Weekly incident summary

Planning & Environment
NSW GOVERNMENT Resources Regulator

Week ending 30 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.

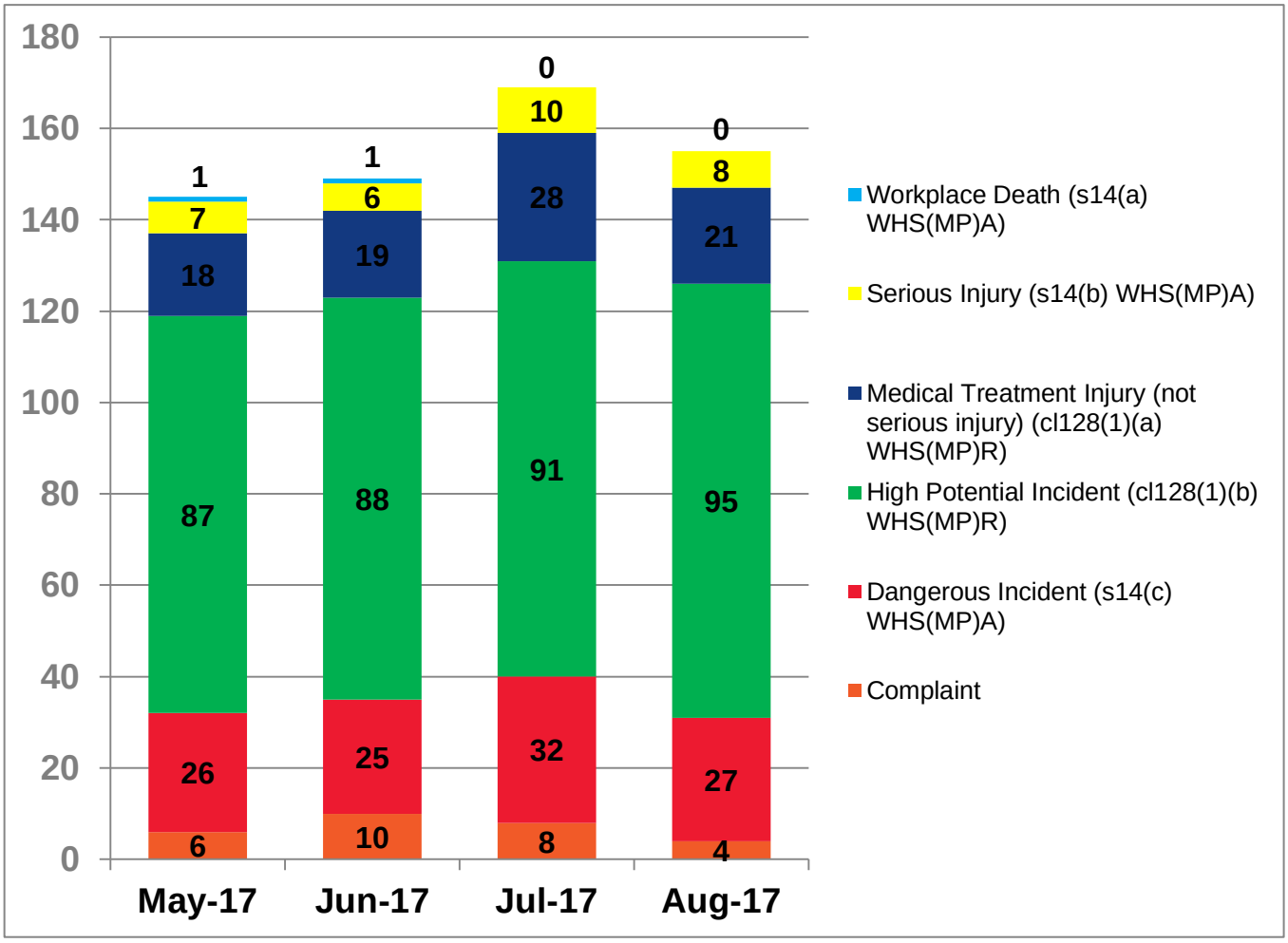
Type	Number
Reportable incident total	51
Summarised incident total	9

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot 2017/01345	Approximately 2 tonne of rock fell from a berm about 10 m onto a 120 tonne excavator, damaging the walkway on the excavator.	'Catch trenches' or other controls should be in place and properly maintained to protect people from the risk of falling face material when mobile plant are operating near high-risk areas. Supervisor daily pit inspections should ensure that the catch trench is in place and maintained. Blasting techniques should be designed (in consultation with blasting contractors and supply engineers) to reduce excessive back break so as to control excessive 'hung up' material. Operators and supervisors should be trained in geological hazard awareness.
High potential incident SinNot 2017/01343	A drill rig was drilling on the surface and trammed over a light vehicle parked on the drill pattern. The vehicle was parked approximately 50 metres away from the drill by another operator. The drill trammed forward, hitting the light vehicle and running over its rear tray.	Mobile plant, including light vehicles, must be parked in accordance with site procedures. Workers should be trained in site park-up procedures. Regular site safety observations should be performed by supervisors to ensure compliance with site procedures. Collision avoidance technologies should be considered.

