Gassing Fatality

MATLA COAL

23 April 2009

Injured Details

Name of the deceased	:	*Jomo Lubisi*
Occupation	:	*General labourer*
Date of incident	:	*20 March 2008*
Time of incident	:	*10:15*
Type of incident	:	*Fatality*
Total length of service	:	*3 months*
Age	:	*25 years*
Experience in current position	:	*3 months*
Marital Status & Dependants	:	*Single with one child*

Incident details

An approved specialised contracting group was tasked to construct gunite walls alongside the newly formed goaf at main gate 8

On Thursday 20 March 2008 at approximately 10h15 four persons accompanied by their team-leader volunteered to fetch scaffolding that was left behind panel 7 service road required to construct a gunite wall

The four volunteers removed their rescue packs before entering the water in order to prevent damage before walking through the water to the opposite side. During this process they were overcome by carbon monoxide

The team leader who had not entered the water observed that the crew was in trouble. He went to assist and at the same time made alarm to the rest of the workers in the vicinity

Jomo was the second last person removed from the water

Mine personnel assisted with the rescue operation and affected people were taken to surface

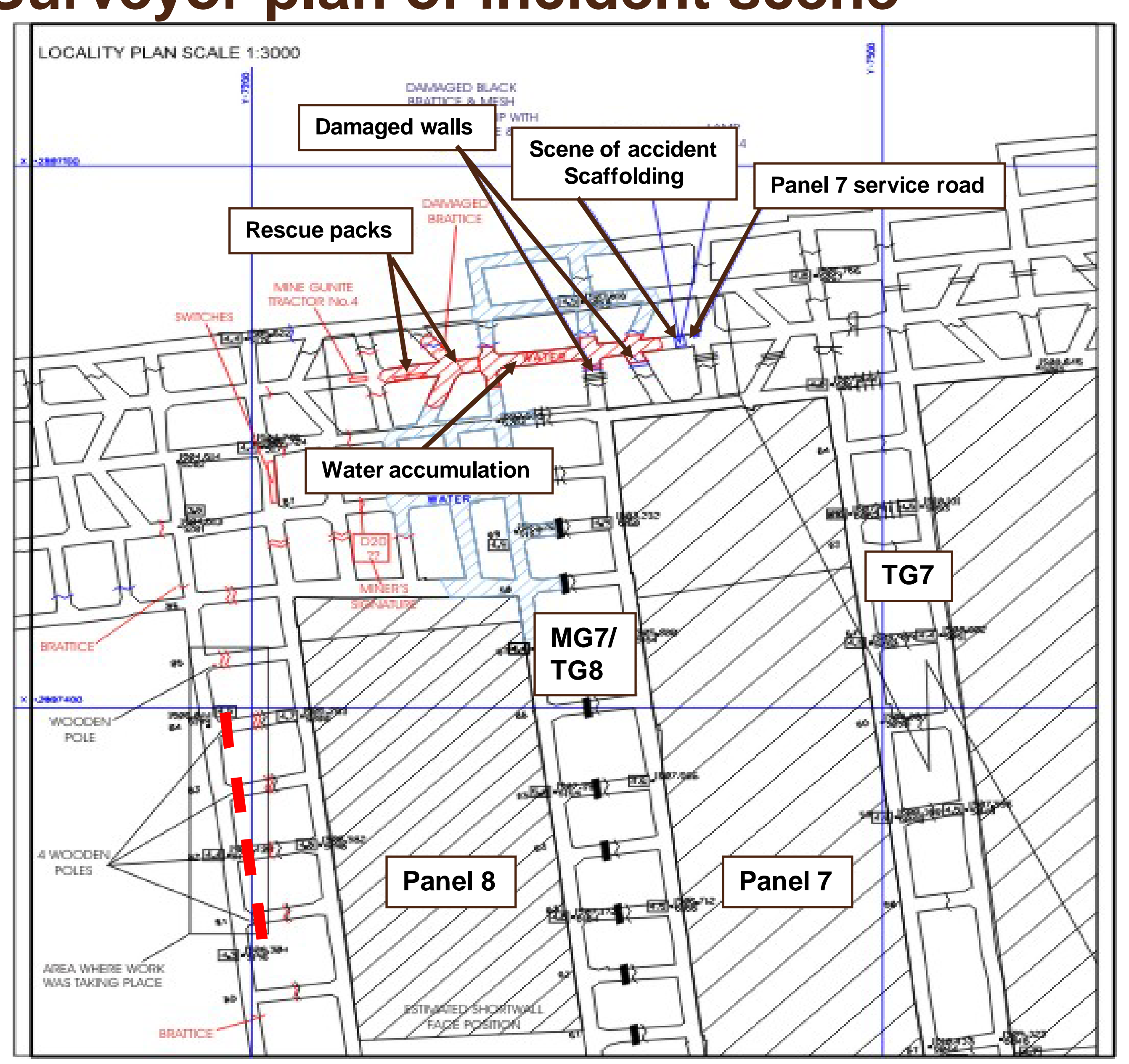
On reaching surface, at about 11:30, the paramedics of NetCare confirmed that Mr. Lubisi was displaying no vital signs where after he was taken to the Matla Health care centre where he was declared dead by a medical doctor.

