Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 14 March 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	50
Summarised incident total	13

Summarised incidents

Incident type	Summary	Recommendations to industry
Serious injury SinNot-2018/00393	A worker was hit on the leg and knocked to the ground when a vehicle rolled backwards. The worker was walking and using a mobile phone at the time of the incident. The worker was taken to hospital for treatment.	Mine operators should review how the hazards associated with using mobile phones and social media devices are controlled on site, both for vehicle operators and pedestrians around mobile equipment.
Serious injury SinNot-2018/00385	A worker was loading a belt structure into a basket when their right middle finger was caught between the basket and the belt structure. Colleagues applied first aid and took the worker to the surface. The worker suffered a broken finger and was taken to hospital.	Mine operators should review how the hazards associated with any manual handling tasks are controlled.
Dangerous incident SinNot-2018/00380	An electrician was conducting weekly tests on a continuous miner in the maingate underground. When the electrician touched the lead connected to the continuous miner while connecting it to the remote (to function test the continuous miner) they reported feeling a tingle in their hand. Workers then isolated power to the	Mines should confirm all enclosures onboard mobile equipment are correctly earthed, and plug/sockets have the correct ingress protection (IP) rating and are maintained in a fit-for-purpose state.

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	continuous miner and barricaded the area to preserve the scene. The electrician was taken to the surface and site electric shock protocols were enacted.	
Dangerous incident SinNot-2018/00378	Two fitters were removing bolts from a track plate using a pneumatic torque gun. While removing the last bolt, the reaction arm broke and flew three metres hitting the second fitter on the head, cracking the hard hat along the cap line. The reaction arm then rebounded towards the fitter who was operating the tool. No one was reported to be injured.	Work Health and Safety Regulation 2017 clause 213 deals with the maintenance and inspection of plant. This includes such tools and equipment as high torque pneumatic wrenches. Mine operators should have a process to ensure tools and equipment permitted to enter site have an appropriate maintenance history. High torque wrenches should be maintained, inspected and/or tested in accordance with original equipment manufacturer (OEM) recommendations. Non-destructive testing could be appropriate for load bearing components where failure could represent a risk to health and safety. Mine operators should also ensure: → pre-use inspections are available for workers and completed → pre-use inspections address safeguards and externally visible load bearing components for cracking or damage → defects are reported and fixed → operators should be aware of avoiding the line of fire should failures occur.
Dangerous incident SinNot-2018/00373	An electrician was investigating an intermittent fault on a cooling pump at a surface gas plant and suffered an electric shock. The electrician was using a multimeter to fault find inside the energised 415V switchboard supplying	Work Health and Safety Regulation 2017 clauses 146 and 157 define electrical work and stipulate when electrical work on energised electrical equipment is permitted. The Work Health and Safety (Mines

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	the cooling pump when contact was made between the test probe and the switchboard chassis. The 415V circuit was protected with earth leakage protection set at 300mA and did not trip when the electric shock occurred. The site enacted the electric shock protocol and an ambulance attended site to perform an ECG. The electrician was cleared of any injuries.	and Petroleum Sites) Regulation 2014 requires live work to be notified under schedule 3 as a high-risk activity. Mines should look at their electrical control plans and confirm and communicate to all electrical workers and electrical contractors that live work is prohibited, unless it is in **full** compliance with the respective regulations and the mine operator has approved it.
Dangerous incident SinNot-2018/00367	A fourth-year electrical apprentice was working on an elevated work platform (EWP). While moving from one work site to another (to continue running a cable) the knuckle of the EWP hit and damaged a light vehicle.	Mine operators should review how hazards associated with the potential interaction with mobile equipment are controlled. This should be done using the hierarchy of controls.
Dangerous incident SinNot-2018/00366	An underground worker became trapped after a generator cut out on low water leaving a material hoist in a position that blocked access to a ladder. The worker was trapped underground from 3.30pm Thursday to 7am on Friday. Operators at a nearby mine found the worker on the Friday morning.	Mine operators should review how often their emergency response procedures are tested and any shortcomings should be reviewed and changes implemented. Mine operators should review having a second escape route in the event of an emergency.
Dangerous incident SinNot-2018/00365	An apprentice electrician under the direct supervision of an electrician was resetting a hydraulic pump of a lighting plant. When the apprentice pushed the start button they suffered an electric shock. An initial investigation found that the insulation of an internal wire had rubbed through.	Workers should not suffer electric shocks when conducting any form of work. AS/NZS 3000 requires all exposed metallic parts and panel lids to be earthed. Control switches that have voltages above ELV should have suitable protection and maintained in a fit-for-purpose state throughout their life cycle.
Dangerous incident SinNot-2018/00364	A worker was changing an eluate filter. The worker had isolated the pump correctly and opened the vent line. The worker removed the bolts on the far side of the filter housing and was removing the bolts on the near side when they were scalded by a release of steam. Injuries included burns to the forearm	Mine operators should review how supervisors monitor and ensure that safe work procedures and their controls are followed. Mine operators should also review how the hazards associated with