Dangerous incident SinNot 2017/01342	An operator was adjusting the cable reel anti-whip valve on a shuttle car with a spanner when he suspected that his right hand was injected with pressurised fluid. The operator was assisting with a belt move and was adjusting the amount of cable on the shuttle car reel.	Adjustment of hydraulic pressures should be performed by people trained and assessed as competent for the task. This is normally a mechanical tradesperson (fitter). Mine operators should have a protocol in-place with how to deal with and manage a suspected fluid injection. These protocols need to be communicated and followed whenever an injection is suspected.
Serious injury SinNot 2017/01356	A mine worker had a metal shard lodge in his lower lip after hitting a drill steel with a 2 kg hammer. The worker was drilling through floor concrete with a panther bolting machine when the drill steel jammed. The mine worker then attempted to lift the panther off the drill still but found the drill steel was also jammed in the panther. He has then 'tapped' the drill steel with the hammer in an attempt to release the drill steel.	All mine workers should be reminded of the dangers associated with the use of hard metal tools, including contact with hard metal surfaces. Stuck drill steels in drill chucks are reasonably foreseeable. Fit-for-purpose tools and equipment, work procedures and training should be provided to workers, including overcoming stuck drill steels.
High potential incident SinNot 2017/01318	Detection of methane exceeding 2% in the general body of air. Maximum level CH4 was 2.5% in bleeder road because of a drop in barometric pressure.	Ventilation officers are reminded that major barometric falls are a reasonably foreseeable event that should be addressed in the ventilation control plan. Barometric trending should include both the effects of diurnal barometric change as well as major barometric events. To assist in determining barometric trend, barometric monitoring should be installed. Mine operators are reminded of the effects a falling barometer can have on sealed goaf areas, and hence methane levels in accessible roadways. 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%.
Dangerous incident SinNot 2017/01339	A small fire was reported in the engine bay of a truck in an underground metal mine. The automatic fire fighting system deployed and immediately extinguished the fire. Component failure of upper drive shaft	The hazard identification and control of fires on mobile plant should be carried out in accordance with AS 5062:2016 *Fire protection for mobile and transportable equipment*. Fires on mobile plant require a thorough

	universal joint causing excessive lateral movement and vibration to output yoke. This has in turn caused failure of the output seal of the torque converter. The high turning speed of the drive shaft has caused the oil to splash up onto the heat shields beneath the exhaust piping. The oil has caught fire from the high temperature exhaust.	investigation by a competent person to determine: • the 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.
High potential incident SinNot 2017/01351/01335	A number of longwall tailgate methane levels were detected at greater than 2%. Falling barometric pressure along with the longwall shearer in the tailgate zone for extended period caused goaf flushing.	Production activities should be appropriately monitored and 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 2017/01332	While conducting a pre-shift inspection, an undermanager detected methane levels greater than 2%. The maximum level found was believed to be 2.7%. The workforce was withdrawn from the area.	Decommissioning booster fans coupled with a falling barometer and the distribution of ventilation in roadways in the vicinity of affected seals was inappropriate to adequately dilute gas from some of the seals resulted in the reported gas exceedances. Personnel must be withdrawn consistent with trigger action response plans.
High potential incident SinNot 2017/01320	While in the process of starting a forklift on the surface, an operator could not get the forklift to respond to the accelerator pedal despite going through the correct start-up sequence. The operator repeatedly removed and reconnected the seatbelt in an attempt to get the forklift to respond. On about the seventh attempt the operator noted that with the seatbelt disconnected in his hand the forklift propelled itself forward about 2 m without operator input. The forklift was bought to rest through the application of the foot brake. No personnel were placed at immediate risk at the time of the incident as no-go zones were in place.	Forklifts used on mine sites must be maintained and serviced at regular intervals and should be subjected to operator pre-start checks. Issues identified with control systems, over-revving and unintended activations and unplanned movements must be fully investigated and the root cause identified. The forklift should be repaired to maintain safety. People operating forklifts must hold high-risk work licence.



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.

Recent publications

- Causal investigation preliminary report

Disclaimer

The information contained in this publication is based on knowledge and understanding at the time of writing. However, because of advances in knowledge, users are reminded of the need to ensure that information on which they rely is up to date and to check the currency of the information with the appropriate officer of NSW Department of Planning and Environment or the user's independent advisor.

Office use only	
RM8 reference	PUB17/574
Mine safety reference	ISR 17-34
Date published	31 August 2017