Weekly incident summary

NSW RESOURCES REGULATOR

Weeks ending 3 & 10 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	47 & 56
Summarised incident total	4 & 3

Summarised incidents

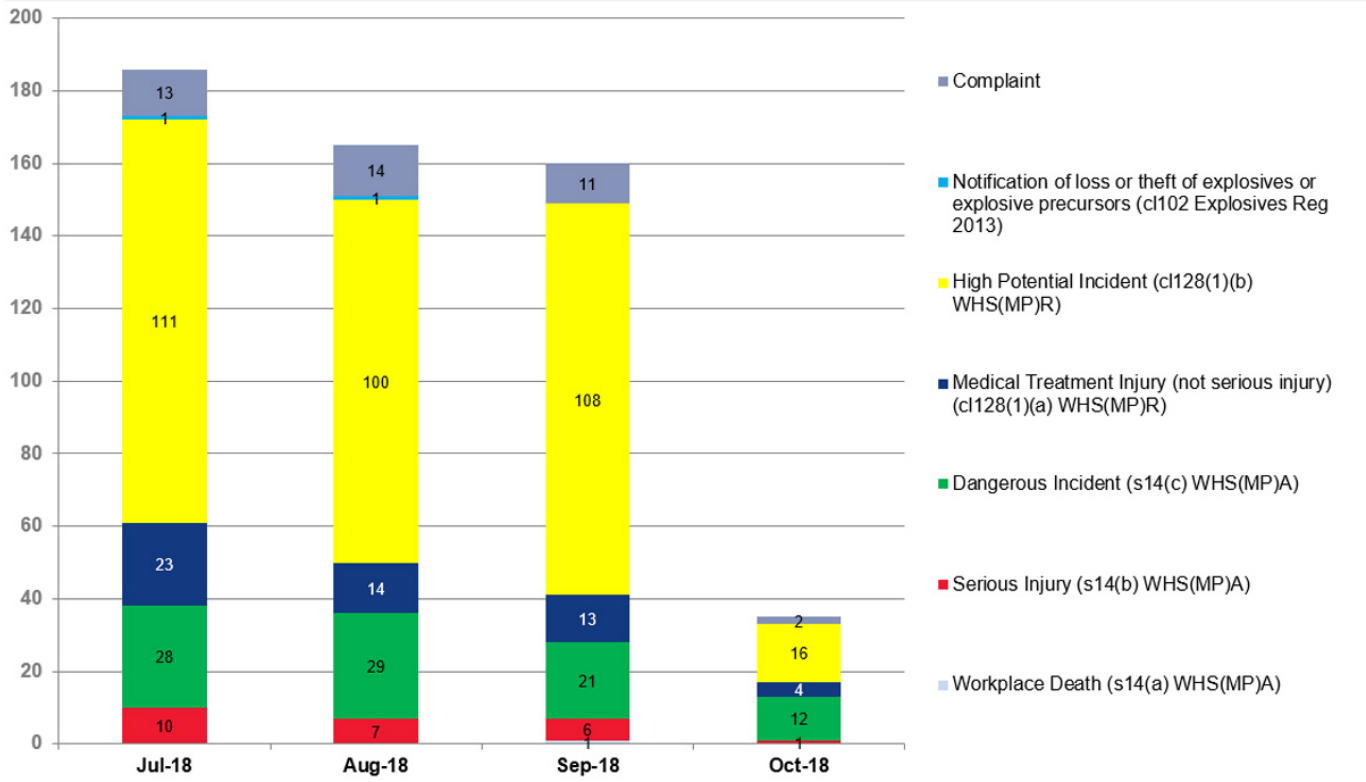
Incident type	Summary	Recommendations to industry
Dangerous incident SinNot-2018/01596	Several workers were hospitalised after lightning struck the ground 10 to 15 metres from their work area. One worker experienced tingling in the right hand, soreness in a left shoulder and ringing ears. Another reported arcing between his hand and the hand rail he had contact with at the time of the incident.	Mines must have a system in place including TARPs that minimise the likelihood of workers being exposed to the risks of lightning. The system must include a robust communication method with all workers on site and to consider to proximity of lightning strikes.
Dangerous incident SinNot-2018/01591	A worker fell 6 metres from a conveyor gantry he was working on at a quarry. The boilermaker had tack welded handrails in place. When a worker leaned on a hand rail it gave way and the worker fell onto a small sand stock pile. The worker landed face down. The worker did not lose consciousness.	When modifying or installing hand rails, stairs and walkways suitable controls must be in place to stop people falling from height. The hierarchy of controls must be considered when developing controls such as barricading, temporary hand rails, personal protection equipment (PPE such as harnesses, fall arrest devises). Work Health and Safety Regulations 2011 Part 4.4

Incident type	Summary	Recommendations to industry
	 	SafeWork NSW have published managing the risk of falls at workplaces code of practice.
Dangerous incident SinNot-2018/01578	A worker was sprayed with hydraulic oil while bolting on a continuous miner in an underground coal mine. The oil spray originated from the bottom of the bolting rig feed cylinder.	Fluid injection protocols have long been established and implemented at mines. Mines should review their protocols to confirm contact details and reference to specialists are still relevant.

