

# WEEKLY INCIDENT SUMMARY

Week ending Friday 13 December 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	39
Summarised incident total	6

## Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
High potential incident IncNot0036237	A significant gas push from an active longwall goaf tripped power and forced the evacuation of an underground coal mine (under trigger action response plans [TARP] conditions). The gas appeared to come from a roof break in the goaf. Peak gas readings were 3.7% in the tailgate and 1.9% in the bleeder return heading. The longwall had pre- and post-drainage and the mine increased its post drainage suction after the event to manage the gas levels. The mine followed all withdrawal TARPs at the time of the event.	Effective gas drainage and main ventilation systems are essential for the control of gas and the safe operation of coal mines.  Withdrawal TARPs must be enacted immediately after alarms have been activated.  Mines should identify, through a risk assessment, all events that would require withdrawal of workers from the mine.

High potential  
incident  
IncNot0036250

A substantial amount of rock fell from a low wall in an open cut mine, hitting an excavator. The excavator was not being operated at the time of the incident and no workers were in the vicinity at the time the fall occurred.



Operators and supervisors should be trained in geological hazard identification and must implement effective controls including, but not limited to, installing catch berms, water management and set-back distances for parking up machines. The minimum controls implemented must be defined in the principal hazard management plan (PHMP) - taking into account the level of risk.

Dangerous  
incident  
IncNot0036275

Operators were fault finding on an Airtrack hydraulic circuit. Upon repressurisation of the load sense circuit (about 25 Bar standby pressure), an operator was hit in the neck by a quarter inch hydraulic hose and was covered in hydraulic oil. The operator was cleared of any fluid injection injuries.



Mine operators are reminded that when equipment is being tested after maintenance and repairs, effective no standing zones are to be put in place that remove workers from the line of fire if a failure occurs.

We have published the following safety alerts, bulletins and guides on this topic:

[SB13-01 Fluid injections result in surgery](#)

[SB12-03 Fluid power isolation failures](#)

[SA06-16 Fatal high-pressure hydraulic injection](#)

[SA09-04 Hydraulic injection near miss](#)

[MDG-41-Fluid-power-systems](#)

[MDG-40 Guideline for hazardous energy control](#)

Dangerous  
incident  
IncNot0036300

While installing a roof support on the longwall installation face, a fitting failed on the power take off (PTO) manifold block resulted in the fitter being sprayed with Solcenic oil. The fitter was standing about 50 centimetres away at the time of the fluid release. The procedure identified controls that would remove people from the area, however these were not implemented



When tasks cannot be completed in line with the procedures provided, workers must stop the task and, in consultation with their supervisor, implement additional controls to maintain an equivalent level of safety. The recommendations from IncNot0036275 (above) must also be considered.

Dangerous  
incident  
IncNot0036240

A PTO supply hose failed during a longwall installation. The hose was installed and pressurised for about five minutes before it failed. The failure occurred at the ferrule and was a clean break. No-one was hit by the release of fluid. The hose was sent for testing to determine the cause of failure.



With any equipment failure, the mine has an obligation to determine the cause to ensure a reoccurrence does not happen. The use of metallurgical specialist to assist mine personnel to determine causes is one method mines have of ensuring this is done thoroughly.

Dangerous  
incident  
IncNot0036277

An electrician was about to start investigating a fault on a magnet within a coal handling and preparation plant. He touched the magnet control panel located in a switch room and felt a shock across his chest. His other hand was touching earth.

The investigation identified the fault to be in an adjacent braking resistor panel that was connected to a variable speed drive (VSD). Following consultation with the original equipment manufacturer (OEM) it was identified that resistance between the braking resistors and earth was low and the cable earthing was incorrect for the installation. The resistors were replaced, and the cable earthing was corrected.

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.

Mines should ensure maintenance practices are suitable for the application and ensure cable earthing associated with VSDs meet the manufacturer’s specifications.

See [Safety Bulletin SB11-04 Electrical hazards associated with variable speed drives and earth fault current limited systems.](#)

**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.

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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (January 2020). However, because of advances in knowledge, users are reminded of the need to ensure that information upon which they rely is up to date and to check currency of the information with the appropriate officer of the NSW Department of Planning and Environment or the user’s independent advisor.

**DOCUMENT CONTROL**

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**Mine safety reference** ISR19-49

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