Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 24 October 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	63
Summarised incident total	8

Summarised incidents

Incident type	Summary	Recommendations to industry
High potential incident SinNot-2018/01753	Subsidence on an opal claim has developed and is creating an impact on a neighbouring claim.	Miners and prospectors must manage subsidence and other mining-related impacts from posing a safety risk to people on their title, on adjoining areas or members of the general public.
Dangerous incident SinNot-2018/01747	A lead acid battery was charged and reinstalled on a diesel fire pump. When trying to start the fire pump, it exploded. The battery exploded out onto the opposite side to the worker.	Safety bulletin SB16-02 Exploding lead acid batteries was issued previously. This bulletin must be reviewed by mines to determine if the risk is present at their operation.

High potential incident SinNot-2018/01741	While drilling a new shot pattern, a drill rig inadvertently drilled a new hole about 300 mm from an unknown misfire in the previous shot pattern. 	The procedure for locating and mapping out blasting patterns should include controls to prevent misalignment or overlap of patterns with previously shot ground. Additionally, blasting procedures should include inspections to identify misfired holes and the logging and communication to all relevant workers the location of these misfires.
Dangerous incident SinNot-2018/01740	A loader was putting rock into a dump truck when a large rock slid across the head board and fell. The rock bounced off a handrail and back onto the passenger's side window, smashing it.	Truck operators should always stay within the cab during loading activities. Trucks should not be overloaded and loads should be distributed appropriately.

Dangerous incident SinNot-2018/01736	At an underground metalliferous mine, a worker was sitting in a parked light vehicle with the lights and beacon on. An underground loader entered the same level and when it turned right it clipped the light vehicle. No workers were injured and minimal damage was reported. 	Schedule 1 of WHS (M&PS) Regs 2014 requires mines to implement controls to manage mobile plant including operator vision in *The principal hazard management plan for roads or other vehicle operating areas*. The hierarchy of controls places higher value on controls such as collision avoidance and proximity detection systems than procedural controls.
Dangerous incident SinNot-2018/01730	A dozer rolled on its side in an open cut coal mine at night. The dozer was reversing from the push at which time the left track moved over an embankment and the dozer slid backwards about 6.5 m coming to rest on the left track. The operator removed himself from the plant unassisted but suffered pain from the seat belt.	Suitable controls must be put in place to allow equipment operators to determine the safe limits of their work area. Deferring tasks to daylight hours or installing appropriate lighting should be considered when risks are present due to a lack of visibility.

Dangerous incident SinNot-2018/01728	Two workers fell when the platform they were working on dropped 1 metre to the floor. The workers were on a platform suspended off a monorail (Malibu) in an underground coal mine. Three roof bolts suspending the monorail pulled from the roof. There were no injuries reported. 	Workers installing support must be trained to identify poor strata conditions that affect the integrity of roof bolts. This can include: → 'jumping' drill steels → loss of chemical → changes in expected conditions. Procedures should direct mine workers to seek supervisor assistance and direction when encountering these conditions.
Dangerous incident SinNot-2018/01727	While driving down a decline in an underground metalliferous mine, a fire occurred on a haul truck. The operator heard a grinding noise and saw sparks on the rear vision camera. He immediately stopped the truck and investigated. The rear drive shaft centre bearing housing was glowing and he saw several small flames (up to 50 mm). The	Fires on mobile plant was addressed at the 2018 Mechanical Engineering Safety Seminar. The presentation can be accessed from this link.

