Weekly incident summary

Week ending 30 May 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.

Туре	Number
Reportable incident total	38
Summarised incident total	7

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot- 2018/00854	An operator on a continuous miner had his arm trapped between the rib protection and a rib bolter. A piece of rib 0.5 metre wide by 2.8 metre high slumped down under the bolting platform. The platform then pivoted, jamming his left forearm. Several other workers had to free his arm.	Workers should constantly monitor strata conditions to identify areas that pose a risk. Mines should review how work platforms and walkways on machines are retained and secured to minimise the risk of platforms pivoting and injuring workers.
Dangerous incident SinNot- 2018/00837	A watercart hit a fixed structure. The watercart reversed into position and as the operator was leaving the cab, the truck rolled backwards about one metre and hit the fixed plant.	Park-up procedures should be document and supervisors should monitor compliance. In areas where routine parking is required, engineered controls should be in place to control the risk of unintended movements of vehicles or for vehicles to contact structures.





Dangerous incident SinNot- 2018/00829 Packaging from a black powder product was found smouldering in the extraction drive by the shotfirer and his assistant.

Four cartridges were found in this state.

The root cause of packaging being found in the drive was due to the rifling of the cartridge due to incorrect drill hole dimensions.

When carrying out any drilling the correct drill size must be identified and used.

Dangerous incident SinNot- 2018/00822 A coal burst occurred during longwall mining. Ejected coal was found in the walkway of the longwall. Face pressure was lost.



The Work Health and Safety (Mines and Petroleum Sites) Regulation 2014 has been updated to include coal burst at a mine as a dangerous incident.

Coal burst should be included in the mine's principal hazard management plan for strata for both longwall and development or considered as a stand-alone principal hazard management plan.



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Dangerous incident SinNot- 2018/00816 Coal and gas was ejected from the rib from the vicinity of a borehole. The power to the miner was tripped by the methanometer. There were three operators at the miner at the time of the incident. One operator suffered bruising and abrasions when he fell while clearing the area.

The scene was preserved immediately however was later disturbed by mine workers.



When scene preservation is required the mine must take all necessary steps to prevent people from disturbing the scene. This may include placing sentries.

Section 17 of the Work

Health and Safety (Mines and

Petroleum Sites) Act 2013

allows for treatment of injured workers, activity to make an area safe and actions directed by an inspector irrespective of any non-disturbance requirements.

Mines should have in place systems of work for mining in proximity of boreholes.

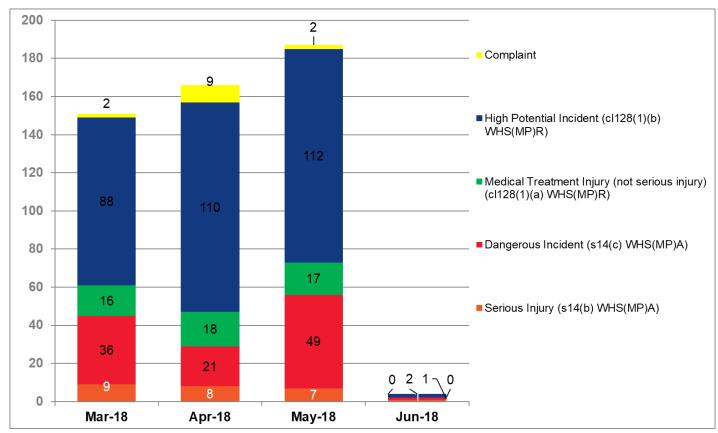
Serious injury SinNot- 2018/00815 An operator suffered a fractured toe and lacerations requiring stitches when a drill steel crushed his foot. The operator was installing a cable bolt. The third drill rod extension was being installed when the timber jack was lowered, punching the drill steel through his boot and injuring his foot.

Tools and equipment should have designated secure storage areas incorporated in the work area. Supervisors should routinely monitor worker compliance with routine storage and housekeeping requirements.

Dangerous incident SinNot- 2018/00805 A worker reported receiving a suspected electric shock when he turned on a light switch in a control room. The worker was managed in accordance with site's electric shock procedures.

It was identified the switch was an aged unit that did not have a mechanism rated for fluorescent lighting. The electrical engineering control plan for a mine must take into account the reliability of electrical safeguards used at the site to protect persons from electrical hazards, and the rating and design of plant for prospective loads and operating voltages.





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.

Recent Resources Regulator publications

• Safety Bulletin SB18-10 People warned of fall risk in opal mine fields

Other safety publications of note

Date received	Publication	Topic/s and suggestions
28/05/2108	MinEx newsletter (May)	→ A guide to worker health in the extractives industry available on website http://www.minex.org.nz/assets/Uploads/A-guide-to-Worker-Health-in-Extractives.pdf
29/05/2018	Worksafe NZ	→ There have been two recent incidents involving remote control unit failure in mining and quarrying operations that WorkSafe wishes to bring to the attention of the sector. There was no harm caused in



either occasion but the potential is high for injuries should recommended steps below not be followed.

https://worksafe.govt.nz/about-us/news-and-media/safety-alert-mining-and-quarry-operations-unintended-track-movement-due-to-remote-control-unit-failure/

29/05/2018 HSE

→ A construction company has been fined after a tipper vehicle driven by one of its employees came into contact with overhead power lines during the construction of a waste transfer station. There have been similar incidents in NSW.

Company fined more than 500k following overhead power lines incident.

http://press.hse.gov.uk/2018/company-fined-more-than-500k-following-overhead-power-lines-incident/?cr=25-May-2018&eban=govdel-press-

<u>release&utm_content=&utm_medium=email&utm_name=&utm_sourc</u> e=govdelivery&utm_term=

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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