NSW GOVERNMENT

Weekly incident summary
Mine Safety News
Emerging trends, reportable incidents and safety advice

NSW Resources Regulator

Week ending 22 February 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

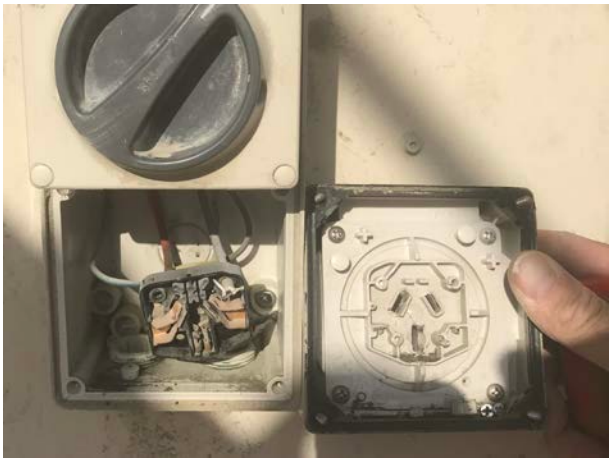
High level summary of emerging trends and our recommendations to operators.

Type	Number
Reportable incident total	55
Summarised incident total	10

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident IncNot0033948	At an open cut coal mine, a dozer was hit with a large rock. In line with the mine procedure, the dozer entered the swing radius of an excavator once the haul truck was driven away. The truck had left without being directed by the excavator operator, who intended to load another bucket into the truck. As the excavator slewed around, it saw the truck had left and stopped. As it stopped, a rock slid off the front of the bucket and landed on the bonnet of the dozer. 	Operators must review and should implement the recommendations from safety bulletin SB18-06 Lack of Positive communication.

Dangerous incident IncNot0033945	At an underground metalliferous mine, a gas ignition occurred in the development end when a loader was cleaning up at the face. An operator saw a 20 cm flame from a lower 7 metre-long gas probe hole. The Jumbo operator reported that gas levels were being monitored at the time of the event. Ventilation observations were taken including gas measurements and ventilation flow. The area was barricaded. The ventilation engineer and geologist were deployed to inspect it.	Mines must implement effective controls to manage the risks associated with gas release from probe holes, and the potential ignition of this gas.
Dangerous incident IncNot0033937	A worker was sprayed with oil while fault finding a haul truck recovery power pack. The powerpack was not connected to a truck and when it was started, a hose failed, spraying the operator. No injury was reported. It was identified that the power pack did not have any internal pressure relief and relied on the relief valve fitted to the truck. 	All hydraulic systems must be protected for over pressure events. When designing pressure relief systems, consideration must be given to all applications and situations when the equipment is used.
Dangerous incident IncNot0033939	A worker suffered an electric shock while welding. The shock occurred when the worker steadied the welder hand piece by placing his hand on the bench. The worker was taken to hospital and was cleared of injury. 	There has been a recent increase in welding-related electric shocks. Mine operators should verify that workers completing welding activities have identified appropriate earthing points, personal protection equipment (PPE) is dry and they are appropriately trained.

Dangerous incident IncNot0033916	A contractor preparing to carry out repairs in a hopper suffered an electric shock. The worker was setting up a portable welder and felt the electric shock as he tested the welder. A mine investigation identified that the there was no connection to earth on the earth pin of the 15-amp outlet because the back of the outlet had come loose inside the outlet enclosure. 	A NSW Resources Regulator inspector attended the mine and issued several s191 improvement notices. Mine operators should verify that workers completing welding activities have identified appropriate earthing points, personal protection equipment (PPE) is dry and they are appropriately trained.
Dangerous incident IncNot0033933	A piece of glass hit a worker when a haul truck right-hand inner tyre burst in an open cut coal mine. The worker was operating a tool carrier adjacent to a haul truck on the workshop apron. 	The life cycle management of tyres should include the changing out of the tyre before failure. Degradation signals that failure is imminent.
Dangerous incident IncNot0033929	A 50-tonne slew crane rolled while travelling down a ramp at an open cut coal mine. The incident occurred on the second successive long ramp of the journey. It was reported that the crane lost brake function. The operator attempted twice to slow the crane by steering it into a windrow. No injuries were reported. Workers exited via the windscreen.	NSW Resources Regulator inspectors attended the mine and issued a s195 prohibition notice preventing the crane from being recovered until appropriate risk controls have been established. Before heavy vehicles are escorted into the mine,

		hazards of the travel route need to be assessed including the route to be taken, operating grades and vehicle interaction. Appropriate means of slowing vehicles should be used to minimise braking including gear selection, exhaust braking and retardation.
Dangerous incident IncNot0033917	A dozer pushing dirt on the slope of an old bund slipped sideways and rolled onto its right hand side. The driver exited the cabin and was uninjured. 	Operators need to plan work around grades to minimise the amount of work completed on cross grades. Work area inspections must be completed before beginning work to determine ground stability.
Dangerous incident IncNot0033910	An excavator was cleaning overblast that was against a 10-metre highwall. While the bucket was low into the material, further material fell onto the bucket. The machine was caught by the material on the bucket. There were no injuries. 	A s195 prohibition notice was issued to the mine preventing recovery of the machine until appropriate risk controls had been established. Ground and slope stability need to be considered when completing any task. The introduction of new risks needs to be assessed and appropriate action taken to reduce exposure.

Dangerous incident IncNot0033900	A worker was hit with a piece of coal that was ejected from a conveyor chain. A large piece of coal appears to have been stuck in the throat of the conveyor of the continuous miner, it then shattered, ejecting a piece of coal that was about 100 x 50 x 50 mm. This piece hit the shuttle car operator on the right check. The operator suffered a laceration from the impact to his safety glasses. The operator went to hospital but was released without treatment.	Where workers cannot be removed from potential lines of fire, appropriate protection needs to be installed. Where protection is installed, it cannot be removed without equal or greater controls being implemented.

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
	International (other, non-fatal)
MinEx NZ	**Worker falls from track crusher** A worker was preparing to start washing down a mobile crusher when he noticed some larger rocks on the machine. He climbed up onto the track using the mounted steps and began removing the stones. When the worker had removed the stones, he turned around and began to walk along the track. In attempting to pull up his wet weather pants, he lost his balance and fell. He suffered a fractured hip that required surgery. **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.

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.

Office use only	
CM9 reference	DOC19/172635
Mine safety reference	ISR 19-08
Date published	4 March 2019