NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 16 August 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: 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	32
Summarised incident total	3

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Fatality IncNot0035311	A dozer and light vehicle collided at a mineral sands mine. The light vehicle operator was fatally injured during the incident.	Investigators and inspectors attended the incident site. The Regulator has commenced a major investigation, and an initial investigation report will be released in the next week.
Dangerous Incident IncNot0035328	A secondary haulage shaft winder apparatus was being tested. The skip was being operated in manual mode when the top of the skip contacted the stops in the headgear. Cause reported to be positive communication failure between the worker controlling the slow raise test and the winder driver. Secondary means of egress was available for workers underground.	Communication protocols must be adhered to when winding systems are being operated manually during testing or maintenance.

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous Incident IncNot0035336	 The operator of a mobile crushing unit smelled smoke. On further examination, the operator observed flames coming from the battery compartment. The operator shut down the unit and used a single hand-held extinguisher to put out the fire. Initial investigation indicates that a belt guard had become loose and contacted the battery terminals, causing a fire.	Plant that is subject to constant, heavy vibration must be appropriately inspected and maintained. Mine operators should consider all risks associated with the placement and guarding of lead acid batteries fitted to such plant.

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	**Open pit, non-metal (sand and gravel); Final report** On 18 May 2019, a 35-year old plant operator with eight years' experience, died after falling 28 feet from the basket of a personnel lift. The worker was using the personnel lift to access a cone crusher feed box to clear a stoppage. He was wearing a fall protection harness with a retractable lanyard, but the lanyard was not attached to the basket's tie off points. Details

PUBLICATION	ISSUE/TOPIC
MSHA	**Mine fatality alert** On 31 July 2019, a 62-year old contractor with 30 years mining experience sustained fatal injuries when three methane ignitions occurred in an air shaft. The victim and three contractors were preparing to seal the intake air shaft of an underground mine. At the time of the ignitions, the victim was trimming metal so that it would fit inside wooden forms and was in direct line of the ignition forces. Details
International (other non-fatal)	
MinEx NZ	**Bench failure** A bench above an area containing a compressor and generator began fretting. On inspection, some significant cracks had appeared in the bench. The toe of the bench was immediately bunded and an exclusion zone was put in place. Drainage was also installed on the bench to drain water away from cracks. Details
National (other, non-fatal)	
DNRME (QLD)	**Preliminary observations on North Goonyella - High potential incident** On 1 September 2018, all coal mine workers were withdrawn from the underground workings at North Goonyella Coal Mine as a precautionary measure in response to rising methane levels at the longwall. In the hours that followed, the mine's spontaneous combustion triggers were reached, escalating the level of risk. The inspectorate started gathering relevant information in November 2018 and formally commenced its investigation in January 2019, after the site was stabilised. The scope of the investigation is to analyse events leading up to this high potential incident, which resulted in the withdrawal of workers. 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.

DOCUMENT CONTROL	
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