Week ending 19 December 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.

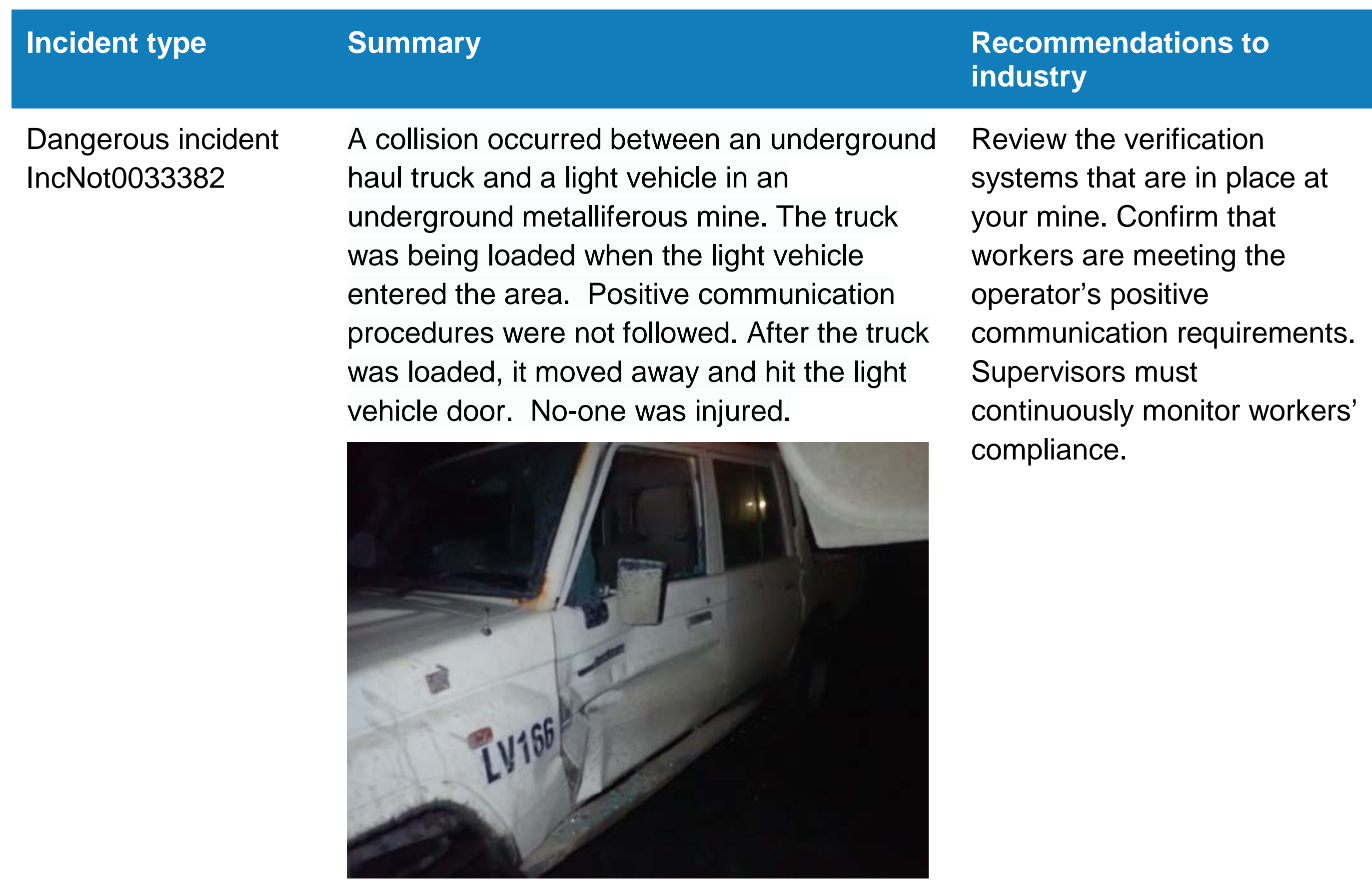
Note: The next weekly incident summary will be published on 10 January 2019.

