Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 25 July 2018

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	42
Summarised incident total	8

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous Incident SInNot - 2018/01189	While installing the casing of a new dewatering borehole, the drill rig winch rope failed allowing the casing to drop. The casing pipe dropped until the lifting lugs on the casing caught on the borehole collar. At the time of the incident there was approximately 210 metres of casing in the hole. 	Winch ropes are to be regularly inspected during all tasks. Triggers for rope replacement are to be determined considering the task, rating of ropes and the risk associated with rope failure. Mines must have adequate guarding and safe standing zones to protect workers in place for rope failure.
Dangerous Incident	A turbo fire occurred on an agitator at an underground metalliferous mine. The	SA18-08 Underground mine fire initiates emergency

SInNot - 2018/01187	operator stopped the machine and extinguished the fire with a hand-held extinguisher. A coolant leak was identified as the cause.	response was recently released. The glycol content of coolant is flammable and once the water evaporates, it can be a fuel source for a fire. Lagging has the potential to soak up liquid and can accumulate fuel for a fire. Deteriorating lagging is a fuel source and should be replaced as required.
Dangerous Incident SInNot - 2018/01182	A collision occurred between a grader and a haul truck. The collision caused the grader to be pushed 15 metres from its location prior to contact. No one was injured. 	Operators of mobile equipment must not place other workers at risk. Maintaining focus and attention is vital to avoiding collisions.
Dangerous Incident SInNot - 2018/01180	A fire was identified on collapsed conveyor idler in an underground coal mine. An operator in the conveyor belt roadway smelled smoke and followed the smell until he saw a small flame (lighter size) emerging from an idler on the conveyor.	The Mechanical Engineering Control Plan for a mine must set out the control measures to manage risks arising from fires being initiated or fuelled by plant. In developing these control measures a mine operator must take into account the prevention, detection and suppression of fires on conveyors. Mines must have a system to identify and change-out rollers. People conducting

		inspections must be aware of the increased risk of roller failure at high tension sections of belt.
Serious Injury SInNot - 2018/01169	A worker received a broken leg and another worker a dislocated shoulder when they jumped from the tray of a runaway vehicle. The vehicle was climbing a steep grade when the vehicle stalled and slid down the hill. The incident was not reported immediately. 	Operators must only ride in designated seats where protective devices are fitted to protect them from injury. Vehicles must be assessed as fit for the intended purpose before starting a job. Assessment must consider all operating parameters such as grade, surface, traction and loading. Section 15 of the *Work Health and Safety (Mines and Petroleum Sites) Act 2013* requires immediate notification of dangerous incidents and serious injuries.
Dangerous Incident SInNot - 2018/01168	Two articulated dump trucks collided when one truck failed to negotiate a bend. It is reported that an operator had a microsleep. 	When overtime shifts are allocated, workers' fitness for work, including fatigue, must be considered.
Dangerous Incident SInNot - 2018/01166	A collision occurred when an excavator slewed around, striking a dozer. The contact separated the access ladder from the dozer. The dozer operator failed to gain positive communication before entering the swing radius of the excavator. The excavator operator also failed to follow the relevant operating procedure for this task.	SB18-06 Lack of positive communications details positive communication and proximity detection and collision avoidance requirements.

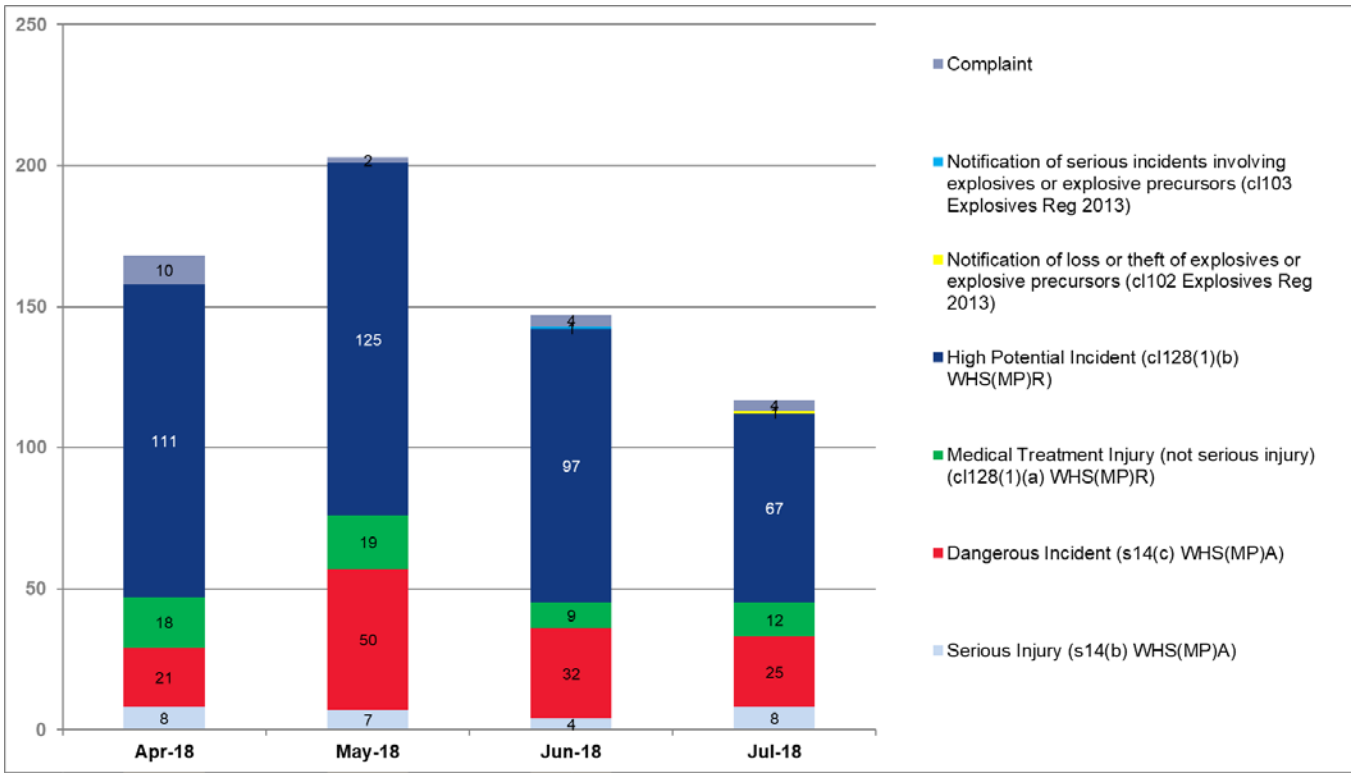
Section 28 of the *Work Health and Safety Act 2011* requires workers to comply with reasonable instructions given to them, in this case a procedure.

Dangerous Incident SInNot - 2018/01158

A worker injured his arm while taking evasive action to avoid being struck by falling strata. The worker was installing bolts between the roof supports when the piece of stone fell (approximately 2.9 x 0.8 x 0.6 metres) from the face. The stone did not strike the worker.

Where unsupported strata exists during longwall face bolt-up there are many operational controls that can be implemented to reduce exposure to operators. These include:

- leaving a bench to improve face stability
- pillar design and roadway rib support to improve tailgate face stability
- installation of temporary roof support
- changes to cutting horizon
- use of rapid face bolters to give operators additional protection.



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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