Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 5 September 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	31
Summarised incident total	5

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot-2018/01427	Damage to an 11kV cable was identified during a routine inspection. The outer sheath was damaged when it was hit by an item of mobile plant. The contact was not reported at the time it occurred.	Mine workers are reminded of their duty under section 28 of the WHS Act 2011 to take reasonable care that their acts or omissions do not adversely affect the health and safety of others. When hazards or incidents are not reported this can lead to people being exposed to health and safety risks.
Serious injury SinNot-2018/01414	A boilermaker suffered a fractured finger and lacerations when a strong back failed while repairing a dump truck body. The strong back was being used to support a portable hydraulic cylinder to enable repairs.	Temporary items used to support and hold loads must be designed and engineered to prevent injury to workers during their use.

Dangerous incident SinNot-2018/01409	A high voltage cable was damaged when it was hit by a longwall roof support being transported to the surface of the mine. The electrical power was not interrupted.	A S195 prohibition notice was issued preventing the mine from transporting supports until a review of procedures and an inspection of the travel route was completed. Before periods of high traffic of large loads, such as a longwall move, a survey should be conducted to identify any infrastructure exposed to damage. Procedures for loading and transporting should include the maximum height permissible as determined by the survey.
Dangerous incident SinNot-2018/01408	A fire occurred on a production drill rig as it was being trammed to the surface of an underground metalliferous mine. The operator noticed a red glow in the engine bay and drove off the decline and then manually activated the onboard fire suppression system. The operator also used a hand-held extinguisher. Initial inspection identified heat damage on a hydraulic hose.	MDG 15 Guideline for mobile and transportable plant for use at mines (other than underground coal mines) 2017 details effective control measures to manage the risk of hoses and pipes creating fuel sources for fires in engine bays.

High potential incident SinNot-2018/01396	A roof fall occurred at a longwall mine. The fall was about 4 m long x 3 m wide x 3 m high and occurred at the longwall face/belt road corner. The fall occurred after the 8 m cable bolts sheared.	A mine safety inspector was deployed to the site to inspect the area where the fall occurred and assess the mine's response. Mines must have adequate TARPs in place to effectively react to changing strata conditions. Workers must be trained in these TARPs to ensure they are acted on appropriately.

