Weekly incident summary

Planning & Environment
Resources Regulator

Week ending 20 September 2017

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

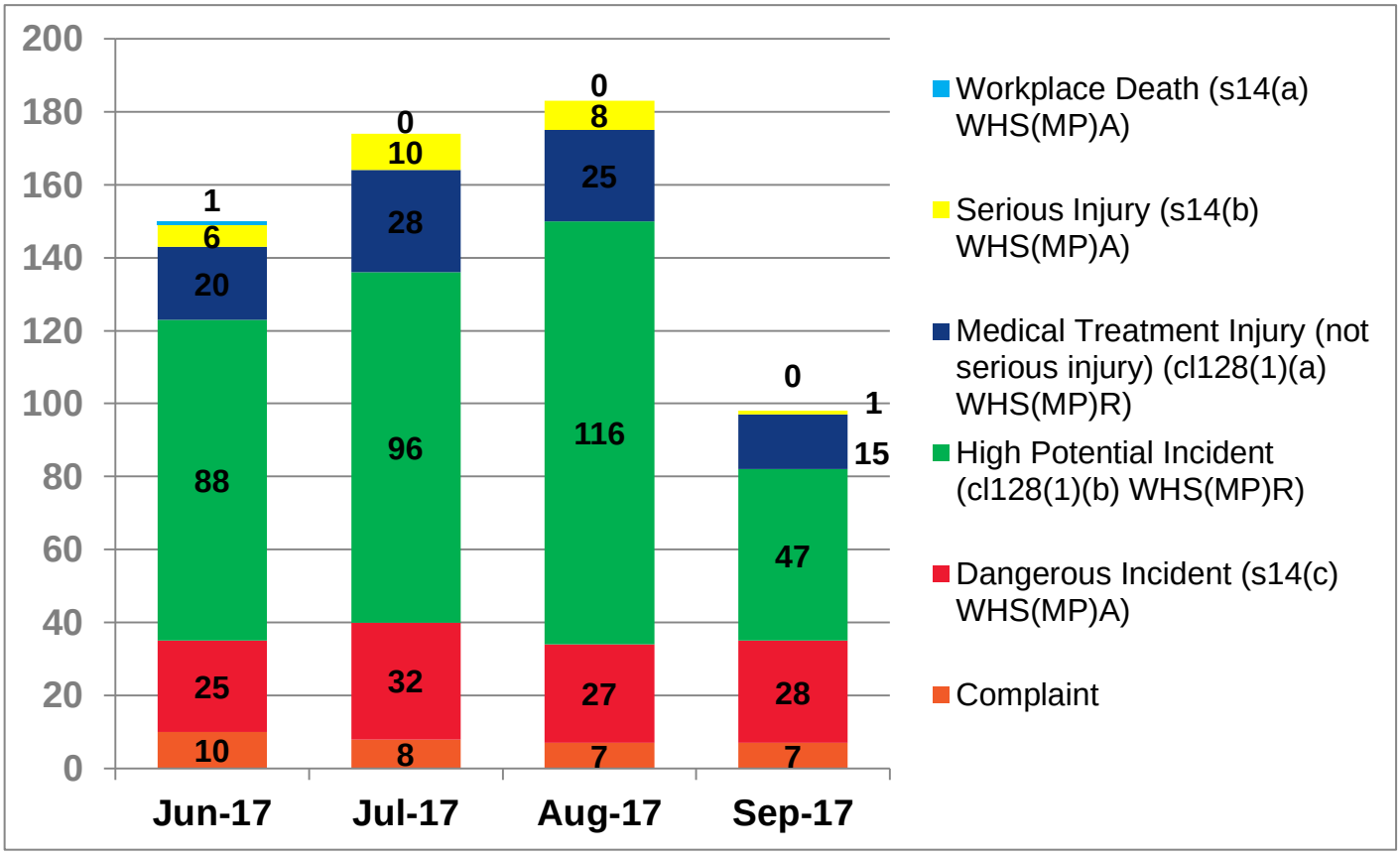
High level summary of emerging trends and our recommendations to operators.

