Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 18 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	45
Summarised incident total	8

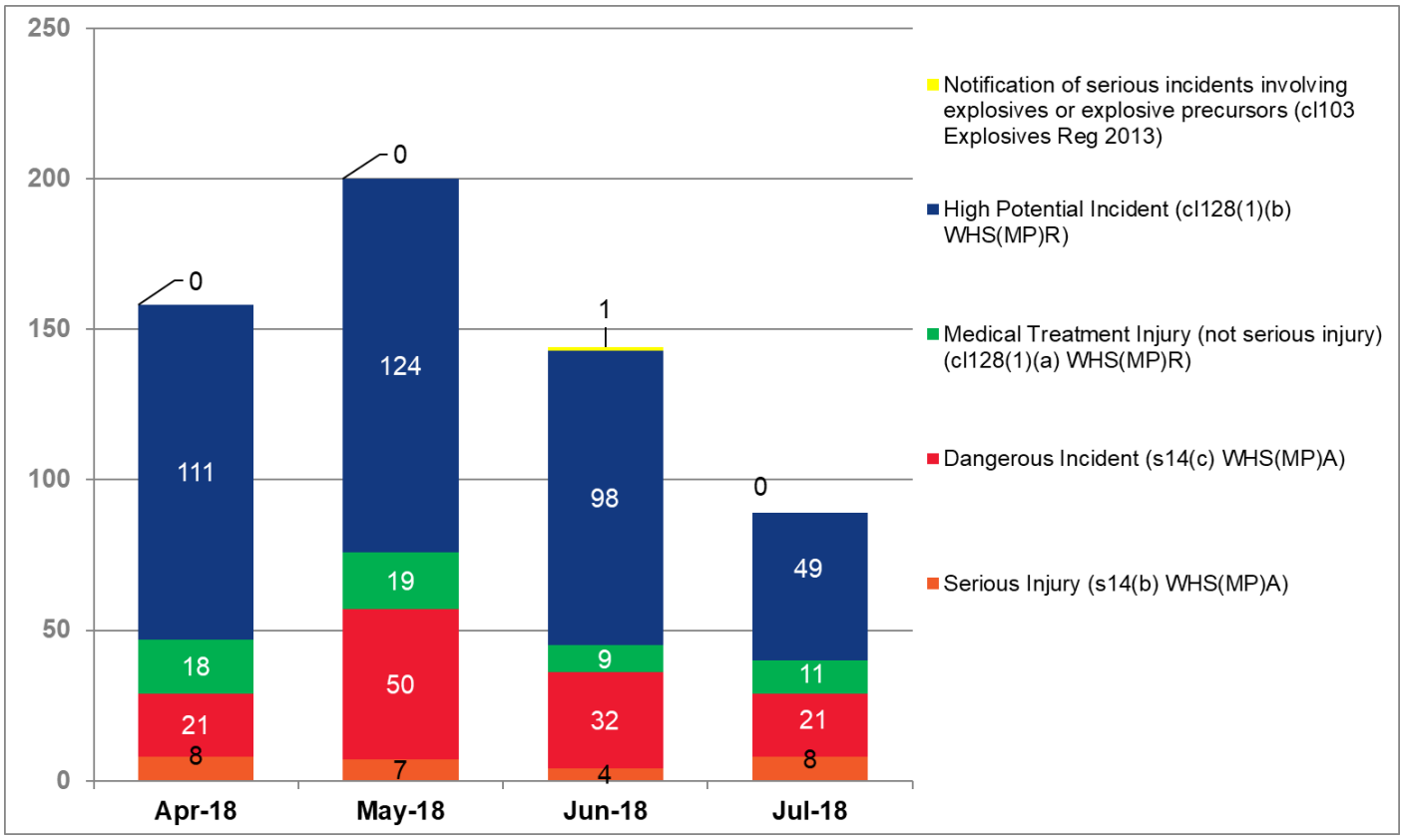
Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot - 2018/01151	A worker suffered second-degree burns in a welding incident. While preparing the task, solvent was used to clean up grease before starting on an oxy cutting task. When the workpiece was cleaned, a pool of solvent was missed. The scene was not preserved and the incident not reported immediately.	The risk of using solvents as preparation for hot work should be included in the risk assessment for the task and controls put in place to protect workers. The Notification of incident and injury guide is available to assist mines in meeting their obligations of the *Work Health and Safety (Mines and Petroleum Sites) Act 2013* when notifying incidents.
Dangerous incident SinNot - 2018/01138	A light vehicle rolled at an open cut coal mine. The vehicle operator reported they had a micro sleep. The operator was traveling on a haul road at 5:30 am when the ute rolled onto its side.	The Resources Regulator is concerned with the increase in fatigue-related incidents being reported in open cut coal mines. Mines should review their fatigue management plans and workers' understanding of these plans.