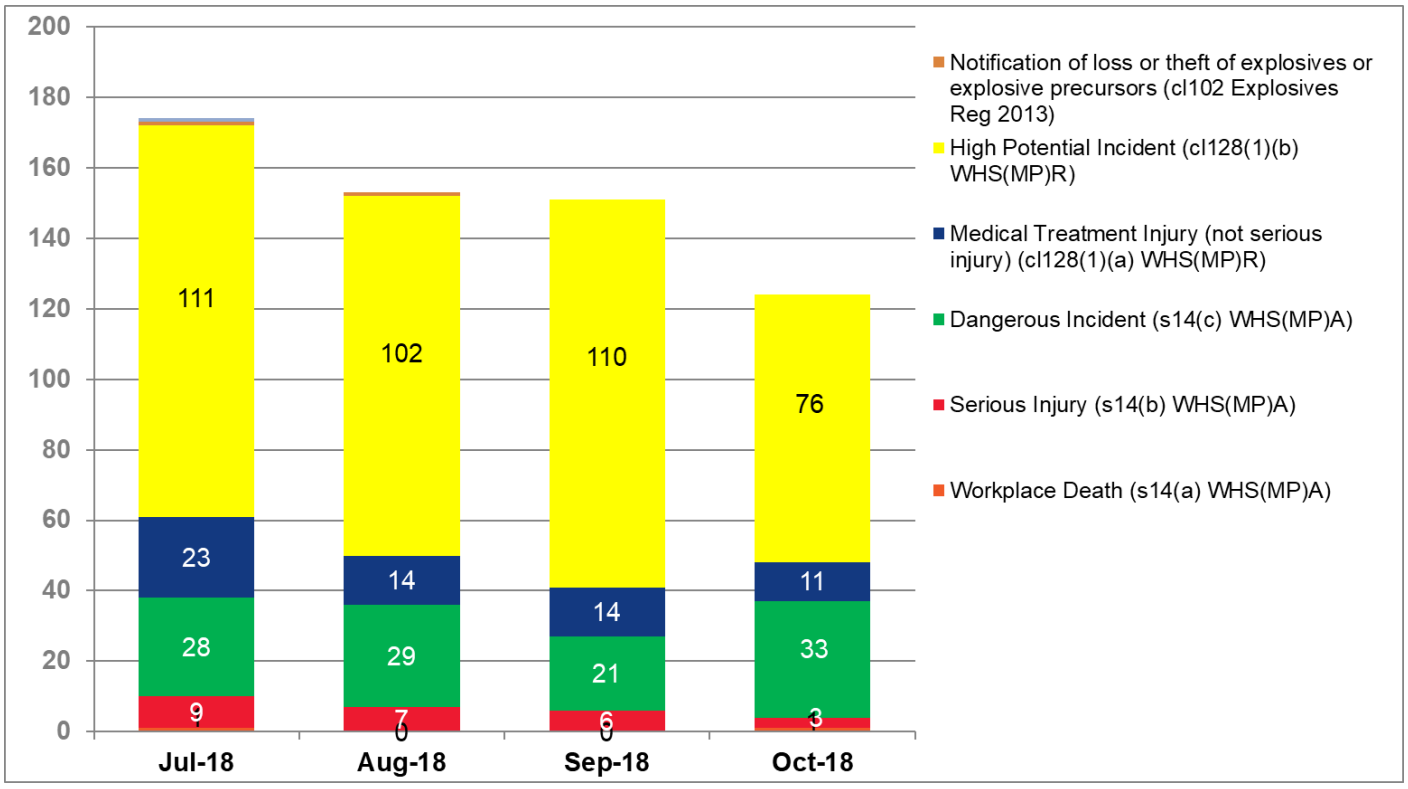
operator extinguished the flames using a hand-held fire extinguisher, raised the alarm and monitored the truck for any reignition.

Resources Regulator recent publications

- Safety Bulletin SB18-16 Detecting gas in confined spaces

Other publications of note

Publication	Issue / Topic
International (other, non-fatal)	
HSE	**Worker seriously injured while repairing machinery** A quarry operator has been fined after an employee had his hand and arm caught in a conveyor belt. • **Details**
MSHA in MinEx NZ	**MNM serious incident** On September 19, 2018, two miners were injured when a building partially collapsed during construction. One miner was transported to hospital and the other miner was treated at the mine and released. • **Details**
MinEx NZ	**Excavator falls off transporter** A contractor was transporting an excavator onto site to sort feature rock on a bench. While unloading the excavator from the transporter the operator felt the rear of the excavator move sideways resulting in the machine rolling off the transporter deck and landing on its side on the roadside bunding. • **Details**
National (other, non-fatal)	
WorkCover Qld	**Worker crushed under his own truck while unloading** In September 2018, a worker sustained serious crush injuries to his hand, leg, pelvis and torso, as well as a collapsed lung when he was trapped under the wheels of his truck while delivering timber and plasterboard. • **Details**
Littelfuse	**Littelfuse – Rechargeable battery in SE-330 Series products** This notice is to advise that recent revisions of the SE-330 Series products contain a rechargeable battery to power a real-time clock. This battery has not been tested to regulatory requirements for hazardous areas. If needed, the battery can be removed from the SE-330 Series products. The battery is not user serviceable and removal must be performed at either the Littelfuse factory, or Startco Pty Ltd, our authorized master distributor in Australia. Removal of the battery does not compromise the protection functions of the SE-330 Series product or cause the loss of device settings through power cycles.



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

Office use only	
CM9 reference	DOC18/812174
Mine safety reference	ISR 18-40
Date published	25 October 2018