WEEKLY INCIDENT SUMMARY

Week ending Friday 30 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	25
Summarised incident total	4

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0035398	 A damaged continuous miner cable arced when a worker picked it up to move it. The continuous miner had previously tripped and the fault was reset. Upon repowering the miner and beginning the flit, an operator	It is crucial that electrical engineers know, understand and maintain electrical protection settings. Mines must have systems in place to complete inspections routinely as well as after any identified fault. Mine operators should also review their preventative maintenance schemes for electrical cables to identify defects that could lead to an arcing incident. The review should include:

	went to move the cable and there was an arcing event.	■ inspections for cable and sheathing damage ■ lifecycle management (age of replacement) for cables
Dangerous incident IncNot0035400	 An operating dozer has pushed over onto a grade and has lost traction and become stuck. The operator has underestimated the grade and, combined with the hard and slippery material, he has not been able to get enough traction to reverse. The operator removed himself from the machine and a recovery plan was developed.	Mine operators need to identify risks associated with working near a steep drop-off when combined with hard and slippery floor conditions. Dozer operators should not be exposed to these risks when pushing shot ground. The risks must be assessed, and suitable controls must be implemented to eliminate or minimise the risks. Pre-task risk assessments (such as JSAs) should be considered as a minimum.
Dangerous incident IncNot0035411	A contracting electrical company was conducting a high voltage test on a DC4100 shovel inside the machine house when an employee on the ground got an electric shock from the cable reeler.	Schedule 2 (3) of the Work Health and Safety (Mines and Petroleum Sites) Regulation 2014 clearly sets out the requirements for an electrical control plan, including: ■ specific procedures for the use of electrical test instruments ■ procedures that detail the control measures to prevent persons from inadvertently contacting energised parts

of electrical plant and electrical installations

- determining if electrical equipment is energised before electrical work is carried out.

Serious incident IncNot0035430	 While reversing a continuous miner, the rib protection became jammed on a rib bolt causing the rib protection to deflect and strike the operator in the head. Before the incident, the continuous miner was driven off-centre for approximately 50 metres, including 'over' correction. No corrective action had been taken.	Mine operators should review procedures that address how their development roadways are driven on centre. Deputies and undermanagers should record when the continuous miner is not on centre and record any corrective action taken.

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	**Mine fatality** On 20 August 2019, a 20-year-old miner with 27 weeks of mining experience was fatally injured when he fell down a shaft to the cement floor below. The miner was working with another miner, unloading a refuse kettle attached to an electric hoist, when he went over the unguarded edge of the shaft. Details
	International (other, non-fatal)
MinEx NZ	**Another rollover** An ADT loaded with rock was travelling down a quarry haul road when the truck started to accelerate. The operator applied the brake, but the ADT did not slow down. In an attempt to slow the truck down, the operator drove up an embankment to his left but this only diverted the truck back onto the haul road where it slid to the right and came to rest on a windrow. Details
	National (other, non-fatal)
DNRME (Qld)	**Use of compressed air for cleaning MSB No 183** In 2017, about 50 percent of respirable dust and respirable crystalline silica (RCS) exceedances that occurred in surface coal mines related directly to the use of compressed air for cleaning down enclosures and equipment during maintenance activities. Approximately 33 percent of all exceedances, related specifically to blowing out of high voltage (HV) cabinets in electric drive trucks or blowing out motor-generator sets in dragline houses. 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.

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