Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 11 July 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.

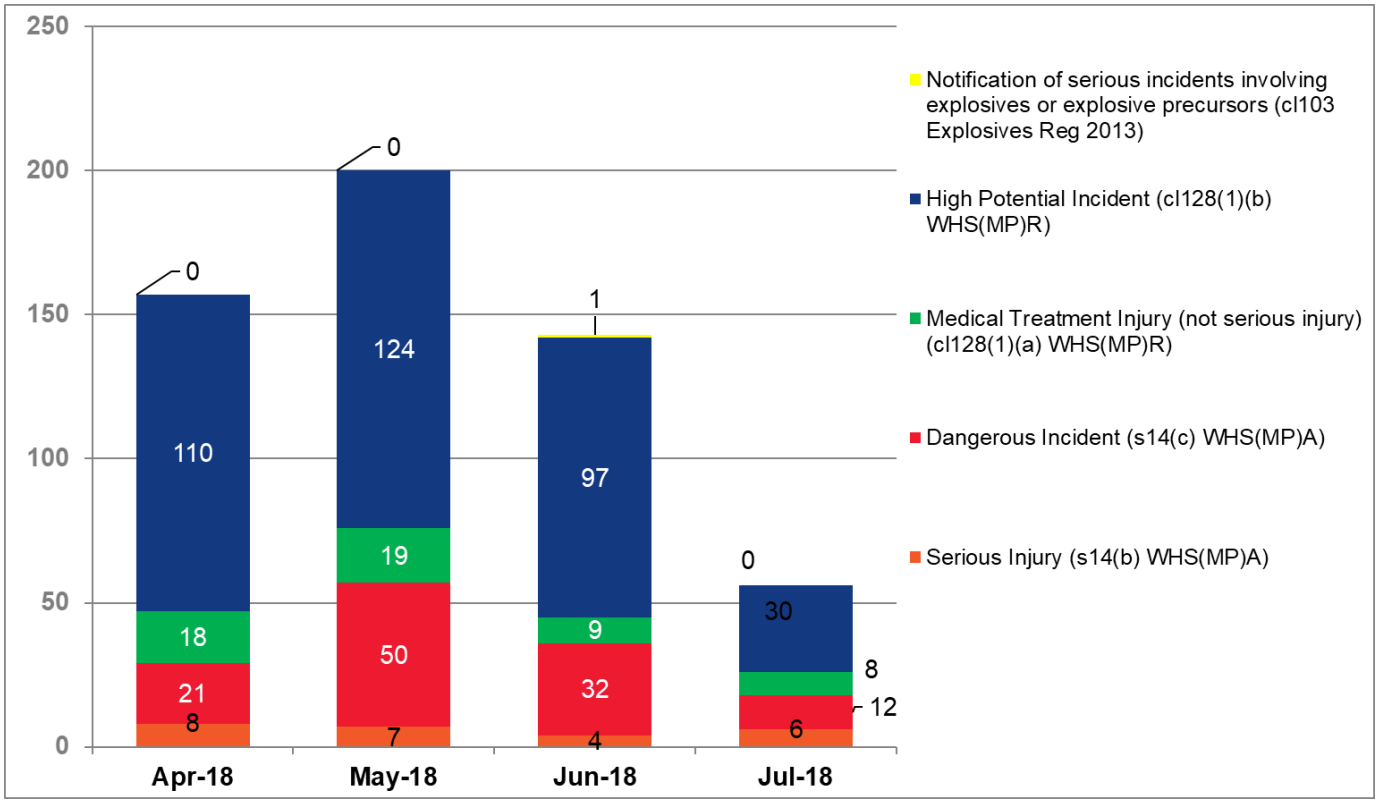
Type	Number
Reportable incident total	44
Summarised incident total	6

Summarised incidents

Incident type	Summary	Recommendations to industry
Serious Injury SinNot-2018/01106	A worker suffered a finger injury that required stitches. While installing support with an air track bolter, a timber jack was lowered and a butterfly plate slid down the bolt, striking the worker on the right index finger.	The retention of plates on the head plate/timber jack should be routinely reviewed to protect workers from falling plates.
Serious injury SinNot-2018/01099	A rib failure occurred, striking two workers. One worker suffered several fractures on his right femur and a fractured vertebra in his back.	This incident is the subject of a major investigation. Further information will be issued shortly.
High potential incident SinNot – 2018/1095	During a routine service on a load haul dump vehicle, the machine failed to shut down on low scrubber water. An investigation found the safety circuit had been intentionally bypassed.	Multiple incidents have occurred recently across different mines in which bypassed safety circuits have been identified. Mines should have a process in place to appropriately manage bridging and forcing of safety circuits. Workers need to be made aware of the hazards and

		potential consequences of unauthorised bridging.
Dangerous incident SinNot - 2018/01088	A service truck rolled while leaving a mine site. At a right-hand bend on a gravel road, the driver swerved, lost control and the truck tipped on its side. A fuel tank was fitted to the truck and was only partially filled. 	When tanks are fitted to vehicles (such as fuel or water tanks), the risk of fluid movement should be considered and appropriate controls put in place including baffles and minimum/ maximum fill levels.
Serious injury SinNot - 2018/01074	A tradesman had the fourth finger on his left hand amputated while preparing a mobile crusher for transport with co-workers. One worker was undoing a nut that was going to be used to secure a tail pulley. Another operator was in position on the opposite side at the controls and mistakenly thought he was given a direction to lift the pulley. The amputation occurred when the worker pulled his hand away. A retaining pin was missing and the nut and bolt were used as a substitute. Emergency procedures were not followed by the workers. 	When planning tasks workers must consider: → isolation requirements → methods of communication → emergency response.