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot-2018/01576	A 85 tonne excavator was at risk of falling 20 metres off a highwall in an open cut coal mine. The excavator was pulling a pipe along the top of the highwall when it was trammed onto the lip of the highwall. This caused the excavator to sink onto the track frame. 	Edges of highwalls must be bunded to clearly mark them. When people are working close to the edge of highwalls spotters should be used and there should be means to quickly stop an operator.
Dangerous incident SinNot-2018/01660	An underground metalliferous mine was conducting drilling operations in a decline using a cable bolter. During this task, an ignition of gas occurred creating a small flame in the roof.	The frictional ignition management plan must cover all methods of drilling, including strata support and exploration drilling and potential sources of ignition.
Dangerous incident SinNot-2018/01651	A worker's shoulder was dislocated and he suffered fractures when he fell from a mobile crusher at a quarry. The worker had unbolted one end of a platform. As the worker walked onto the platform it pivoted and when it stopped he fell to the ground.	When conducting work on platforms, walkways and stairs, procedures must be in place to determine what impacts each task/step will make to the stability of the item. Controls must be in place to prevent workers from accessing platforms, walkways and stairs while work is being conducted

Incident type	Summary	Recommendations to industry
		that affects the integrity of the structure.
Dangerous incident SinNot-2018/01639	A haul truck lost control at a metalliferous mine. The truck was descending a ramp when it lost traction, spun and made contact with a windrow, bringing the haul truck to a halt. 	Overwatering of mine roadways decreases tyre traction (skid resistance) and therefore increases braking time. With the onset of summer and increased watering, the recommendations from Safety Bulletin SB18-09 - Overwatering of roads leads to vehicle incidents should be reviewed and fully implemented.

Number of incident notifications, by commencement month and incident type



Recent Resources Regulator publications

- Investigation report into the serious injury of a worker at the Mt Arthur Coal Mine on 10 August 2017
- Learning from investigations (VIDEO): Refuelling mobile plant

Other publications of note

Publication	Issue / Topic
	International (fatal)
MSHA	**Coal mine fatality** On Tuesday, September 11, 2018, a mobile bridge conveyor (MBC) operator, with eight weeks of mining experience was fatally injured during the mining process. The continuous mining machine (CMM) and attached MBCs had been backed out of a completed cut. While the CMM was being repositioned, it moved the attached MBCs and crushed the victim between his MBC and the coal rib. **Details**

Publication	Issue / Topic
MSHA	**Coal mine fatality** On Friday, September 7, 2018, a 60-year-old haul truck operator with one year of total mining experience received burn injuries while attempting to escape from the cab of the burning haul truck he was operating. Due to complications associated with his injuries, the victim died five days later. **Details**
MSHA	**MNM Fatality** On July 31, 2018, a 62-year old foreman with 40 years of experience, was fatally injured while dismantling a portable crusher. The front-end loader was placing a 20-foot long steel tube onto the screen feed conveyor. The front-end loader operator lowered the bucket and crushed the victim against the conveyor structure. **Details**
	International (other, non-fatal)
MSHA	**MNM Serious Accident Alert | Surface Crushed & Broken Granite** On August 9, 2018, a miner was injured when the pan scraper he was operating stalled, travelled through a berm and rolled over a bench. The operator of the pan scraper was wearing a seatbelt and was able to escape with a cut arm. **Details**
	National (other, non-fatal)
WA dept. of Mines	**Near miss when accumulator components are ejected from haul truck** In May 2018, workers were exposed to potentially serious or life-threatening injuries when disassembling a haul truck's hydraulic accumulator. **SIR No. 268 Details**
WA dept. of Mines	**Inspecting synthetic fibre round slings** Round slings made of synthetic fibres are a type of lifting gear in common use at mining operations. They may be used for lifting suspended loads, either alone or in combination with other lifting gear. **MSB No. 155 Details**

Weekly incident summaries available online

PDF versions of the weekly incident summaries are available on the NSW Resources Regulator website. A spreadsheet of all notifiable incidents that have been published since 4 December 2015 is also available. Click here to view the archive and the spreadsheet.

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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CM9 reference	DOC18/758846
Mine safety reference	ISR 18-38
Date published	12 October 2018