

WEEKLY INCIDENT SUMMARY

Week ending Friday 11 October 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	5

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Serious injury IncNot0035778	<p>A worker was installing a monorail in a maingate area on a longwall face. The worker was operating a malibou (a work platform suspended from the monorail system) with his hand on the monorail. When the malibou came to a stop it rolled back, crushing the worker's finger. The worker required surgery.</p> 	<p>Mine operators and contract companies should review their procedures and training packages to ensure they include the potential hazards associated with placing body parts on solid objects around moving parts and material.</p>

Dangerous incident
IncNot0035753

A shotcrete rig was being trammed to be fuelled when a rubber delivery hose dislodged. The hose fell in front of the exhaust discharge which burned the rubber and created an ignition source. Flames were seen by two operators in a light vehicle who notified the rig operator. A suppression system was activated, together with a hand-held extinguisher.



When a fire occurs, a competent person must conduct a thorough investigation to determine the:

- fuel source and heat sources
- surface temperature value
- cause of the fire
- controls to prevent reoccurrence such as reducing engine component surface temperatures and segregating fuel sources from areas of high temperature, and fire safety inspections
- training workers to identify fire risks such as fuel, oil leaks or worn hoses
- review of the fire risk assessment for the item of plant.

Mine operators should report the issue to the original equipment manufacturer (OEM).

Serious injury
IncNot0035768

An underground mine worker was grouting 8 metre cable bolts when a worker saw grout leaking from between the housing and the reciprocating shaft. The worker discarded the grout and flushed the pump with water to reseal the shaft seal. While the pump was running, the worker tried to block the spray of water from leaking around the shaft. The threaded piston sleeve dislodged from the housing, lacerating the worker's left thumb.

Mines must have systems in place that require appropriate risk management tools to be available for use by workers for tasks. Additionally, supervision arrangements must include checks to ensure that risk management tools are in place.



Dangerous incident
IncNot0035775

A water cart was at a fill point when the operator saw flames. The operator called emergency, activated the fire suppression system and exited safely from the water cart. There were no injuries.

We recently published a [position paper](#) relating to the prevention of fires on mobile plant, which should be considered by mine operators.



Dangerous incident
IncNot0035773

A worker was removing a conveyor belt from a surface conveyor. During the process, a splice plate and shackle became caught on the head drum. The winch wire rope (about 8 mm) broke and recoiled in the vicinity of the winch drum. The belt remained jammed and did not move. The belt was on the surface of the mine and was inclined about 30 degrees. No-one was reported to be injured.

Winch ropes should be regularly inspected during all tasks. Triggers for rope replacement should be determined according to the task, the rating of the ropes and the risk associated with rope failure. Mines must have adequate guarding and safe standing zones in place to protect workers in the event of rope failure.



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	Coal mine fatality On 17 September 2019, an electrician was electrocuted. The worker made contact with a 995 VAC connector while attempting to troubleshoot the scrubber motor circuit on a continuous mining machine. Details

MSHA

Mine fatality alert

On 5 September 2019, a continuous mining machine helper was fatally injured when he was struck by a battery-powered scoop. The worker was in the number 3 entry behind a wing curtain that provided ventilation to the right crosscut being mined. The scoop was trammed through the number 3 left crosscut and struck the victim as it made a right-hand turn and passed through the wing curtain.

[Details](#)

National (other, non-fatal)

MinEx NZ

Worker injured using a grinder

A worker was using a grinder on the edge of a steel bar when the grinder kicked back at him. His overalls became entangled with the tool around waist height. This caused a tiny abrasion to his stomach area. First aid treatment was applied. No further medical assistance was required.

[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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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (October 2019). However, because of advances in knowledge, users are reminded of the need to ensure that information upon which they rely is up to date and to check currency of the information with the appropriate officer of the NSW Department of Planning and Environment or the user's independent advisor.

DOCUMENT CONTROL

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Approved by Chief Inspector
Office of the Chief Inspector