Weekly incident summary

Planning & Environment
Resources Regulator

Week ending 23 August 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	44
Summarised incident total	8

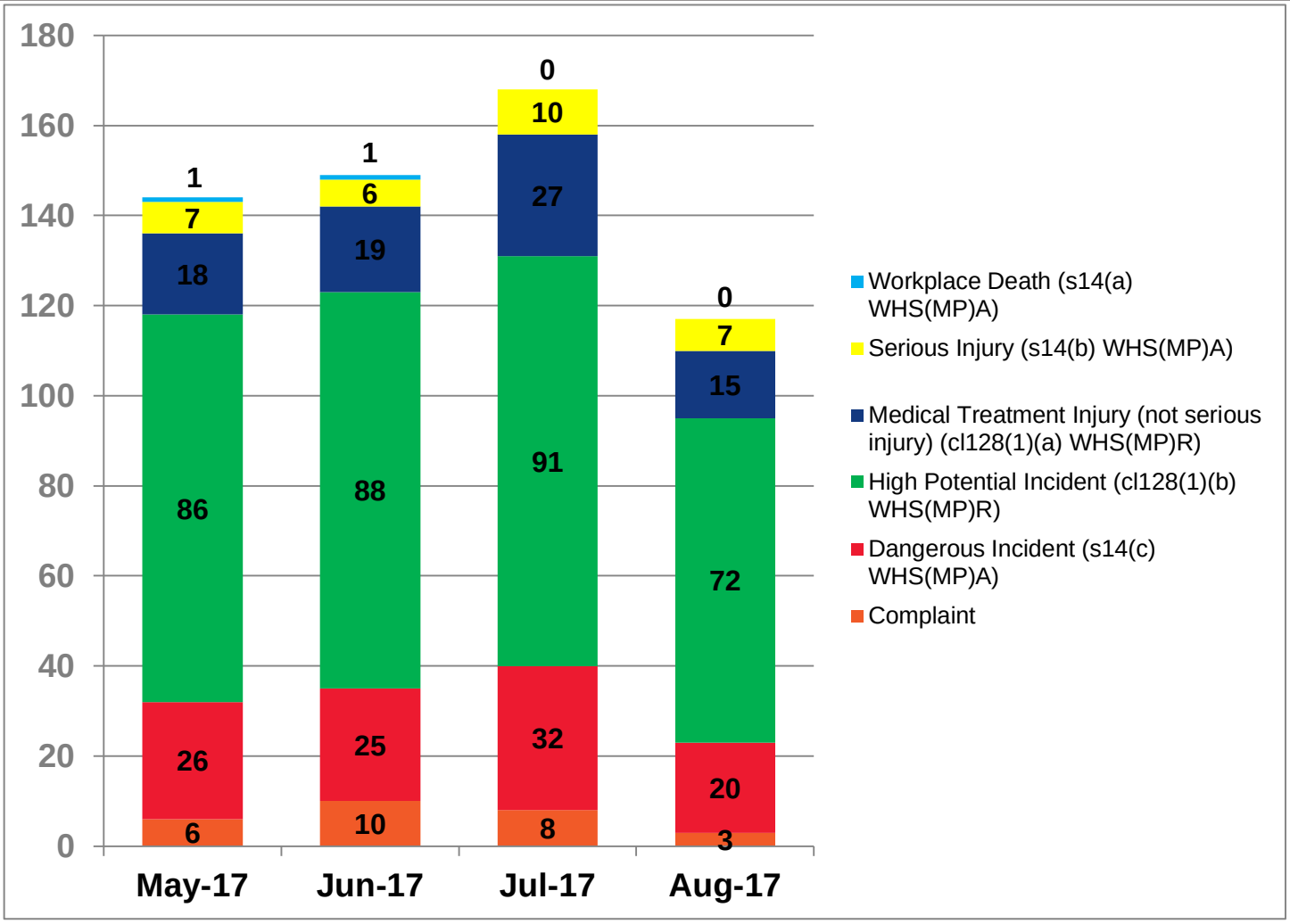
Summarised incidents

Incident type	Summary	Recommendations to industry
High potential incident SinNot 2017/01304	A fire occurred on a turbo charger of an excavator. This was caused by the turbo oil feed hose being compromised by heat from a previous turbo fire incident two days earlier, allowing weeping oil onto the turbo housing. The fire was extinguished by the operator using a hand held extinguisher.	Fires on mobile plant require thorough investigation by a competent person to determine: • fuel source and heat sources • the cause of the fire • controls to prevent re-occurrence such as reducing engine component surface temperatures and segregating fuel sources from areas of high temperature and fire safety inspections. Ancillary forms must be submitted for fires on mobile plant. All repairs must be carried out by a competent person and appropriate checks to ensure the mobile plant is fit for use.

