Weekly incident summary

Planning & Environment
NSW GOVERNMENT Resources Regulator

Week ending 21 June 2017

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

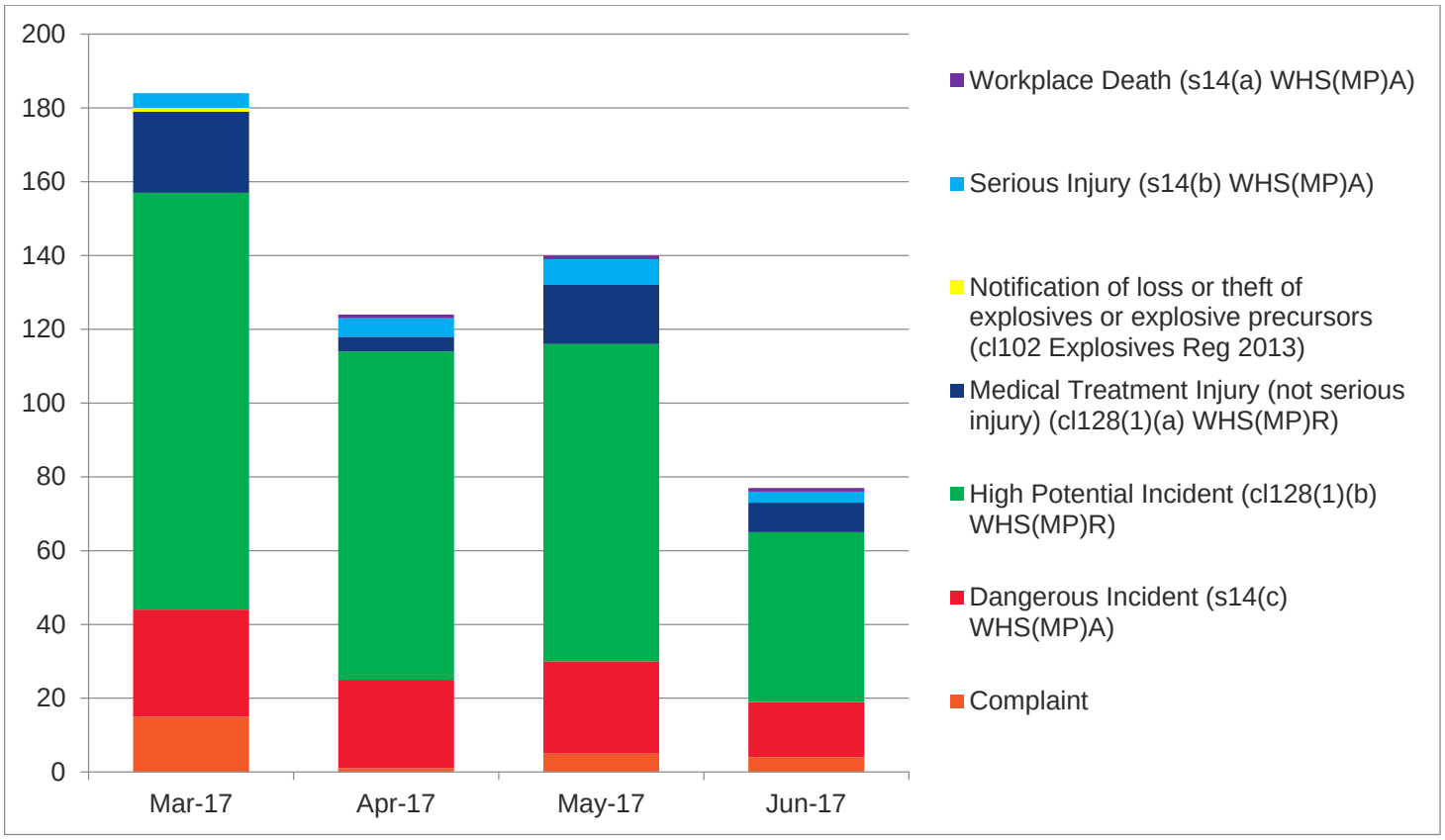
Type	Number
Reportable incident total	32
Summarised incident total	6