Type	Number
Reportable incident total	38
Summarised incident total	5

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot 2017/01482	A fitter was driving a light vehicle to a workshop on a recently watered haul road. The driver lost control and skidded for some distance before rolling the vehicle onto its side. The driver was uninjured.	There have been a number of recent incidents that have resulted in light vehicles rolling over. Mine operators should consider if a road rule/control 'drive to conditions' is sufficient for wet and/or slippery roads or sections of roads.
High potential incident SinNot 2017/01481	A gas exceedance was reported at an underground coal mine. Planned works were being undertaken that involved removing power from underground booster fans and a tailgate real-time gas monitoring point. A separate task was also being undertaken on the gas drainage plant. A tube bundle sample point in the tailgate detected the exceedance. The source of the methane appears to be seals around the longwall 30 recovery area, two of which were incomplete. Methane peaked at 4.04%. Withdrawal of underground workers was delayed but completed. Upon restart of gas drainage plant and booster fans, gas levels fell to normal levels.	Mine operators should consider if a planned task being undertaken may have any effect on other non-related planned tasks. This is especially so when one or more of the tasks may affect the ventilation in the mine. Mine operators should review their gas monitoring alarm response, control room operator training and withdrawal trigger action response plans to ensure that appropriate responses are implemented as quickly as possible following a gas alarms.
Medical treatment injury SinNot 2017/01500	A truck driver was cleaning the draw bar of a dog trailer with the body of the truck raised and the hoist control in the down position. The truck body stayed up and the tailgate rested on the material he had just tipped. As the driver reached in to flick a	This incident could have easily resulted in serious injuries or death (refer to IIR16-08 Fatality after being struck by truck tailgate) Mine operators should: • remind all truck operators (including contractors) of the hazards associated

	rock off the draw bar, the truck body suddenly dropped causing the tailgate to come free and strike the driver on the head. The driver fell and hit his head again. He suffered cuts to his head and was taken to hospital for treatment.	with putting body parts between the tailgate and truck trays • reinforce and communicate to workers the recommendations in IIR16-08 • ensure workers are trained in recognising the hazards associated with gravity and the controls that should be used.
Dangerous incident SinNot 2017/01499	An operator in the area of a fuel farm was sprayed with a fine mist of diesel fuel when the seal on the main delivery line failed. The pump was not running at the time of failure, however there was residual pressure in the line. The operator was not injured.	Mines are reminded that during maintenance, the original equipment manufacturer's recommendations should be followed. In this case, a sealant incompatible with the hydrocarbon was used. The sealant reacted with the hydrocarbon allowing the gasket to be ejected under pressure. When tightening a series of flange bolts it is essential that all bolts are torqued equally to the required tension in the appropriate order. Good practice is to mark bolts to confirm they are tight.
Dangerous incident SinNot 2017/01465	A coaltram was reversing down a roadway with a quick detach system water cart attachment. The diversion valve was operated, lifting the water cart, which hit a high voltage cable. Power dropped to the circuit breaker. No one was injured.	All cables should be installed in locations where the possibility of damage is minimised. They should be installed either: • in roadways that are not used for material transportation • at heights above those required for material and transport movements, or • by installing guards over the cables. Mine operators should ensure that where cables pass under, over or through, obstructions, such as air and water pipes they are positioned in a way that they are not likely to be damaged. Protection relay settings should be set to achieve the quickest operating times at the lowest values that would allow for reliable operation.



Recent publications

- IIR17-12 Unintended movement of conveyor boot end unit
- Targeted intervention program consolidated report – gas outburst risks in longwall mining
- Airborne contaminants – open cut mines
- Airborne contaminants - metalliferous mines
- Diesel exhaust emissions - underground coal mines
- Fire and explosion risks - underground coal operations

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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Mine safety reference	ISR 17-37
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