Introduction to storyline

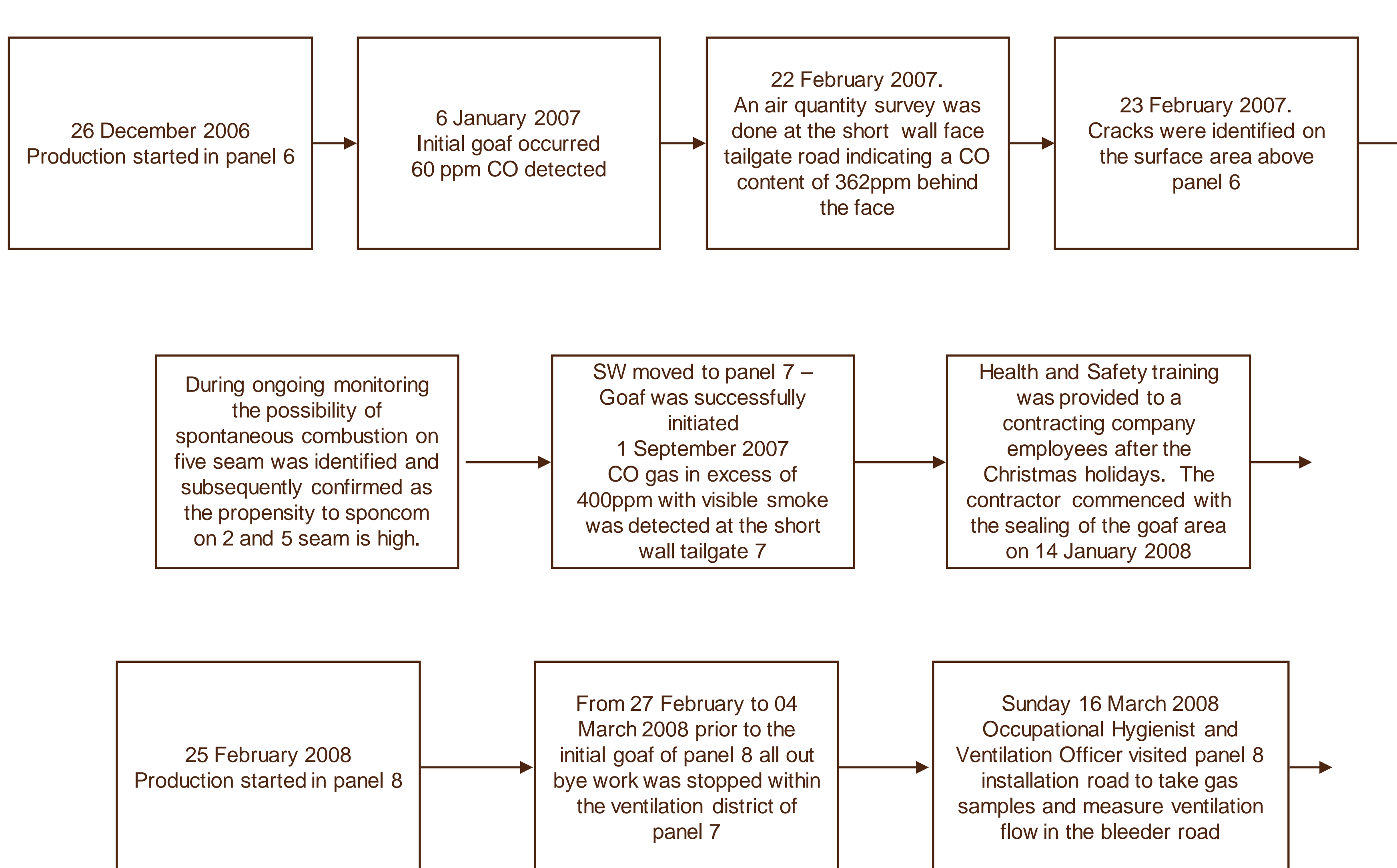
Background

In 2002 short wall mining started on 2 seam. At this stage 5 seam and 4 seam were already mined out. Initially the 2 seam panels were not superimposed with the 4 seam panels. This resulted in abnormal face pressures which resulted in numerous face breaks. A decision was then taken to superimpose 2 seam and 4 seam as from panel 6. This resulted in major subsidence and surface cracks. No CO gas was detected during the mining of the first five panels over a time period of four years