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot 2017/00920	A shearer operator was hit in the face by flyrock that was ejected from the shearer's maingate cutter drum.	Mines that are cutting 'hard coal' that has the potential to throw flyrock from the face should: • ensure that adequate no-go zones are developed and enforced • review the pick choice as the pick may alter the cut-ability and direction, which could influence the positioning of no-go zones • review cutting sequences • exploit longwall automation to minimise worker exposure.
Medical treatment injury SinNot 2017/00909	The ventilation was being extended in the 485FWN when the bag became caught on the roof of an IT machine. The operator put his foot on the step above the rear mudguard to unhook the bag. The step gave way and he fell through. The operator lost balance and put his hand out to steady himself. His hand made contact with the ground support on the wall of the drive. The operator suffered a broken finger.	There should be recognition of increased risk of failure of plant that is increasing in age and is in an environment that may contribute to corrosion and structural failure. Structural components, such as handrails, guardrails, ladders and steps should have an appropriate inspection, maintenance and audit schedule to ensure those structural components are safe.

		Fixed access ladders, steps and guardrail installations should be periodically inspected for rust, corrosion and structural integrity and kept in good condition to ensure the safety of workers.
High potential incident SinNot 2017/00906	During the removal of shields on a longwall 30 faceline, the goaf caved behind the buttress supports for a distance of around 30 shields. This caused gas from the goaf area to be pushed into the return outbye of the longwall face, causing the gas level to rise above 2%. The level was above 2% for about 26 minutes, reaching a maximum of 2.69%.	Mines should consider this risk and implement appropriate controls including trigger action response plans (TARPs) that respond to goaf level stand up distances. Ventilation quantities should be maximised and adequate exclusion no-go zones developed and enforced. Mines should review their windblast management plans to include longwall take-offs.
Dangerous incident SinNot 2017/00092	A haul truck collided with a light vehicle while passing in a decline. The light vehicle was dragged a short distance before the haul truck driver was notified of the incident by radio from the driver of the light vehicle. No injuries were reported.	A number of contributing factors have been identified with this incident, including: • poor radio communications • some pass bays in poor condition for vehicle entry • lack of blind side camera • lack of co-operation between vehicle operators. Mines should not rely on procedural controls without appropriate consideration of the impact and effect of human factors. They should consider among other things: • road design, including intersection design • control measures for separating heavy from light vehicles • night driving conditions and visibility • traffic control systems and intersection speeds • communication systems, collision avoidance and proximity detection systems for both heavy and light vehicles • daily inspections of roads and intersections are carried out by a competent person. Refer to: IIR15-03 Haul truck and light vehicle collide IIR13-06 Collision between haul truck and light vehicle
High potential incident SinNot 2017/00897	Methane was detected above the limit of 2%. The methane level instantaneous peaked at 2.6% and was above 2% for a period of approximately 1.5 minutes.	Mines should review their procedures for degassing of development panels using auxiliary fans with respect to:

		• a pre-degassing inspection where possible. This procedure must include an inspection to determine the gas levels, the position of gas fringe and any possibility of gas layering • notification to the control room to ensure all people are removed from the return side of degassing in the event of an unplanned gas plug • considering having a settling time for each setting when closing the degassing box.
High potential incident SinNot 2017/00890	When longwall operators were in the process of removing a longwall support leg cylinder using a winch, the roof bolt broke and the snatch block fell to the ground. At the time the operators were slowly starting to put tension on the winch. The winch was at the maingate drive, and the first snatch block was attached to a roof bolt adjacent to the #1 support. The snatch block fell to the ground in a diagonal direction back towards the winch. No-go zones had been identified and were in place.	When using winches, ropes and snatch blocks on their own or in combination to pull loads horizontally underground, the lifting, pulling and anchoring equipment needs to be suitably rated to match the potential load combinations. Mechanical engineering assessments may be required to verify the intended system is within the lifting and pulling equipment capabilities. Refer to: SB09-03 Broken pull chain results in fatality SA04-09 Broken chain connector results in serious injuries



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 publications

- investigation information release: Fatality on the surface of an underground coal mine

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