Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 7 November 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	54
Summarised incident total	6

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot-2018/01852	A worker was injured when he was hit by a hose. Two workers were trying to unblock a drain hose from a methane water trap. They broke the line and while one worker was holding the hose, the other worker tried to remove the blockage using compressed air. When the blockage cleared it discharged from the end of the hose with force. The worker holding the hose lost his grip and the hose whipped around hitting him in the jaw and the material hit him in the face. 	The risk of a hose whipping when applying compressed air is reasonably foreseeable. Put controls in place to address this hazard before starting work. Risk management tools must be used and should be appropriate for the task.

Dangerous incident SinNot-2018/01838	A fire occurred while diamond drilling in an underground metalliferous mine. An operator noticed gas spitting from a hole and the gas monitor started alarming. The operator saw flames coming from around the collar. The operator extinguished the fire using a hand-held extinguisher. The gas management trigger action response plan (TARP) was followed, which included retreating from the area and reporting the incident. Once cleared, work was resumed. The scene was not preserved and the mining engineering manager was not made aware until the following shift.	Where TARPs are in place related to notifiable events, clear, specific instructions must be included regarding scene preservation and notification to the appropriate personnel.
Dangerous incident SinNot-2018/01825	A fire occurred on a light vehicle in the decline of a metalliferous underground mine. Flames were seen coming from a vehicle's engine area by an operator following the vehicle. A radio call was made and the driver manually initiated the fire suppression system.	The risk of fires on light vehicles must be considered. Light vehicles should undergo the same assessments as heavy mobile plant. While the fuel load may be reduced, the risk to health and safety can be greater.
High potential incident SinNot-2018/01821	A painter suffered burns to his hands and face. The painter was cleaning out a pot by running thinners through lines and discharging thinners into an empty thinners tin. The thinners ignited in the tin with flames coming out of tin and causing burns to the painter's hand (through gloves) and the side of his face.	When working with flammable gases and liquids the potential for static energy should be assessed and suitable controls used to address the risk.

Dangerous incident SinNot-2018/01818	A buried energised electrical cable was severed while excavating at a quarry. The cable was known to be buried within the excavation area, however, the depth of cover was much less than expected. 	If the depth of cover is questionable, the depth should be confirmed before excavation begins. Any cables in the area should be isolated before starting to dig. Mines should keep surface infrastructure plans up to date.
Dangerous incident SinNot-2018/01802	An operator was assessed for a fluid injection injury at an underground coal mine. The worker was sprayed with hydraulic oil that ejected from the base of a feed cylinder on a hydraulic roof bolter mounted in a man basket on a load haul dump (LHD) vehicle. The worker was cleared of injury.	An update was provided at the recent Mechanical Engineering Safety Seminar by Dr Sean Nicklin, Hand Surgeon, Sydney Hospital, Prince of Wales & Sydney Children's Hospitals. Dr Nicklin's presentation is

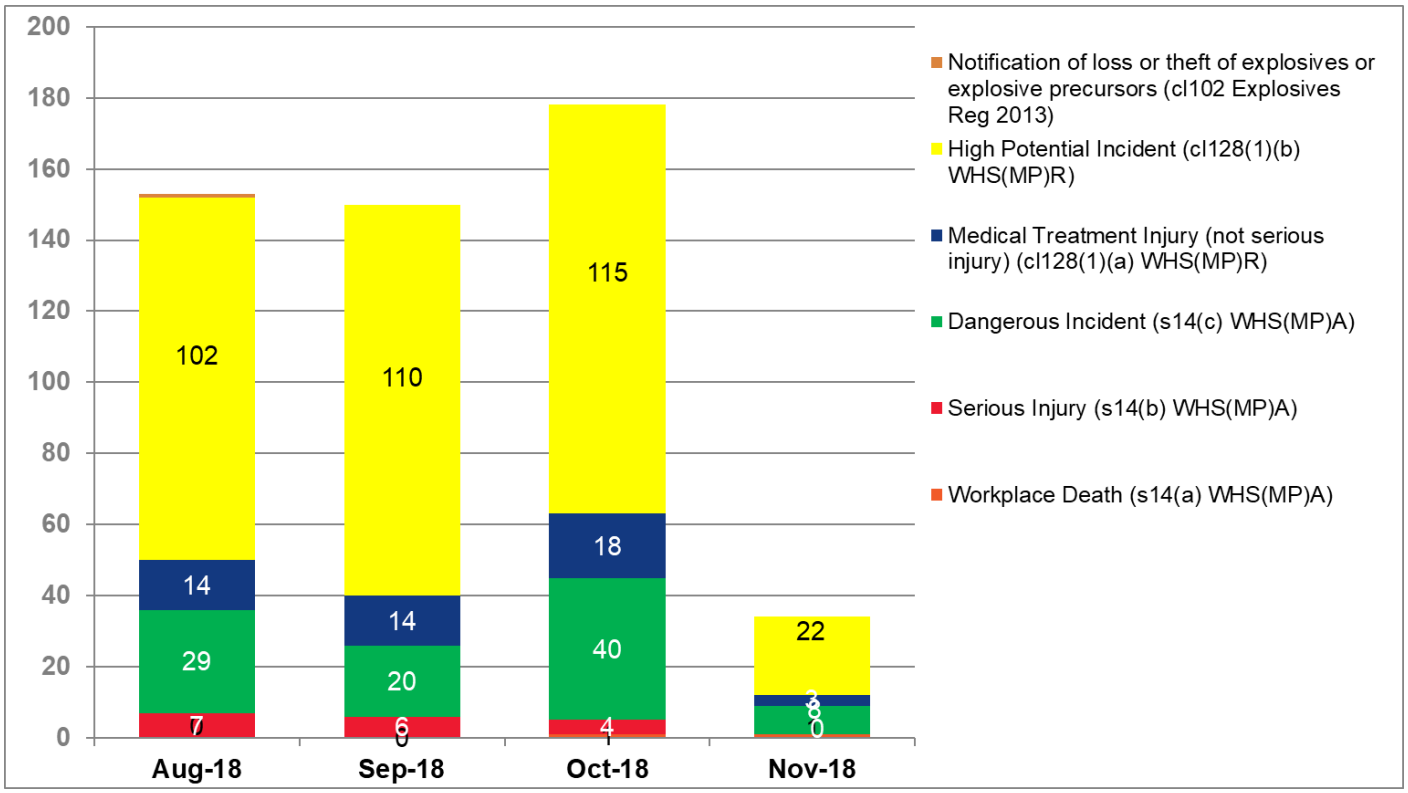
available here. Note, graphic content.

Resources Regulator recent publications

- → SA18-11 Controlling legionella bacteria in mining operations
- → SB18-17 Drill rig safety
- → SB18-18 Welding fume safety

Other publications of note

Publication	Issue / Topic
	International (other, non-fatal)
MinEx NZ	• **Lacerated thumb while installing splits** **An exploration drill assistant sustained a thumb laceration while inserting the HQ splits into the HQ inner tube.** **Details**
	National (fatal)
Komatsu	• **GSN0171 Underground – Aluminium components in pressure filter in Australia** During a machine overhaul, it was discovered that there are aluminium components inside the indicator and plug on the pressure filter (P/N 100410091). This aluminium is a prohibited material in underground coal mines in Australia.



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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