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	and stomach. The worker washed and felt okay and continued to complete the task. The worker was later in discomfort and was taken to hospital and treated for superficial burns and blisters.	potentially stored energies are controlled. There have been several incidents over the past two months associated with the release of stored energy.
Dangerous incident SinNot-2018/00362	While installing roof mesh on a longwall, during bolt up, an unintended activation of the flipper occurred on roof support 12 when an operator manually operated the same roof support that they were standing on. The operator was believed to be attempting to fold out the flipper to pin the mesh when the flipper made contact with the head of another operator standing at the front of roof support 12. The impact knocked the helmet from the operator's head. The operator did not lose consciousness or suffer any obvious physical injuries. The operator was taken to hospital for treatment.	Mine operators should review how supervisors monitor and ensure controls, such as safe standing zones, are adhered to. Mine operators should also review how the workforce, including contractors, are trained and assessed in the hazards and controls associated with the tasks they have to perform.
Dangerous incident SinNot-2018/00355	An excavator was being operated when a dozer was driven behind the excavator to clean up. The excavator operator was not notified about the approaching dozer. The excavator and dozer collided. There were no injuries reported. Damage occurred to the dozer's left hand blade lift cylinder.	Mine operators should review how supervisors monitor and ensure that the controls for the hazards associated with the interaction of mobile equipment, including clear communications, are adhered to.
Dangerous incident SinNot-2018/00351	An electrician opened a single phase three pin power outlet (waterproof outlet). The electrician undertook tests to ensure it was not live. The electrician took the power point apart leaving the wires exposed and then walked down stairs to get cable amour. A contract fitter walked past the exposed power point and yelled out in pain. A quarry manager was nearby and asked what had happened. The fitter said the power point gave an electric shock. The electrician returned and checked if	Work Health and Safety Regulation 2017 clauses 149 and 150 requires that the person conducting a business or undertaking (PCBU) ensures that any unsafe electrical equipment is replaced or permanently removed and electrical equipment is to be regularly inspected and tested. Mines should ensure equipment used to confirm isolation is fit for purpose, tested and confirmed to be working before and after isolation take place. AS/NZS 3000 is a requirement of

