Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 26 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

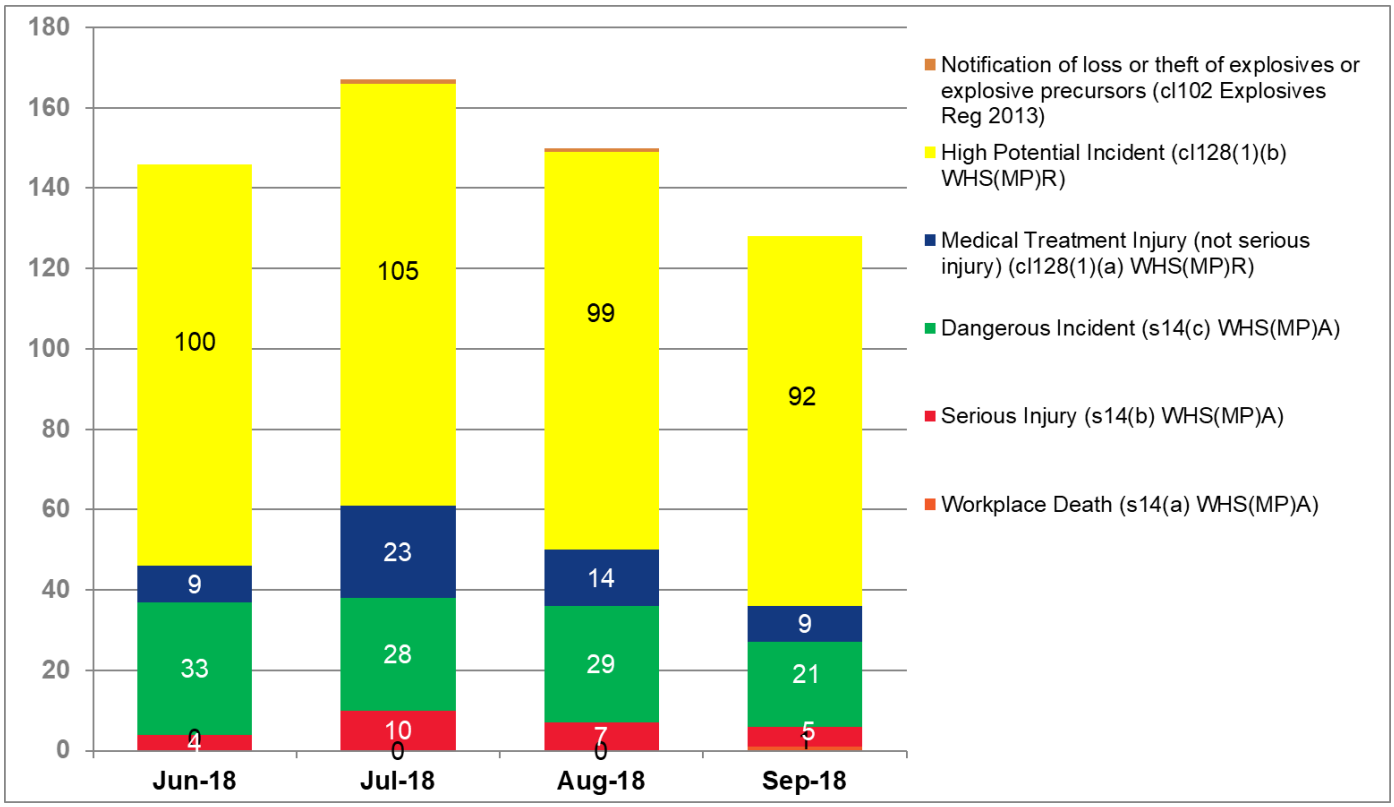
High level summary of emerging trends and our recommendations to operators.

Type	Number
Reportable incident total	34
Summarised incident total	4

Summarised incidents

Incident type	Summary	Recommendations to industry
High potential incident SinNot-2018/01549	A general body of air methane trip occurred at an underground coal mine. The continuous miner in a cut and flit plunge tripped because of methane. The level was observed to rise to 3%.	All ventilation controls such as scrubbers, auxiliary ventilation and panel ventilation must be operational and maintained to prevent unsafe levels of methane accumulating in the mine.
Dangerous incident SinNot-2018/01546	A longwall mine exceeded 2% methane in the return, peaking at 2.29%. Gas levels in the longwall return exceeded 2% methane for more than four hours.	Known factors that affect ventilation such as barometric changes, inter-connection with adjacent goafs and seal leakage must be managed to maintain methane levels below 2%. All workers with responsibilities within the mine's withdrawal trigger action response plans (TARPs) need to be trained and fully aware of their responsibilities.
Dangerous incident SinNot-2018/01537	Two workers were required to evacuate a floating plant when it started to list. It only took 30 seconds for the plant to go from the starting position to the final resting	All vessels must be addressed in an emergency plan and workers should routinely

Incident type	Summary	Recommendations to industry
	position. The plant only became stable when the suspected failed pontoon came to rest on the bottom of the dredge pond. 	practice evacuation drills for a rapidly listing or sinking event. All vessels should have a stability and buoyancy assessment considering if there are any critical scenarios where a vessel could rapidly list or sink.
Dangerous incident SinNot-2018/01526	A bulldozer rolled in an open cut coal mine. An excavator and bulldozer were clearing old pillar workings when the bulldozer slid into the excavated workings (about 2 m) with the machine rolling onto its side. The operator was able to exit the machine and did not suffer any injuries. 	When operating near open or concealed voids, particularly at night, appropriate controls must be in place to allow operators to identify edges and to prevent equipment rolling over. Controls can include change of mining method and lighting.



Recent Resources Regulator publications

- IIR18-09 Investigation information release: Two workers trapped in mine shaft conveyance
- Investigation report into a fatality at a mineral claim near Lightning Ridge on 4 November 2016
- SB18-15 Safety bulletin – Light vehicles in mining operations
- SB18-14 Safety bulletin – Preventing fires on mobile plant: responding to safety alerts

Other publications of note

Publication	Issue / Topic
	International (fatal)
MSHA in MinEx NZ	• Metal/non-metal mine fatality - On August 22, 2018, a 29-year-old miner with one year of experience was fatally injured while cleaning a snub pulley. The victim was working from an aerial lift under the belt conveyor when he became entangled in the conveyor pulley**.** Details

Publication	Issue / Topic
MSHA	• Metal/non-metal mine fatality - On May 9, 2018, a 27-year-old kiln technician with 32 weeks experience was burned while lighting a gas-fired kiln. There was a blow back when igniting the kiln and the miner suffered burn injuries to his head and chest. The miner died from his injuries on May 28, 2018. Details
	International (other, non-fatal)
MinEx NZ	• Not wearing a seatbelt on mobile plant caused driver's head to hit windscreen. A front-loading shovel driver was banging out a bucket while travelling up a ramp. As the bucket tipped forward it dug into the ramp causing the loading shovel to stop suddenly. The sudden stop caused the driver to be flung forwards. However, as he was not wearing a seatbelt, his momentum was not checked, and his head hit the windscreen. Details
	National (fatal)
WA mines Dept. in MinEx NZ	• Haul truck operator loses control descending ramp on haul road - fatal accident. On the night shift of 15 August 2018, a haul truck driver was fatally injured when he lost control of a Komatsu 830E A/C haul truck and crashed into a windrow. The haul truck was descending a ramp with a full load of ore. The Komatsu 830E A/C is an electric drive truck, not a conventional geared unit. 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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CM9 reference	DOC18/734166
Mine safety reference	ISR 18-37
Date published	2 October 2018