NSW GOVERNMENT

Weekly incident summary
Mine Safety News
Emerging trends, reportable incidents and safety advice

NSW Resources Regulator

Week ending 15 March 2019

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 call **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	29
Summarised incident total	5

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident IncNot0034149	During a planned shutdown for the relining of a mill, a maintenance worker was slowly working the mill in an anticlockwise direction. The mill was stopped on completion. The crew saw the mill begin to move in a clockwise direction and increase in speed. The brake failed, followed by a loud bang and then metal parts were ejected from the brake unit up to a distance of 65 metres away. No workers were in the line of fire. 	During maintenance activities the mill became unbalanced, causing it to rotate. Unbalanced loads must be considered as a potential energy source when completing and isolating work areas.

Dangerous incident IncNot0034134	The operator of a 50T truck was travelling down the decline in a metalliferous mine when the truck dropped out of gear, causing the operator to lose control and hit the driver's side with the decline wall. The truck operator did not suffer any injuries, but the truck was damaged.	Defects that effect the safe operation of vehicles that are found during pre-use inspections and while operating must be reported and repaired. Mine operators should review pre-use inspections to include the immediate park up of equipment with safety-critical defects.
Dangerous incident IncNot0034122	A major fire occurred on an excavator. The machine had been back in service for one hour after maintenance. After the fire began, the suppression system activated and four water carts were used to control the fire. An internal fire continued, requiring the emergency response team to put out the fire. No injuries were reported. 	This event is being investigated. Mine operators must treat the recommissioning of equipment after maintenance as equally important as the planning and completing of the maintenance itself. An inspection of potential fuel sources in the machines, such as rags, should be carried out.
Dangerous incident IncNot0034116	A worker was hit on the face with high pressure fluid during live testing on a haul truck hydraulic hoist in a workshop. The worker was hit on the right-hand upper neck and right-hand jaw and cheekbone area. The worker was assessed and cleared of an injection injury.	Workers should inspect all components used during maintenance. All equipment used should be verified that it is correctly rated. High-pressure fluid power systems should be treated with the same respect as high-voltage electricity. The number of high-pressure fluid incidents in the industry remains too high.

		Further information relating to fluid-power systems can be found in MDG's 40, 41 and 3007
Dangerous incident IncNot0034115	An excavator rolled over onto its side in an open cut dozer push area after a track went over a 0.5 metre to 1 metre drop. The operator suffered a 20 mm cut to top of his head and was able to extract himself from the machine. 	Operators must inspect work areas before starting any task. Appropriate actions must be taken if the conditions pose a risk to people or equipment

Other publications of interest

The incidents are included for your review. The NSW Resources Regulator does not endorse the findings or recommendations of these incidents. It is your legal duty to exercise due diligence to ensure the business complies with its work health and safety obligations.

Publication	Issue / Topic
	International (fatal)
MSHA	**Coal mine fatality** On Wednesday, October 17, 2018, a 33-year-old auger helper with three days of total surface mining experience suffered fatal injuries during auger mining activities. The worker was attempting to move a section of auger steel by using an onboard crane when he was struck in the chest. **Details**
	International (other, non-fatal)
MSHA in MinEx NZ	**Worker seriously injured in fall at surface goldmine** On 22 October 2018, a contract employee fell 6 metres during the installation of a building roof at a mine. The employee landed on a concrete floor and was seriously injured. Investigators found the cable in the self-retracting device that the employee was using had broken near the load-end clip. The investigation determined that the

	device was used incorrectly. The device was designed to be used overhead with 0 degrees of swing fall, as stated on the label. However, at the time of the accident, the device was anchored so that there was 90 degrees of swing fall. **Details**
DNRME in MinEX NZ	**Uncontrolled upward movement of drill string** Two similar incidents have occurred on separate drill rigs in separate operations within a 12-month period. In both cases, while the rig was drilling out the surface casing shoe, the drill string was lifted out of the hole causing significant damage to the rig with the potential for serious injury or a fatality. Both incidents appear to be caused by the drilled surface casing plug lodging between the drill string and the 9-5/8” casing, blocking the tight clearance. This prevented drill fluids from circulating and caused an increase in the circulating pressure. This resulted in hydraulic pressure forcing the drill string to be lifted out of the hole. **Details**
MinEx NZ	**Damaged power cable** Pressure release (high pressure, electricity, explosive atmospheres) are a major cause of fatalities in the extractives sector, both in New Zealand and internationally. Mechanical errors from improperly used or malfunctioning mining tools (such as safety lamps or electrical equipment) are common causes of fatality and serious injury. **Details**
DNRME in MinEX NZ	**Fatal incident as bulldozer overturns into pit (update)** On Monday 31 December 2018 at 10.30pm, an experienced 49-year-old coal mine worker was fatally injured while operating a bulldozer at an open-cut coal mine near Dysart, Central Queensland. The bulldozer was traversing-with the blade not in contact with the ground-along a bench in an area where three bulldozers were pushing overburden material. The bulldozer being operated by the worker went over the bench's crest and rolled downwards approximately 20 metres. The reason for this is yet been determined, but the bulldozer came to rest on its roof in an area of mud and water about two metres deep. **Details**
	National (other, non-fatal)
DMIRS	**Near miss** A near miss occurred when a failed rod ejected from a hydraulic pulling kit. Workers were exposed to potentially serious injuries when using hydraulic tools to extract pins from articulated joints on heavy earthmoving machinery. Recent examples include:

	1. In September 2018, a 13 kg pulling rod failed and was projected approximately 26 metres during pin cartridge removal from the boom of a front-end loader. 2. In January 2019, a 19 kg pulling rod was projected approximately 25 metres and embedded itself into the workshop wall, during removal of bucket pin on a front-end loader. Publish **Details**
WorkSafe Vic in MinEx NZ	**Safety when working in confined spaces** In October 2018, an apprentice died while working in an open-ended tanker. WorkSafe is still investigating the causes of this incident, including whether the apprentice was in fact and at law working in a confined space but in the meantime, we remind you of the dangers of working in confined spaces. A confined space means a space in any vat, tank, pit, pipe, duct, flue, oven, chimney, silo, reaction vessel, container, receptacle, underground sewer or well, or any shaft, trench, tunnel or other similar enclosed or partially enclosed structure, which meets certain conditions set out in regulations. **Details**

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

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.

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