Serious injury SinNot 2017/01306	A worker was replacing a drill stem. The top of the drill pipe swung and struck him above right eye, knocking him off his feet. The worker suffered a cut above his right eye. The mine's first aid personnel treated the injury. Ambulance attended the site and transported the worker to hospital.	This incident is a reminder to ensure: • operational risk assessments include documented safe work procedures for the replacement of a drill stem which are readily available • workers are not exposed to hazards of rotating drilling equipment. Numerous entanglement injuries have been reported in recent years • effective guarding to protect from entanglement is installed, where reasonably practicable • drill rig operators are trained • pre-operational checks and hazard identification systems are used.
Dangerous incident SinNot 2017/01283	A worker was operating a tilt tray truck for delivering shotcrete materials to site. When the driver was alighting from the vehicle the truck moved forward hitting a rock wall. The driver suffered an injury to his left knee.	Lessons that should be communicated through took box talks include: • compliance with correct parking procedures at all times • being situationally aware of hazards. Mine operators should consider: • audible warning systems audible and/or visual alarms that warn of the lack of park brake application • interlocking that automatically applies the park brake when the operator leaves the operator's positon (ie door interlock). functional testing of park brake application warning systems • the recommendations in SB13-02 Unplanned movements of vehicles - too many near misses
Critical incident SinNot 2017/01276	A worker was fuelling a tyre handler from the cap on the top of the tank from the main fuel farm delivery point. The fuel ignited and resulted in a fire covering an area from the tyre handler to the fuel distribution point. The worker suffered serious burns.	The regulator's Major Investigation and Emergency Response team is investigating the incident. High flow refuelling systems should not be used on mobile plant, which is not designed to accept high flow fueling systems. Refer to the Investigation Information Release Mt Arthur serious injury fire and the recommendations in safety bulletin SB15-03 Fires ignite while refuelling mobile plant with quick-fill fuel systems.

Dangerous incident SinNot 2017/01301	When an articulated dump truck reversed to the topsoil dump, the left hand side of the trailer mounted some previously dumped material and rolled over.	Mine operators should identify all work activities on the mine site where trucks are used and review control measures for truck rollovers. This should consider the following risk controls to prevent a truck roll: • tipping areas should be level without cross grades • tipping areas should be stable, and capable of withstanding the truck wheel pressures and not prone to subside. The recommendations in safety bulletin SB17-01 Industry reports more truck rollover incidents should be considered.
High potential incident SinNot 2017/01289	A series of methane exceedances have been notified to the regulator at a number of underground coal mines. The exceedances were related to development operations where methane has accumulated due to changes in face ventilation. In all instances, the Deputy withdrew workers from the area, degassed the face by restoring adequate ventilation and purged electrical equipment before restoring power.	Mine operators are reminded that where background methane levels are high, caution needs to be exercised during all ventilation changes and ventilation work. This should include procedures for establishing ventilation to faces when auxiliary ventilation is stopped. Mine operators are reminded to ensure de-gassing procedures are in place and that they should include methods to purge electrical enclosures from potential explosive concentrations of gas.
High potential incident SinNot 2017/01291	A series of methane exceedances have been notified to the regulator at a number of underground coal mines. The exceedances were related to longwall operations associated with production activities.	Mine operators are reminded of the obligation under WHS (MPS) Regulation clause 72 to ensure methane levels in the general body are as **low as reasonably practicable** and not greater than 2% by volume. Production activities should to be appropriately monitored to so that production activity can be modified where increasing methane trends are detected. This can be achieved through the application of appropriate trigger action response plans and implementation of documented cutting sequences into the tailgate roadway.
High potential incident SinNot 2017/01307	The regulator was notified of a methane gas exceedance due to a major barometric fall. The falling barometer has resulted in an increase in methane being liberated into the accessible roadways of the mine.	Major barometric falls are a reasonably foreseeable event due to the availability of short-term monitoring and prediction available from the Bureau of Meteorology. A significant barometric fall can result in the ventilation system of the mine not being able to deal with the additional gas make.

		Mine operators are reminded of the effects a falling barometer can have on sealed goaf areas and methane levels. Mine operators should prepare appropriate trigger action response plans supported by both real-time and predictive services to understand barometric trend and magnitude and so provide adequate time to allow the implementation of mitigating controls to minimise a potential increase in methane gas levels more than 2%. Such mitigating controls may include: • ventilation changes • halting production • increasing gas capture • a combination of mitigating controls.



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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