At a glance

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

Type	Number
Reportable incident total	90
Summarised incident total	6

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident IncNot0033382	A collision occurred between an underground haul truck and a light vehicle in an underground metalliferous mine. The truck was being loaded when the light vehicle entered the area. Positive communication procedures were not followed. After the truck was loaded, it moved away and hit the light vehicle door. No-one was injured. 	Review the verification systems that are in place at your mine. Confirm that workers are meeting the operator's positive communication requirements. Supervisors must continuously monitor workers' compliance.

Dangerous incident IncNot0033366	When working in a confined space, a worker escaped injury when water started flowing into a launder box (chute) at a metalliferous processing plant. The worker was completing chute repairs to the launder box when a control system was repowered and pumps automatically started. A mine investigation identified that an isolation valve was locked in the open position.	Site isolation procedures should include a method of isolation verification when parts of systems have been shut down.
Dangerous incident IncNot0033362	A dog trailer overturned when it was unloading at a sand mine. The driver had emptied the trailer and was reversing to tip the load. The front axle of the trailer rode up a pile, rolling the trailer.	Tip areas should be designed with enough room for trucks to safely perform tipping operations and to account for trailer position and procedure when unloading truck and dog combinations.
Dangerous incident IncNot0033333	An electrician suffered an electric shock while changing a circuit breaker. The supply to the circuit breaker was isolated but an uninterruptible power supply (UPS) that was connected to the system was not identified. An ambulance was called and cleared the worker of injury.	Uninterruptible power supplies (UPS) are an essential part in the security of supply. Testing and proving dead all sources of energy including back-feeds is a critical part of isolation. Workers who are isolating equipment must understand the circuit they are working on. Mines should have isolation procedure available for complex isolations or those that are rarely carried out.

Dangerous incident IncNot00333	A welder suffered an electric shock while performing gouging work on an excavator mainframe. The welder was working under category C conditions and went to adjust the rod when he felt the shock. The welder was checked first by onsite paramedics and as a precaution, the welder was transported to the hospital for further assessment. An ECG confirmed that the welder was not injured.	Workers using electrical welding equipment should undergo refresher training on the importance of following correct welding procedures. They should ensure that personal protection equipment (PPE) should be maintained fit-for-purpose throughout the task. Additional PPE should be available for these workers.
Dangerous incident IncNot0033310	A worker was sprayed with hydraulic fluid when a hose failed on a continuous miner drill rig in an underground coal mine. The worker was transported to hospital where he was cleared of injury.	MDG41 Fluid power systems section 3.4.4 requires designers to consider fitting guards to prevent fluid release from entering a work area. Mines should review guarding of hoses in work areas and correct any deficiencies. When buying new or overhauling equipment hydraulic hoses in work areas should be eliminated where practicable or appropriately guarded.

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.

Publication	Issue / Topic
	National (other, non-fatal)
Qld dept of Mines (DNRM)	• **Unintended initiation of charge during secondary blasting (Explosives safety alert no. 99)** A shotfirer was using deflagrating (low strength) explosive cartridges to blast oversize material at an open cut metalliferous mine. While cycling through the test procedure, the electronic test unit delivered a test/energising current that was greater than the fire current for the deflagrating explosive cartridge. The cartridge initiated in the blast hole less than a metre from the shotfirer's head. The shotfirer was standing offset to the line of fire and was uninjured by the blast. Details
MIRS WA	• **Operator trapped between EWP and overhead structure** In July 2018, an operator and a surveyor were working 27 metres above the ground in a mobile elevating work platform (EWP), taking survey measurements on a stacker structure to improve conveyor belt alignment. When the operator moved the EWP basket upward, his head was trapped between the stacker frame and the secondary guarding sensor bar in the basket. The alarm at the EWP base alerted the spotter, who then proceeded to lower the basket. The operator suffered injuries that had the potential to be serious, and he lost consciousness for a few minutes. Details

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.

The incidents are included for your review. The 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.

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