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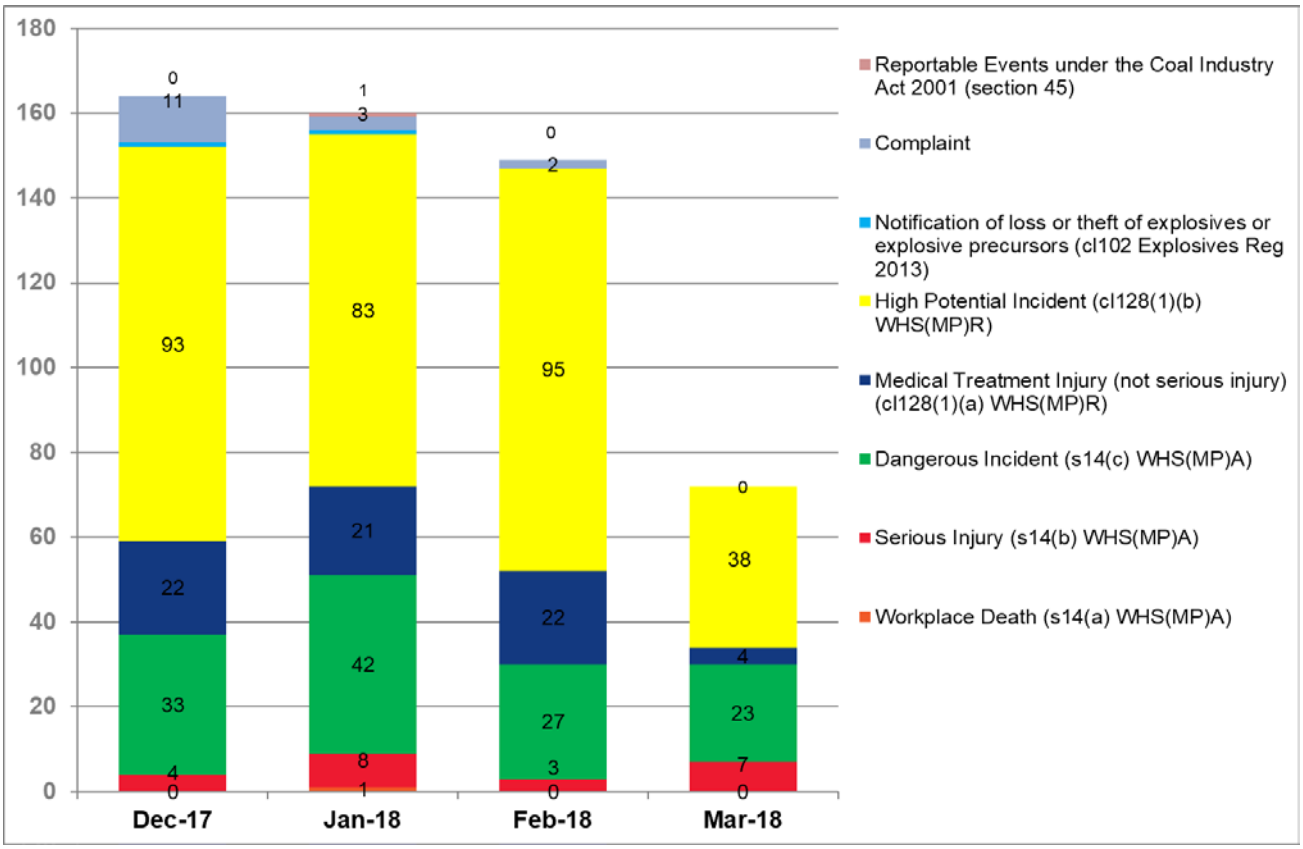
	power was on using a multimeter and it did not register any power. The electrician used a second multimeter that detected 240 volts. The tip of the first multimeter fell off on examination. The power point label read SB-1 CB 6. This was compared to the lock-out in the switchroom that indicated the power point had been isolated. The electrician then turned off the circuit breakers one by one and found SB-1 CB 9 to be the circuit supplying the power point label SB-1 CB 6. The fitter had two marks on their arm and was sent to the hospital for examination in relation to electric shock as per the mine's protocol. The ECG did not show an electric shock.	the Work Health and Safety (Mines and Petroleum Sites) Regulation 2014 for the surface of a mine. The standard requires circuits to be labelled and identified. Mines should confirm that isolation points are correctly identified.
Dangerous incident SinNot-2018/00346	A surface production drill rig had a hydraulic hose failure that released oil over an engine cover. Some oil caught fire, igniting from an exhaust pipe. A water cart was called and extinguished the fire.	Mine operators should ensure the maintenance and replacement of all hoses are identified and a system is in place to ensure they are changed at the appropriate time intervals.

Number of incident notifications, by commencement month and incident type



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.

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