shoulder.

[Details](#)

National (other, non-fatal)DNRME
QLD**Using non-slewing mobile cranes**

Non-slewing mobile cranes continue to be involved in incidents in the Queensland mining and quarrying industry. They are used regularly around sites and have specific hazards associated with them, such as:

- travelling with a load
- lifting loads whilst articulated in combination with being on a side slope
- used in congested areas.

This document provides guidance regarding lift plans.

[Details](#)

PUBLICATION	ISSUE/TOPIC
DMIRS	Electrical shocks – Health and safety snapshot
WA	Infographic fact sheet.
	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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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (May 2019). However, because of advances in knowledge, users are reminded of the need to ensure that information upon which they rely is up to date and to check currency of the information with the appropriate officer of the NSW Department of Planning and Environment or the user's independent advisor.

DOCUMENT CONTROL

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Mine safety reference	ISR19-17
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Date published	10 May 2019
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Approved by	Chief Inspector Office of the Chief Inspector
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