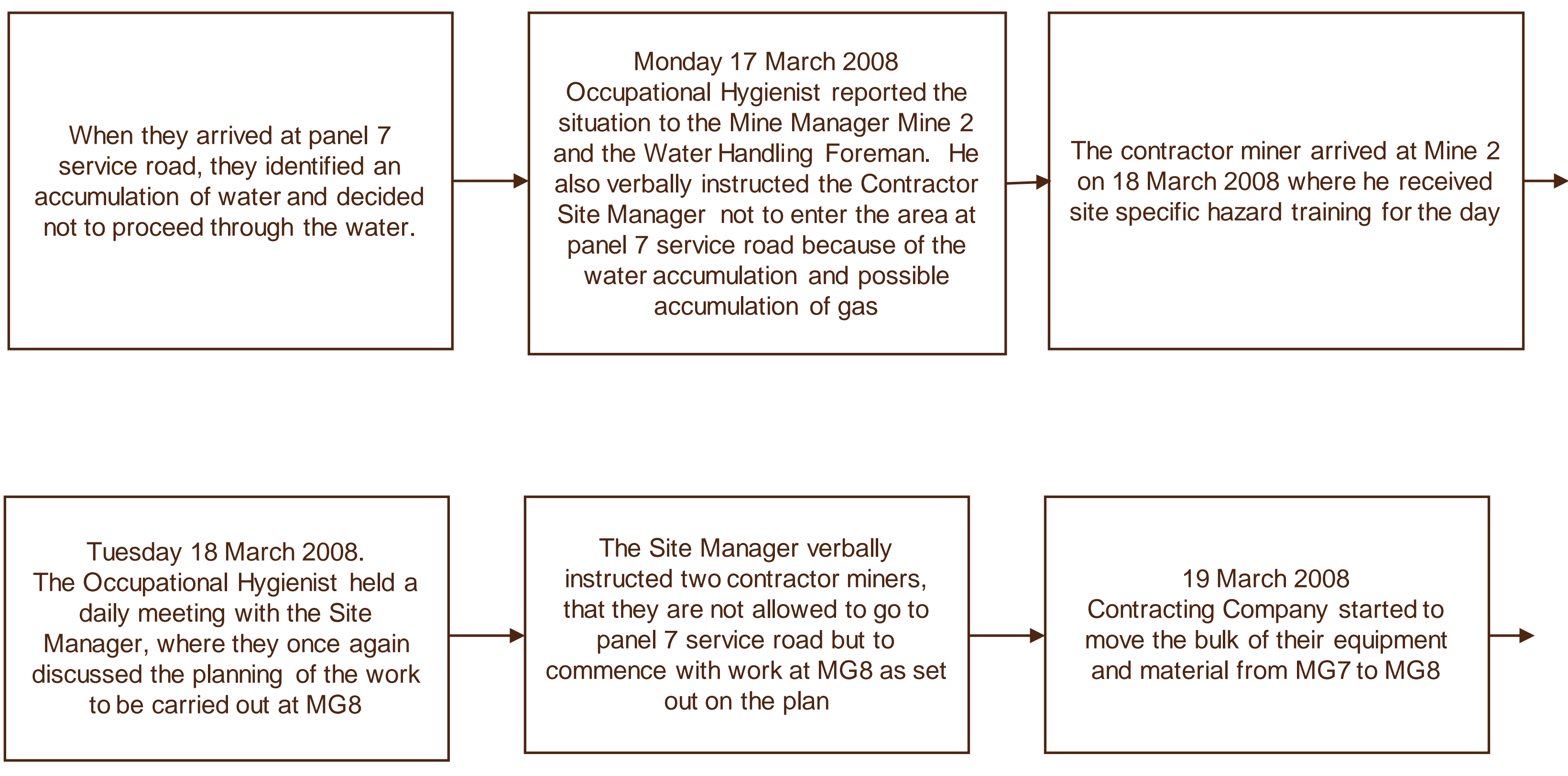
Surveyor plan of incident scene



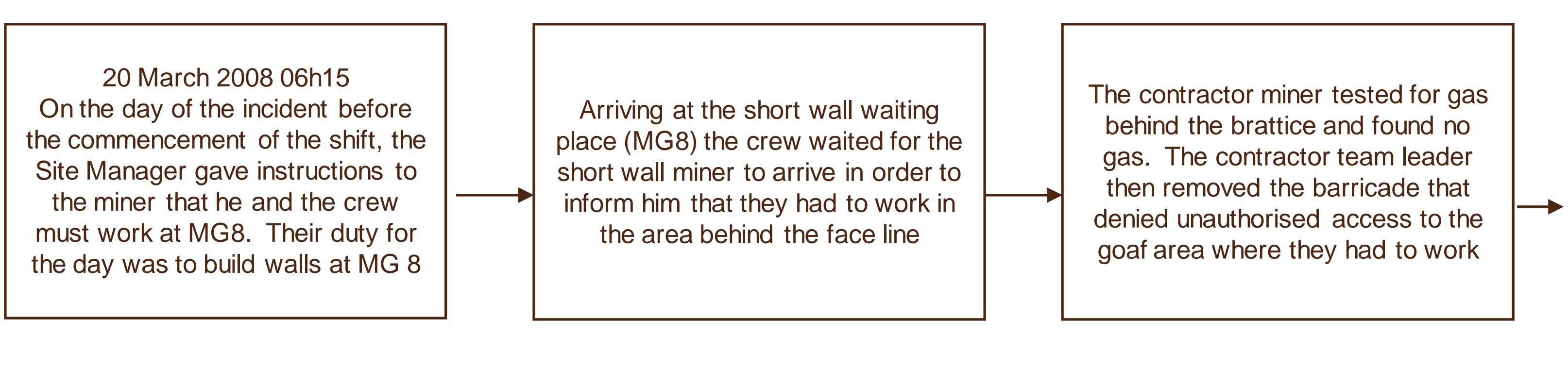
Storyline preceding the incident



Storyline preceding the incident



Incident storyline



The miner proceeded to inspect the rest of the working area and test for gas. The team leader and the crew stayed behind and did a mini HIRA on the work to be performed

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On completion of his inspection, the miner returned to the crew where he and the team leader divided the team into their various duties

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Work progressed for ± 2 hours during which time the tractor with material and equipment also arrived from MG7

