



Queensland Government

Incident Notification

(Mines Inspectorate)

Mine Name Grasstree Mine
Operator Name Anglo Coal (Capcoal Management) Pty Ltd
Mine Type Coal Mine - Underground
Mine Region Central Region
Mine Office Mackay Office
Mine File No 31507

NOTIFICATION DETAILS

Notifier's Name Kelvin Schiefelbein
Notifier's Position/Title UMM
Notifier's Contact Number [REDACTED]
Notification Received on 20/03/2020 **at** 01:50 PM
Notification Received By Paul Brown
Entered By Paul Brown **on** 21/03/2020

INCIDENT DETAILS

Incident Date & Time 20/03/2020 12:00 PM
Location (Section/area) 6ct A/Hdg 808 TG
Equipment Involved Longwall TG gas sensor
Concise Description

A gas exceedance occurred in a longwall TG when the shearer (at chock 185) was leaving the TG (final chock 197). The TG Drive and shields were beginning to push over when the gas exceedance occurred. A purge of gas came from the goaf due to the ventilation changes resulting from the shield movements and shearer position. A peak of 4.27% was recorded for a period of 15 minutes

Other details

The gas accumulation caused an immediate trip of power supply to the AFC and shearer at 2% as per requirements.
 The gas accumulation did not present as exceedance at the TG drive gas sensors or at a TG roadway gas sensor positioned further Outbye.
 A peak reading of 4.27% was recorded during a period of 15 minutes.
 A ventilation arrangement of flaps was installed / adjusted at 193 to the TG prevent further exceedances.
 A thorough review of controls was undertaken and additional steps to control the situation included: MG seal brattices to be renewed, MG shield brattices to be adjusted, TG 6ct man door adjusted, brattices and flaps adjusted and arrangement tested with smoke tubes,
 A goaf drainage borehole was late to become active at this location and this also contributed to the exceedance. This issue was verified as major factor as gassy goaf bleed was found issuing between shields 195-196-197 by the ERZC. Shields 196-197 were found to be left back and 193-194-195 were found to be forwards. Shield staggered in this way also contributed to ventilation obstructions and gassy ventilation from behind the shields.

Incident Classification Other

Other Inspectorates to be notified

INJURIES

Injuries - Person(s) Involved 0

FATALITIES

Fatalities - Person(s) Involved 0

RESPONSE

Actions Taken By Mine / Operator

Actions taken (see other details)

Instructions or advice given to Mine / Operation

When notified of the exceedance UMM Shiefelbein was blaming a roof fall for the exceedance. When I questioned the shearer position and cutting sequence it was apparent the cutting process contributed to the excessive goaf wash. I questioned goaf well performance to be checked.

After receiving the Form 1A from another Inspector I am requesting further information on the exceedance.

INCIDENT CATEGORY**Event Type**

High Potential Incident

Incident Category

A ventilation failure causing a dangerous accumulation of methane or other gas if it endangers the safety or health of a person

<input checked="" type="checkbox"/> Oral Report confirmed by notice within 48 hours	22/03/2020
<input checked="" type="checkbox"/> Notify an Inspector as soon as possible	20/03/2020
<input checked="" type="checkbox"/> Report to be submitted within 1 month	19/04/2020

INCIDENT FOLLOW-UP**Officer allocated to investigate and/or follow-up reports**

Paul Brown

Oral confirmatory report received**Written report received****External DB Accident ID (LTAD)****144448****IR Summary Title**

A Gas Exceedance has occurred in the LW808 TG ROADWAY airway when the S243a sensor recorded intersection 6ct with the TG roadway. The shearer had left the tailgate after the completion of the TG occurred. (The TG shield is number 197.) (The TG Drive and shields were beginning to push over as a result due to gas being purged from the goaf due to the ventilation changes resulting from the shield movement) Immediate trip of power supply to the AFC and shearer at 2% as per requirements. The gas accumulated at a TG roadway gas sensor positioned further Outbye. A peak reading of 4.27% was recorded during the installation / adjusted at 193 to the TG prevent further exceedances. A thorough review of controls was conducted. MG seal brattices to be renewed, MG shield brattices to be adjusted, TG 6ct man door adjusted, brattice tubes, A goaf drainage borehole was late to become active at this location and this also contributed to the gassy goaf bleed was found issuing between shields 195-196-197 by the ERZC. Shields 196-197 were staggered forwards. Shields staggered in this way also contributed to ventilation obstructions and gassy ventilation.

Incident Date

20/03/2020

Processed Date

07/04/2020 04:26:46 PM

(MIR Web Site submission processed)

Mine Name

Grasstree Mine

Incident Type

High potential no lost time

Injured Person(s)**Organisational**

The goaf drainage well spacing is predetermined during design and based upon estimates - in this case

Task / Environmental Conditions

The proximity to the TG cut-through increases goaf pressure and gas make.

Individual / Team Actions

the production crew have advanced shields unevenly due to the way automation mode was applied - over the sensor when the shields have advanced

Absent / Failed Defences

the arrangement of flaps and brattices in the TG were not optimal for the situation and dilution of gas

Preventative Action

the ventilation arrangement of flaps and brattices was improved and design specified by the ventilator specified.

DETAILS OF PERSONS ADVISED

EMAILED

<u>Emailed To</u>	<u>Comment</u>	<u>Emailed Date</u>	<u>Emailed Time</u>
andrew.smith Anthony.Logan Claire.Buchanan Creswick.Bulger fritz.djukic Graham.Callinan keith.brennan kevin.poynter Matthew.Kennedy Michael.Scully neil.randolph neville.atkinson Paul.Brown2 paul.sullivan Patrick.Hurley Laurie.Crisp Shaun.Dobson Stephen.Smith2 theo.kahl Geoff.Nugent Malcolm.Brownett John.Tolhurst Rodney.Keane Peter.Newman		21/03/2020	07:41 AM

ORALLY (if any)

<u>Notified</u>	<u>Comment</u>	<u>Date</u>	<u>Time</u>
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