NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending 22 and 29 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: 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.

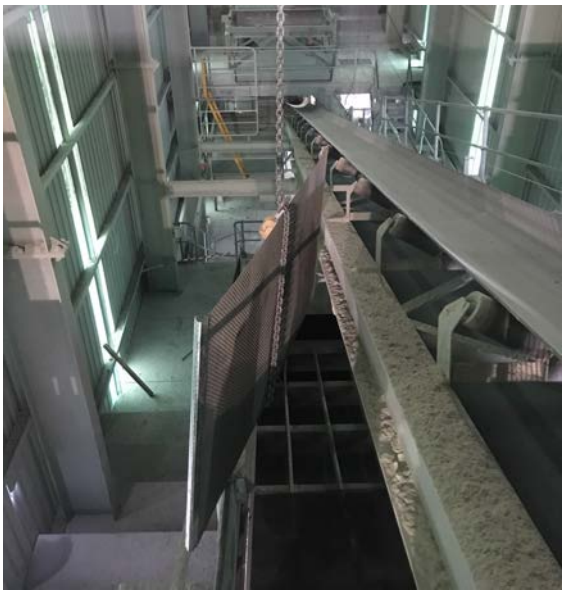
TYPE	NUMBER	
Reportable incident total	Week ending 22 March: 28	Week ending 29 March: 28
Summarised incident total	Week ending 22 March: 4	Week ending 29 March: 6

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0034201	A tip head slumped while a truck was dumping in an open cut coal mine. As the truck was tipping its load, the edge dropped, and the truck was unable to move forward.	Tip heads and dumps must have suitable inspection regimes in place. Changes in conditions, such as wet weather, should trigger a change in inspection frequency.

Dangerous incident IncNot0034194	An operator was sprayed with high pressure fluid when a hose failed. No injury was reported. A beam stage loader in the longwall maingate was tight against a block due to off-centre drivage and steering issues. While correcting this, the dog bones between the maingate cube and ramp pan failed. This resulted in the misalignment of the cable tray. A bulkhead fitting then failed, releasing the fluid and spraying the worker's forearm. The worker was taken to hospital but cleared of injury. 	When misalignment of longwall components occurs, increased inspections and suitable controls must be put in place. This is to protect workers from an unplanned energy release. This is applicable to damage to hydraulic hoses and face cables and sudden failures of joiners between equipment (such as dog bones).
Dangerous incident IncNot0034184	A fire occurred on a load haul dump machine at an underground coal mine. The LHD was travelling outbye when its engine failed. The operator noticed flames coming from the engine compartment and activated the on-board fire suppression system, which failed to fully extinguish the fire. The operator put out the fire using a hand-held fire extinguisher. The fire was	Mine operators should ensure that the maintenance of diesel engine systems and the inspection and testing of the safety-related components and systems be carried out in accordance with recommendations of the vehicle's original equipment manufacturer,

	caused by the release of oil due to a catastrophic engine failure.	the engine manufacturer and the ExDES registration holder.
Dangerous incident IncNot0034149	A brake failure occurred resulting in projectiles being thrown from a brake unit. At a planned shutdown for the relining of a mill, the mill was being inched in an anticlockwise direction. The mill was stopped and then started to move in a clockwise direction and increase in speed. The brake failed, and metal parts were ejected from the brake unit. 	Hold brakes must be suitably sized for all intended operations and should be suitable for their operation. Standby equipment such as slow run drives and pony drives should have an appropriate maintenance strategy documented and implemented.
Dangerous incident IncNot0034226	A worker suffered an electric shock in a processing plant. An overhead crane was being used to change screen mats. While the screen was being lowered, the worker was holding the screen and had the other hand on an adjacent beam. When the crane was activated, the worker felt an electric shock.	Mines that operate overhead cranes that rely on earthing via the rails and the drive wheels, should implement regular earth continuity checks to ensure compliance with AS/NZS 3000. Mine operators should also consider install an earthing rail to these types of installations.



Dangerous Incident IncNot0034221	Fire occurred on an agitator truck in an underground metalliferous mine. A hydraulic hose failed in the articulation area. Oil then ran onto the drive shaft and was flicked onto the exhaust. The fire was extinguished using a hand-held extinguisher.	Hoses in articulation areas are prone to rubbing and damage. MDG41 Fluid power safety systems at mines provides guidance for protecting hoses from damage. Controls should include hose retention, protection, guarding and appropriate length.
Dangerous incident IncNot0034220	A ventilation wall collapsed in an underground metalliferous mine. The wall had been built to control dust and air flow. Wet material had been stowed against the wall, causing it to fail. The wet material flowed into the drive below. 	When assessing areas to store material, the surrounding infrastructure must be assessed as suitable. When storing wet material, the risk of inundation must be assessed.
Dangerous incident	A worker was sprayed with hydraulic fluid. No injury was reported. Two workers were	When working with hydraulic cylinders, there is the potential for