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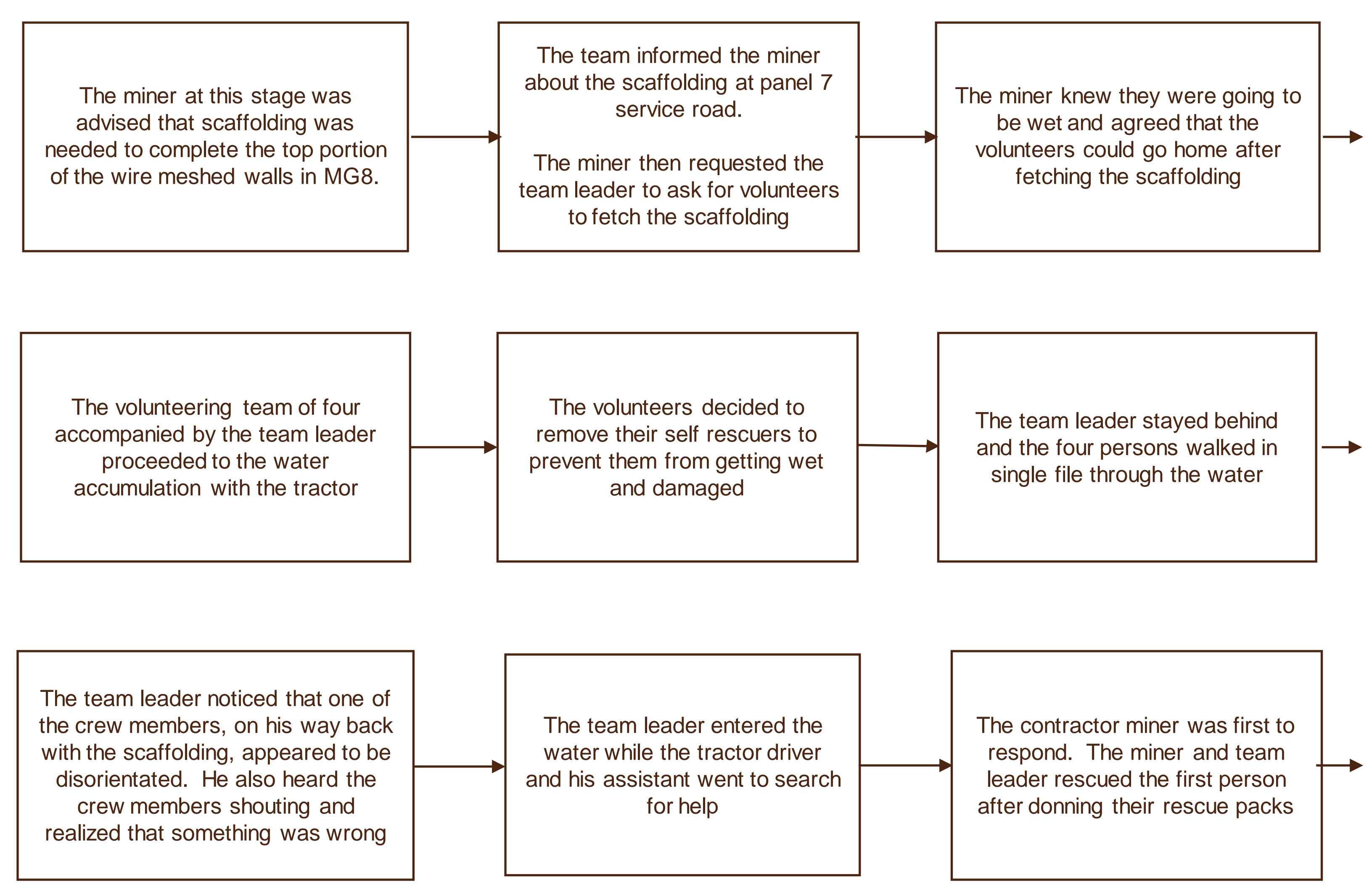
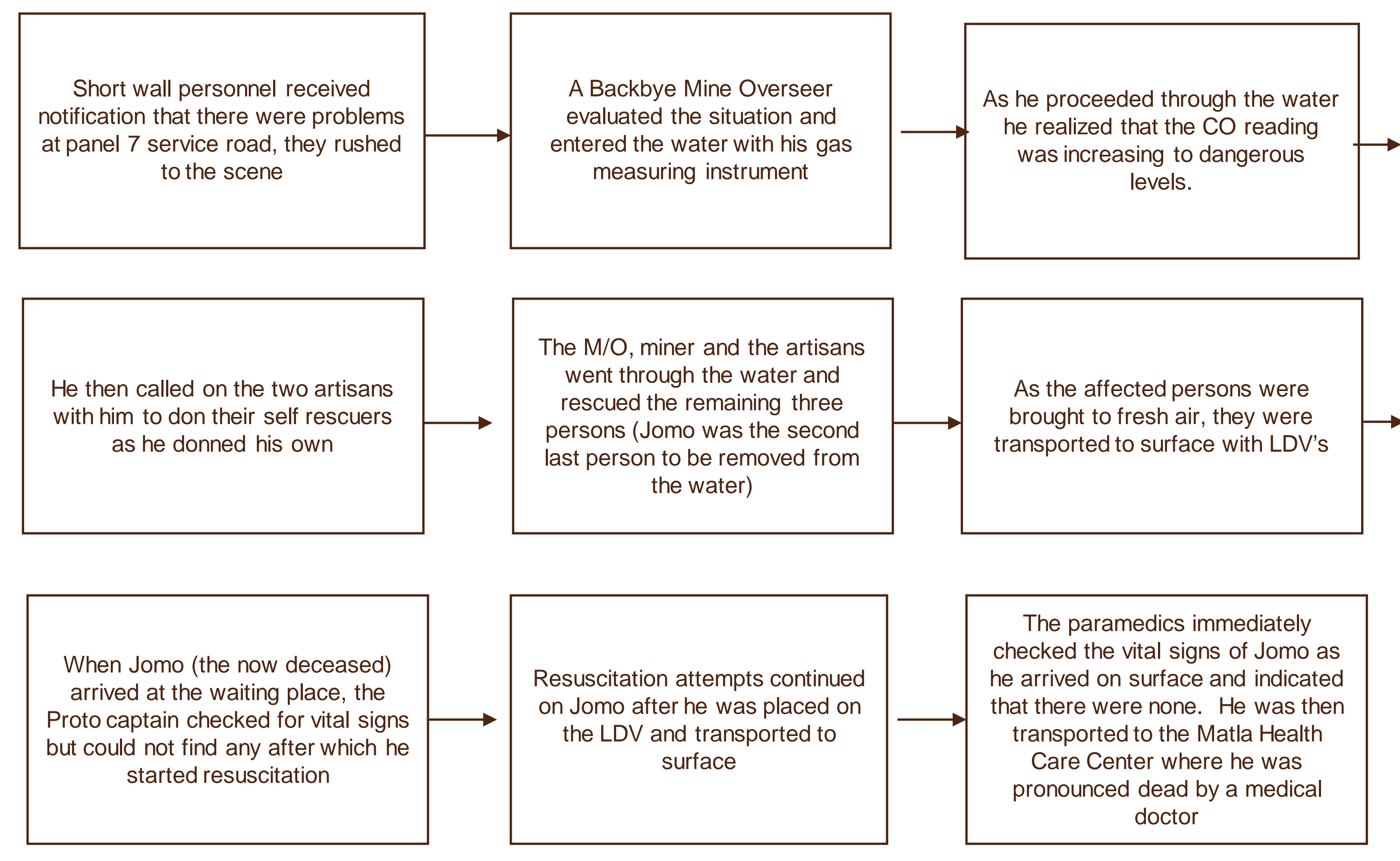
