

Week ending 29 August 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	38
Summarised incident total	3

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident SinNot-2018/01391	<p>A fire occurred on an agitator truck in the decline of a metalliferous underground mine. The operator saw a glow on the decline wall and stopped to investigate. There was a small flame around the exhaust lagging, which was extinguished with a hand-held extinguisher.</p> 	<p>Lagging can become a fuel source when hydrocarbons accumulate in it. This risk should be addressed in the fire risk assessment for the item of plant.</p> <p>SA18-08 Underground mine fire initiates emergency response details a recent serious incident in similar circumstances.</p> <p>In-service fires on mobile plant - September 2017 should also be reviewed.</p>

Serious injury
SinNot-2018/01385

An opal miner severed three fingers at the first knuckle on his hand. The miner was adjusting a belt drive while it was operating, when his fingers were drawn into the pulley.



All mines must have a system where workers isolate equipment before working near rotating parts.

SafeWork NSW has issued [Managing the risks of plant in the workplace code of practice](#), which is applicable to all mines.

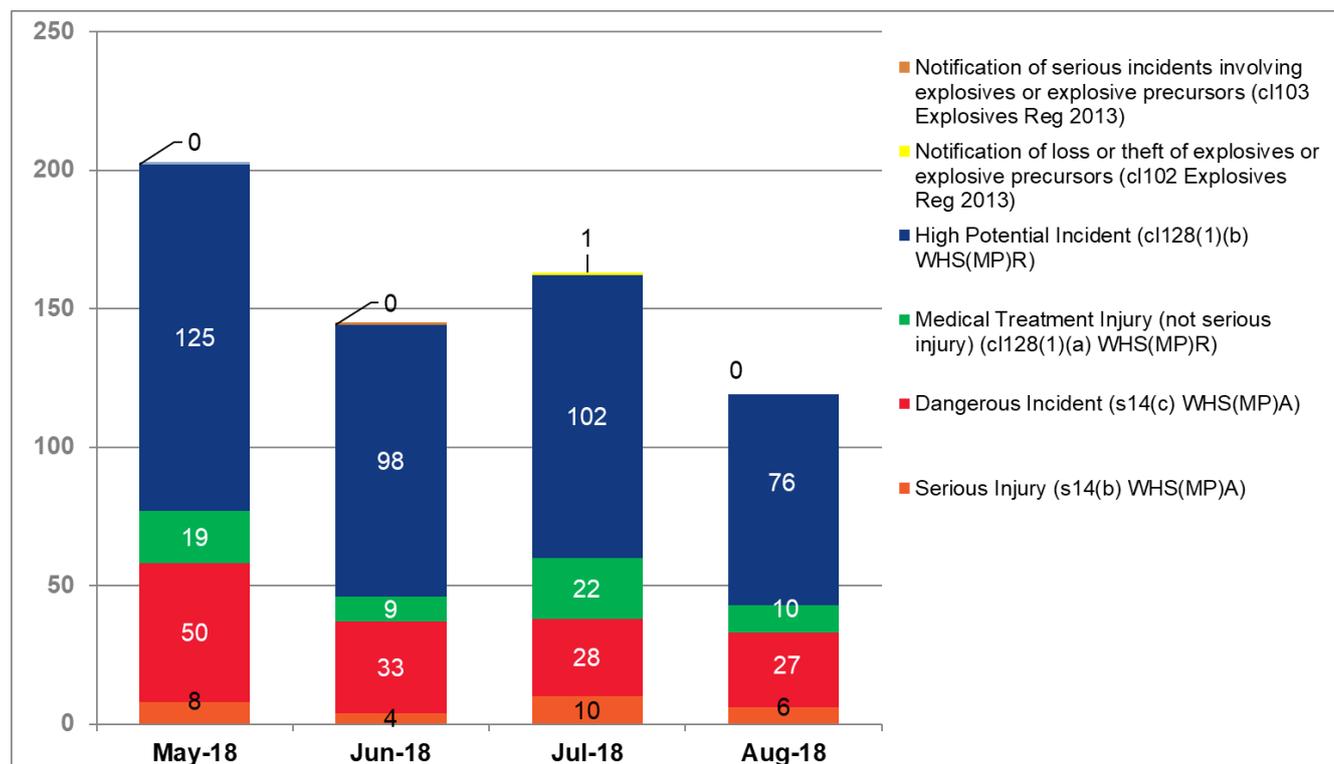
Dangerous incident
SinNot-2018/01367

An excavator rolled onto its side when the ground gave way under the right-hand track. At the time, the excavator was digging a sump for water due to a 'hot shot'. The cab door was open at the time.



When working near heat-affected ground, the ground stability needs to be considered when preparing a safe work procedure.

When a risk of roll over exists, additional controls must be implemented to minimise the risk including set back distances, further pad construction and use of alternative machines.



Other publications of note:

Publication	Issue / Topic
International (fatal)	
DNRME QLD in MinEx NZ	<p>South African copper mine conveyor fire</p> <ul style="list-style-type: none"> On 15 July 2018, six mine workers in a South African underground copper mine died in a refuge chamber as a result of a fire on a conveyor. <p>Details</p>
International (other, non-fatal)	
MSHA in MinEx NZ	<p>Surface - Gold</p> <ul style="list-style-type: none"> On 19 June 2018, a miner was seriously injured while making repairs on a rotating screen plant. A chain used to lift a thrust bearing failed and struck the miner in the head. The miner was knocked unconscious and found lying on the deck. <p>Details</p>
MinEx NZ	<p>Air hose connection blows off</p> <ul style="list-style-type: none"> A worker was operating a jackhammer while cleaning out under a crusher, when an air hose connection came loose and flew off. The projectile narrowly missed the worker's face. <p>Details</p>
DNRME QLD in MinEx NZ	<p>Miner struck by rockfall at development face</p> <ul style="list-style-type: none"> During charging of a perimeter hole on a development heading at an underground metalliferous mine, about 11 tonnes of rock fell from the middle and upper portions of the face, trapping an operator in a Normet Charmec basket. <p>Details</p>

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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