Dangerous incident SinNot - 2018/01137	At an underground coal mine, an operator was sprayed with oil on the face and neck when a roof bolter feed hose failed on a continuous miner. The fluid release protocol was followed and the worker was cleared of injury.	Hydraulic hose management must include routine inspections of hose routing, protection and guarding.
Dangerous incident SinNot - 2018/01136	At an underground metalliferous mine, a collision occurred between a drill rig and a light vehicle. The light vehicle sustained significant damage. As the light vehicle approached, the operator stopped but was unable to make radio contact. The drill continued to drive and the boom made contacted with the windscreen. The driver and passenger in the light vehicle were not injured.	The risk of collision when vision is restricted is well documented and reasonably foreseeable. Suitable risk controls such as cameras and vehicle escorts should be used when tramming large items of plant with restricted visibility around mine sites.

Dangerous incident SinNot - 2018/01135	While recovering longwall roof supports, two operators were sprayed with oil when an interchock hose failed. The operators were two supports away from where the failure occurred. The mine investigation identified the hose had been damaged when recovering the adjacent roof support.	The risk assessment for longwall equipment recovery should include the risk of damage to hydraulic components and appropriate controls should be implemented.
Dangerous incident SinNot - 2018/01130	While bogging out a cuddy (stub) an operator saw an ignition of gas that resulted in a one metre pulsing flame. The gas was being emitted from a drill hole. There was no response when emergency was called by the operator and supervisor. Subsequent calls raised the alarm.	When controlling gas emitting from boreholes, the effectiveness of sealing arrangements should be reviewed before starting other works. Mines must have an emergency management system in place that ensures workers are capable of rapidly raising the alarm in an emergency.

Serious injury SinNot - 2018/01128	Two shot firers were treated at hospital after completing a shift spent charging a shot. They returned to their accommodation camp at 7 pm and at 11.30 pm took themselves to hospital. The cause of illness was unknown at the time of writing. Potential causes were ammonium-related, heat-related or pre-existing flu-related factors.	The safety data sheet and handling instructions must be made available so that adequate controls can be implemented to manage the exposure of workers to hazardous substances. When used underground, the ventilation required should be assessed. When working in hot areas, controls must be in place to manage the exposure of workers.
Dangerous incident SinNot - 2018/01127	At an open cut coal mine, a light vehicle rolled after losing control on a freshly watered section of a haul road. The driver was uninjured and was put under observation in the first aid room at the mine. Drug and alcohol testing was undertaken. The scene was preserved with normal operations undertaken on an alternate circuit. 	Following several similar incidents, SB1809 Overwatering of roads leads to vehicle incidents was issued. Mines should review the recommendations detailed in this safety bulletin.



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.

Other safety publications of note

Publication	Issue / Topic
DNRME Qld Alert reported in MinEx NZ	• Fatality resulting from kinetic energy release of springback plates during maintenance. • Details
MSHA	• **METAL/NONMETAL MINE FATALITY** – On June 13, 2018, a 65-year old truck driver with 4 years of experience was fatally injured when his truck travelled over a berm and into an impoundment of water. Divers recovered the victim in 20 feet of water. • Access the MNM Fatality Alert here
Worksafe NZ alert reported	• Articulated truck roll-overs • 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.

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