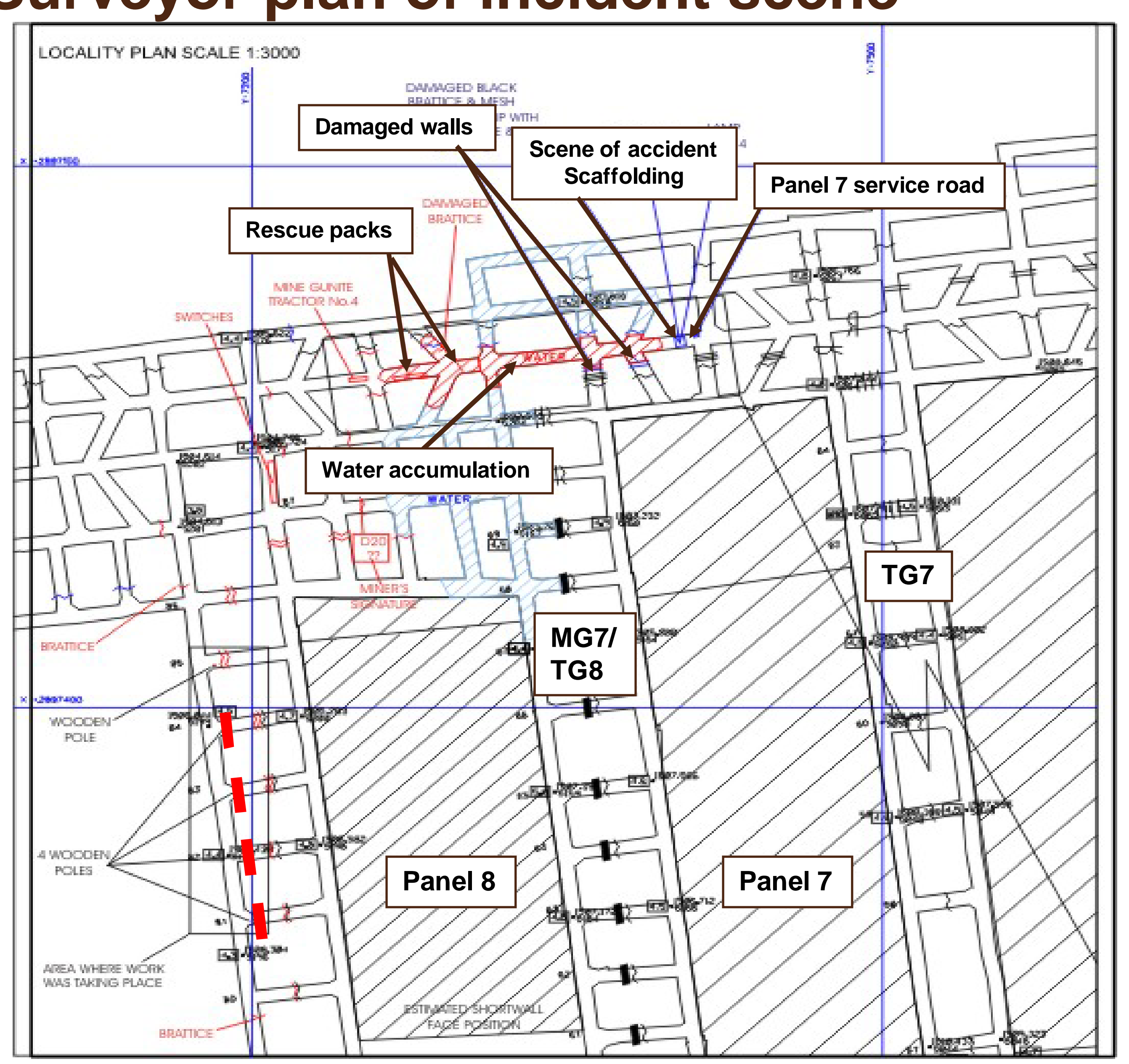
Incident storyline



