NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 14 February 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	44
Summarised incident total	5

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0036722 Underground coal	A continuous miner was buried when an intersection fell in during a breakaway that was being supported in accordance with the mine's support plans. The fall was about 9 metres x 5.4 metres x 2.5 metres. No injuries were reported.	Mines must have adequate trigger action response plans (TARPs) in place to effectively react to changing strata conditions. Workers must be trained to use these TARPs to ensure they are acted on appropriately. Workers should constantly monitor strata conditions to identify areas that pose risks. When strata conditions change or mining commences in new areas, the risk assessment and controls identified should be reviewed and the principal hazard management plan should be updated. Refer to:

- NSW code of practice: Strata control in underground coal mines
- Safety Bulletin SB18-12 Rib failures in underground coal mines.

Serious injury IncNot0036687 Open cut coal	An operator's wrist was cut while trying to get out of a partially submerged, bogged dozer. The operator lost footing, reached out and grabbed the dozer blade. A burr on the blade caused the cut, which needed four stiches. The area where the incident occurred was very confined, and the site had received about 160 millimetres of rain overnight. 	Operators should review and update site procedures for managing bodies of water on site. Geotechnical consideration should be given to the potential for voids, slumping and subsidence areas to form, particularly following significant rainfall. The potential for drowning in a submerged vehicle must be considered in such circumstances. Refer to: Safety Bulletin SB19-10 Dozer incidents increase despite warnings
Dangerous incident IncNot0036709 Underground coal	An operator of a diesel man car (DMC) stopped and reportedly activated the dump valve. The operator exited the DMC and turned to switch it off, but it began to roll forward. The operator activated the intake emergency shut-off valve, but the machine continued to roll downhill. The DMC travelled about 17 metres to a set of catch points that were closed and travelled a further 23 metres before hitting another parked DMC.	Operators should review the risks associated with parking machinery on inclines and should implement suitable procedures to eliminate the risk of unattended machines rolling away. Catch points should be maintained and form part of rail maintenance plans.

	There was no-one in either DMC. The catch points were closed due to excessive build-up of coal and fines. 	
Dangerous incident IncNot0036711 Underground coal	Following pick replacement on a longwall shearer, it was repowered and placed into automation. Maingate shields 6, 7 and 8 were advanced in manual while the shearer was stationary. The shearer was stopped at shield 8 and an earth leakage test was conducted on the machine. The machine then proceeded in automation towards the tailgate, when the maingate drum lifted and hit the roof support 8 flipper on the underside of the shield. An operator suffered a cut to the back of his left leg from a metal shard.	Mines operating longwall shearers should have an earth leakage reset procedure that ensures the operating system is not acting on the drum-position encoder's last retained value, particularly when the drum height has been altered during testing. Safe standing zones should form part of the procedure during restart.
Dangerous incident IncNot0036731 Open cut coal	A skid steer machine fitted with a mulching attachment overturned while it was clearing vegetation on an embankment. The operator was uninjured.	Equipment operators must maintain situational awareness and remain vigilant of the risk of machine rollovers. This incident underpins the importance of wearing seatbelts as a mitigating control. When planning tasks and travel paths, supervisors must consider rollover hazards. Refer to Safety Bulletin: SB17-01 Industry reports more truck rollover incidents

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** A miner fell into a portable load out bin on January 8, 2020 and died at the scene. Details
MSHA	**Coal/non-metal mine fatality** A mine examiner was travelling down the slope in a personnel carrier on his way into the mine. Evidence indicates that the personnel carrier struck the left rib near the bottom of the slope. The mine examiner was found unresponsive beside his vehicle. Details

MSHA	**Metal/non-metal fatality** A contract maintenance mechanic was performing elevator maintenance when the elevator car descended, crushing the mechanic against an elevator platform. The person died at the scene on December 3, 2019. Details
	National (fatal)
SafeWork NSW	**Apprentice auto electrician fatality** An 18-year-old apprentice auto electrician died in an incident at a workshop in Brocklehurst, north of Dubbo. The young worker was found trapped between the cab of the truck and its engine. Details
	National (other, non-fatal)
DMIRS	**Braking performance of relocation systems for heavy mining equipment – MSB No 170** Relocating heavy mining equipment within surface mining areas and on mine roads is a common task in the industry. Due to their large size and weight, tracked excavators in the 400-500 tonne class present issues when they require relocation. 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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