Serious injury SinNot-2018/01069	A worker's finger was crushed while installing a 6 metre cable bolt. The worker was removing a 4 metre drill string when the gripper jaws failed to hold the drill steels and his hand was crushed between the drill string and the dolly.	The alignment of drill steels and gripper jaws should be monitored to confirm an effective hold of drill steels is achieved.



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.

Recent Resources Regulator publications

- → Safety alert SA18-09 Drill rig breaches highwall windrow
- → Safety bulletin SB18-12 Rib failures in underground coal mines
- → Safety bulletin SB18-11 Windrow management and demarcation
- → Safety alert SA18-08 Underground mine fire inititates emergency response

Other safety publications of note

Publication	Issue / Topic
MSHA	• **COAL MINE FATALITY** – On Friday, March 16, 2018, a 34-year-old mechanic with 16 years of total mining experience was fatally injured while operating a diesel personnel carrier on the mine haulage road. The vehicle hit the right rib and rolled onto its left side. The worker was partially ejected from the mantrip and the canopy of the mantrip came to rest on his chest. Access the Coal Final Report here
MSHA	• **COAL MINE FATALITY** – On Wednesday, March 28, 2018, a 29-year-old belt foreman with eight years of total mining experience was fatally injured while he and a co-worker were in the process of splicing an underground conveyor belt when the conveyor belt inadvertently started. The worker became entangled with the belt splicing tools as the conveyor belt moved. Access the Coal Final Report here
MSHA	• **COAL MINE FATALITY** – On Wednesday, February 21, 2018, a 38-year-old high wall mining machine operator, with 21 years of total mining experience, was electrocuted when he contacted an energised connection of a 7200 volt electrical circuit. The worker was found inside a transformer station troubleshooting and/or performing electrical work on the electrical system that supplies power to the mining machine. Access the Coal Final Report here
MSHA	• **COAL MINE FATALITY -** On Monday, June 4, 2018, a 43-year-old miner with 10 years of mining experience, was fatally injured when a roof jack struck him in the head. At the time of the accident, the miner was a passenger in a personnel carrier that travelled over the roof jack, which was lying in the roadway at the time. Because of being hit, the roof jack was propelled into the passenger's compartment, striking the worker. The worker was flown to a hospital where he died from his injuries. Access the Coal Fatality Alert here
MinEx Safety Alert NZ MSHA alert reported in MinEx NZ	• A loaded CAT ADT lost engine power while travelling up a ramp. The secondary braking system failed to operate, leaving the ADT with no brake pressure, resulting in the truck rolling back down. On investigation, the brake accumulators were found to have reduced pressure within the nitrogen charge. Details • A high potential near miss was reported when an operator was seen in the feed hopper of a mobile crusher without having properly isolated the machine. Details • **Underground – Zinc**; On May 15, 2018, while operating a locomotive underground, a miner hit his head on a low clearance ventilation bulkhead. The miner suffered head injuries but could walk out of the mine and never lost consciousness. The operator drove him to a hospital, not expecting the injuries to be serious, but the miner was admitted to the ICU with severe head injuries. Details • A worker was holding onto the feeder while trying to clear a blockage in a jaw crusher, when a rock hit his hand and he sustained injury to the hand, requiring medical treatment. The cause of blockages within a crusher is commonly knownas "bridging"— where oversize material prevents product from entering the crusher chamber or stalls the crusher. Details

MSHA	• **MNM close call accident alert**; On May 21, 2018, a dozer operator was working on a waste pile when the soil beneath the dozer sloughed into the adjacent pond, causing the dozer to become submerged in the pond. The dozer came to rest approximately 12 feet beneath the water's surface. Fellow miners could dig a trench and drain the pond, which allowed rescue crews to access the cab. The miner climbed free from the cab after spending over two hours below the surface. • Access the MNM Close Call Accident Alert here
WorkSafe Vic alert reported in MinEx NZ WA dept. of mines (DMIRS) alert reported in MinEx	• Warning devices on powered plant deliberately fitted with overriding switches. Details • Gasket rupture at processing facility results in gas leak Details • **Potential emergency**: Gas cutting at a quarry causes bush fire Details
WA dept. of mines (DMIRS)	• WorkSafe is investigating an incident with preliminary evidence indicating an employee, who was fatally injured, may have been struck in the head by a 48 inch pipe-wrench spanner. The spanner was attached to the rotating drill rod at the drill table section of a rock drilling truck. Safety alert 04/2018 - Worker fatally injured during maintenance to a rock drilling truck
WA dept. of mines (DMIRS)	• Asbestos containing material (ACM) disturbed during power transformer refurbishment SIR No. 263: Asbestos-containing material (ACM) disturbed in power transformer
SafeWork NSW	• Following an amendment to the WHS Regulation, the NSW Government published a register of individuals who hold asbestos, high risk work and demolition licences, as well as… Read more

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.

Office use only	
CM9 reference	DOC18/481135
Mine safety reference	ISR 18-27
Date published	12 July 2018