IncNot0034219	replacing a shear cylinder on a continuous miner. The cylinder was replaced and then function tested. They found it was hosed up incorrectly. The machine was isolated, and the first hose removed without issue. When the second hose was removed, hydraulic oil and pressurised air escaped from the hose and sprayed one worker's wrist.	trapping fluid under pressure. Before any work begins, stored pressure must be dissipated. SB 19–04 Workers injured by high pressure fluid was recently issued and highlights the risks involved in working on hydraulic systems.
Dangerous incident IncNot0034218	Cable damage resulted in an arc occurring in an underground coal mine. An LHD was being reversed down a roadway. The bucket of LHD raised and made contact with two high voltage cables. A flash occurred and the power to the mine tripped.	Operators must remain vigilant while in control of mobile plant. This applies to all attachments and trailers. High voltage cables must be installed to a standard and include mechanical protection in areas identified as being at risk of interaction with mobile plant.
Dangerous incident IncNot0034211	Workers were withdrawn from an underground coal mine due to elevated methane levels. A supervisor detected an increase in gas levels coming from floor cracks on the longwall face. Workers retreated to a safe area in accordance with mine procedures. The gas levels continued to rise and all workers were withdrawn from the mine. Gas levels in the longwall return airway, and the main return continued to climb, with peak levels of 16% CH4 and 16% CO2 being recorded in the longwall return, and 4% CH4 in the main return.	A causal investigation has commenced. Further information will be released shortly.

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	**Metal/non-metal mine fatality** On 2 October 2018, a 40-year old miner with 20 years' experience was fatally injured when struck by stemming sand ejected from a borehole. While conducting a blasting operation in a new vertical raise, a contract foreman was attempting to clean out a previously blasted vertical borehole with high-pressure air. A sudden release of energy forced stemming sand from the bottom of the borehole, striking the miner. **Details**
MSHA	**MSHA mine fatality** On 6 March 2019, a 35-year-old contractor with 35 weeks of experience was fatally injured when he was struck by a relief valve that was ejected from a 500-ton hydraulic jack. The hydraulic jack was being engaged to make contact with the frame of a P&H 4100A shovel, when the relief valve was ejected**.** **Details**
MSHA	**MSHA mine fatality** On 7 March 2019, a 46-year-contractor with three years' experience was fatally injured when he lost his balance and fell backwards through a narrow gap between two log washers and landed on a cable tray about 3.5 metres below. The worker was changing drive belts on a log washer motor when his wrench slipped off a bolt he was tightening, causing the loss of balance. **Details**
MSHA	**Metal/non-metal mine fatality** (final report) On 25 October 2018, a 42-year old miner with 13 years' experience was killed when the back/roof fell and buried him while he was loading explosives in the face. The material was comprised of cemented backfill and weighed about 150 tons. **Details**

International (other, non-fatal)

MinEx NZ	**Rock falls from excavator bucket** An excavator operator was moving rocks into a stockpile when a rock fell out of the bucket. The rock slid down the stockpile towards the digger. The operator proceeded to track backwards however the rock still hit the bottom of the left-hand corner of the cabin, bending bars and denting the walkway on the front of cab.

	Details
MinEx NZ	**Loss of control of dump truck** A watercart was being used to water a haul road to suppress dust in a quarry. After the haul road was watered, a dump truck was descending the road when the dual wheels locked up and the operator lost control of the dump truck. The operator was able to steer it towards the inside batter rather than the edge of the road. No injury or major damage was sustained. Details
National (other, non-fatal)	
DMIRS	**SIR No. 274: Structural failure of fixed conveyor stacker** In February 2019, a fixed conveyor stacker collapsed during normal operation. Other than the temperature reaching 47°C, there were no extreme weather events at the time nor any abnormal operational loads. It was not running at full capacity at the time of failure, although it had run close to its limit earlier in the day. Details
DMIRS	**MSB No. 162: Inspection and maintenance of special purpose lifting plant and hoists** Mine inspectors repeatedly identify plant, such as shaft reliners, hopper trolleys, workshop mobile jib cranes and other multi-purpose lifting devices, in poor condition and without maintenance and inspection records. Details
DNRME QLD.	**MSB no. 179 Overload protection in lifting gear** A maintenance fitter suffered multiple injuries. A hoist he was using fell on him when the upper hook detached from the rest of the assembly. The chain hoist—installed within a dragline house—was being used to attempt to lift a 2.6 tonne segment of a large ring gear. The hoist had a working load limit (WLL) of 4 tonnes and weighed approximately 200 kg. Details
DNRME QLD.	**MSB no. 180 Worker disabled after leg is trapped by airlock door** A mine ERZ Controller sustained permanent disabling injuries after his leg was trapped in an airlock door for over five hours. This potentially life-threatening injury also had a high risk of amputation. 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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