Incident storyline



Surveyor plan of incident scene



Photos of the damaged walls behind MG7

Third split after entering the water

Fourth split after entering the water

Investigation Findings

- Spontaneous combustion occurred at 5 seam
- The initial goaf damaged two ventilation walls at panel 7 installation road allowing gas to escape into the workings
- An instruction not to enter the area where the incident took place was contravened by the miner and the team
- An effective barricade was not installed at the accumulation of water at panel 8 service road
- The contractor employees removed their self rescue packs in order to prevent water damage
- The contractor miner didn't have all the correct equipment to complete the work
- The specific area at panel 7 service road was not tested for gas before the crew were allowed to enter
- The miner was new in the area
- The contractor employees removed their self rescue packs in order to prevent damage
- Occupational Hygienist responsible for contractors but not responsible for declaring work areas safe to work

Remedial actions

ISSUE	ACTION
Spontaneous combustion occurred at 5 seam	Re-visit the goaf sealing strategy and investigate best practices. Install additional telemetry gas detectors around goaf bleeder road
The initial goaf damaged two ventilation walls allowing gas to escape into the workings	Complete 140 kPa walls to seal off goaf area. Purchase dual gas detection cap lamps for backbye pesonnel (including contractors).
An instruction not to enter the area was contravened by the miner and the team	Investigate a "Black box" recording telephonically and two way radio communication in the control room. Firemans report. Formal instruction system implemented.
An effective barricade was not at the accumulation of water at panel 8 service road	Access control to goaf bleeder road Construct lockable barricade over the full road width with key control Purchase additional gas testing equipment for all operations

Remedial actions

ISSUE	ACTION
The contractor employees removed their self rescue packs in order to prevent water damage	Make use of close circuit presentations on the shafts television network to alert employees on unsafe behaviors Upgrade the induction programme on Mini HIRA, testing for gasses and SCSR training
The specific area at panel 7 was not tested for gas before the crew were allowed to enter	Improve gas training techniques for all underground employees during weekly safety meetings and part of induction training
Contractor disobeyed instructions	Contract terminated. Miner blacklisted from future employment at Matla.

Remedial actions

ISSUE	ACTION
The miner was new in the area	Contractor management system reviewed ito training, skills etc. Scrutinise supervisors qualifications and retention of skills. Ensure all team leaders receive competent A training
Occupational Hygienist responsible for contractors but not responsible for declaring work areas safe to work	Appoint a Shift boss to take charge over contractors performing mining work
Demonstration of VFL	The quality of demonstrating VFL at all levels of management to be improved.
Management of leading indicators	The management of leading indicators for high risk areas needs to be improved on by ensuring quality PTO's, incident reporting etc and analysis thereof

Thank you