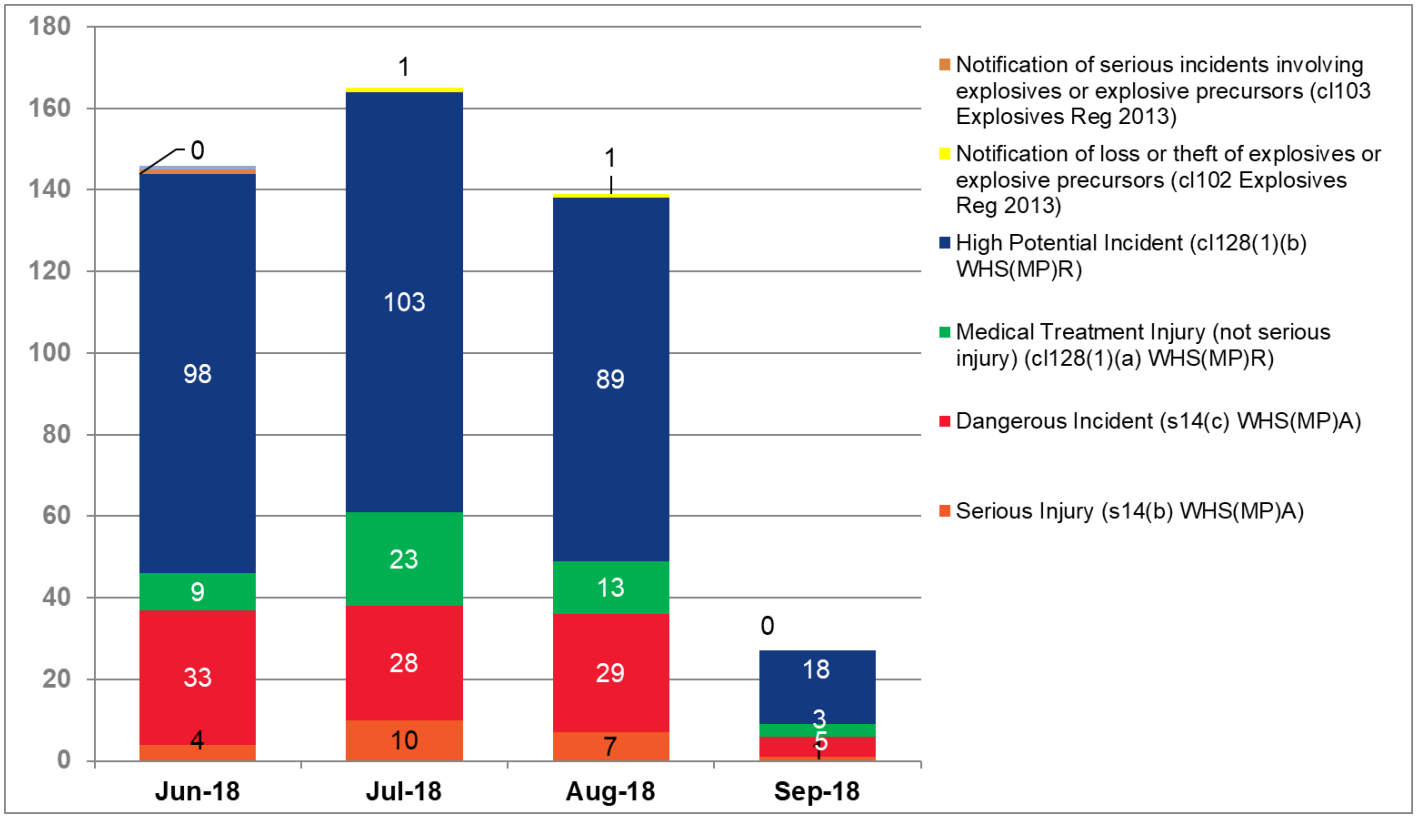
Other publications of note

Publication	Issue / Topic
International (fatal)	
NIOSH	• **Prevalence of 'black lung' continues to increase in US coal mine workers.** • Latest figures suggest that 1 in 10 US coal miners are likely victims of black lung or pneumoconiosis. In fact, workers in some coal mining areas 1 in 5 have signs of the disease. • Details
National (other, non-fatal)	
WA Dept. of Mines (MIRS)	• **Underground operator struck on the head by a high-pressure air line** • In August 2018, a service crew was extending air and water services underground. Upon reenergising the lines, it was noticed that the water line was not connected properly and was leaking. While the water line was being repaired, the adjacent pressurised airline disconnected at the coupling of a poly fitting and steel isolation valve. The failure of the coupling caused the airline to whip around, breaking a holding chain and striking a service crew operator in the head. The operator collapsed and lost consciousness. He was stabilised and transported to hospital for treatment of concussion and lacerations to his head. • Details • **Noise-induced hearing loss at mines** • Analysis of noise exposure data submitted to the Safety Regulation System (SRS) shows that a large percentage of mine workers are regularly exposed to noise levels that could cause permanent and debilitating damage (see graph below). There is a notable trend towards overreliance by employers on personal protective equipment (PPE) in place of engineering or administrative controls of noise hazards. Worryingly, exposure-monitoring data also show that workers in noisy conditions often neglect to use PPE. • Details

WA Dept. of Mines (MIRS)	• **Product safety alert** • The WA Department of Mines has been made aware of an issue relating to the sampling efficiency of specific SKC cyclones (Model 225-69 Cyclone Sampler with re-usable cassette for 25mm filters and Model 225-69-37 Cyclone Sampler with re-usable cassette for 37mm filters). • SKC Plastic Cyclone Notice • SKC Cyclone Samplers for Respirable Dust – operating instructions • State mining engineer directive – SKC Cyclones

Resources Regulator recent publications

- MDG 41 – Fluid power safety systems at mines (revised September 2018)



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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