
North Goonyefla Mine Spontaneous Combustion Incident - Event Descriptors

63	2/1/98	5.00 PM	The TB was ordered from Blackwater by the Chief Mining Engineer	The TB took 24 hours to arrive and 12 hours to commission.	
64	2/1/98	6.00 PM	Sealing of 9 c/t via borehole was completed		
65	2/1/98	8.00 PM	The water pump was turned on to pump into 5 cit borehole		

66	2/1/98	9.00 PM	The Manager		The ICM was advised of the action.	
			develop•ed notification trigger levels in conjunction with the Consultant		These triggers were exceeded to around 1 1.00 PM and the Consultant 'returned to the mine. Hourly samples were initiated and the results returned rapidly to near fresh air status at 5 cit.	
			with the Consultant		LW4 TG was monitored hourly in order to detect POC leaking if a seal had been breached.	
				J. 4.	The resuKt ivas that a tube bundle blockage was diagnosed.	
67	3/1/98	AM	Bag samples were taken rro•n 4, 5 and 7 cit, water coming out	opened. Water was leaking abundantly around the periphery of 6 c/t seal.		
67A		8.15-9.15 AM	The second batch of CO, was started	f	Having noted a reduction in 02 content accompanied by a reduction H2 and CO at 5 c/t when the initial batch of CO was introduced, decanting of the second batch was implemented.	
					This was intended to cool the heating, deplete oxygen and allow access to the mine and re-establish the 5 c/t monitoring point.	
				3.	3,0001 of CO, were introduced producing 1,500 m ³ of gas.	
				4.	This resulted in a reduction in 02 concentration at 5 c/t seal to 9% from 15-18% and an increase in C02 to 57%.	
68	3/1/98	1 1.15 AM	The Manager returned underground to check the water pressure behind 6 c/t (2 psi)		The MM and Undermanager measured water pressure at 6 c/t through sample pipe. The pressure was 2 psi, indicating at that stage that the water pressure was approximately 1.5m. The 5 c/t sample tube was now clear begins been water filled earlier.	
68A	3/1/98	1 1.15 AM	Bag samples were taken to Moranbah North for comparison readings		The 5 c/t sample tube was now clear, having been water filled earlier. The GC at Moranbah North was used to check the results obtained at North Goonyella since critical decisions were being made, based essentially on GC data.	

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69 3/1/98	10.00 AM - 2.30 PM	There was a phone conference with the	A discussion was held to update the CMI and SIMTARS chemists on the situation.
	2.30 T W	Incident	The CMI again advised consideration of ventilation changes to the system. The Incident Team did not elect to e*ercise
		Management Team, CMI and SIMTARS	this option.

70	The TB arrived at 1 1.00 AM	Problems were encountered in gaining access to the TB at Cook Colliery and also with parts being left behind at Cook.
	2.	Cranage ivas a problem in that cranes and drivers had to be organised once the TB arrived on site, rather than being organised prior to that event.
	brack J.	The authorisation of crane drivers was an issue in that some of the North Goonyella staff are authorised as crane drivers but this resource was not used.
70A	The Manager, Undermanager,	After the introduction of water at 5 c/t, the tube bundle line had become blocked by water.
	Surveyor, and Consultant went underground to 2.	Having introduced 1,500 m of C02 at 5 c/t there was evidenced that the area was blanketed by C02 and was therefore depleted of oxygen.
	reestablish a tube bundle sampling point at 5 c/t 3.	The decision was taken with the agreement of the ICM and DCI to send a team to repair the tube bundle system in order to re-establish monitoring at the key point.
71	The TB was commissioned	The TB was commissioned at midnight, ran for I .5 hours and then stopped. The TB re-started in earliest at 5.00 AM. The TB was connected to the 5 c/t borehole which was 4" diameter rather than the normal 6".
	2.	The second inerting hole at 4 c/t was completed and the decision made to continue at 5 c/t rather than move the TB as the monitoring results •were favorable.
	J.	Pipes were laid out such that the TB could be connected to the 4 c/t borehole without moving the TB, or both holes could be placed on line in parallel.
	5.	The 02 concentration at 5 c/t reduced to approximately 4.5% within 7 hours. Over the next 36 hours it reduced to 0.5% but stabilised at approximately 2.5% following adjustment of the TB fuel system.

72	3/1/98	6.00 AM - 12.00 PM		2. J. 4. 5.	A surface borehole was being drilled at LW3 2.5 c/t for the purpose of sealing behind LW3 1-4 chocks and reducing leakage to the area of the heating. This hole was also a back up inerting hole. At this stage, the need to seal at LW3 MG was reduced as the inerting at 5 c/t borehole was taking effect, evidenced by the EMS data (ref. graphs). Difficult drilling and reduced requirement led to the decision to abandon and drill a back up inerting hole at 4 c/t. The 4 c/t hole was part of the strategy and this decision represented deletion of an element no longer required. The difficulty in drilling into goaf at this point accelerated the decision.
72A	3/1/98	6.00 AM - 12.00 PM	There was observed a dramatic reduction in 02, 1-12 CO readings at 5 c/t seal	2	Following introduction of C02 at 5 c/t borehole the readings of 02, 1-12 and CO at 5 c/t sampling point showed large scale reductions, indicated by the EMS graphs. Similar reductions were not seen at 7 c/t until later.
73	4/1/98	8.00 AM	There was an Incident Management meeting - action plan		Remedial work to get back underground i.e. grouting of LW3 MG area. Repair tube bundles at 4 and 7 c/t. Stone dusting LW3 and LW4 TG. Based on zero 1-12 reading.
74	4/1/98	8.30 AM	The decision was taken to conduct one hourly sampling at 5 c/t		This was decided in order to establish trends resulting from inertisation.
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75	4/1/98	I 1.20 AM - 1.40 PM	The Manager, 2 Undermanagers, Mines Rescue Officer and Miners Officer went underground	3. 4.	Bag samples •were taken from 3, 4, 5 and 7 c/t. The 5 and 6 c/t seals were repaired. The pressure drop across seals was measured The pressure drops were as follows: 3 c/t = 135 Pa 4 c/t = 135 Pa 5 c/t = 160 Pa 7 c/t = 80 Pa.
	4/1/98	5.30 PM	BHP Moura were contacted regarding a spare TB		BHP was placed on standby in case of a problem with the TB.

77	4/1/98	5.30-8.30	Level was declared by	Based on interpretation of monitoring data, the decision was made to commence the return to normal operations.
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Incident - Event Descriptöfs

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78	4/1/98	5.30 PM	The Manager established triggers for notification to the Manager and Ventilation Engineer	The trigger levels were established according to the SCHMP, 100 ppm Hi, > 200 ppm CO; >7%02. If triggers were reached, then hourly sampling WOUtd be implemented. If two consecutive samples of greater than 200 ppm H2, 400 ppm CO and 9% O, were recorded, then the mine would be evacuated.	
79	4/1/98	8.57 PM	The TB stopped at 8.57 - 9.15 and again at 9.42 - 10.56 PM	The stoppage was caused by a dirty fuel filter. 02 at 5 c/t seal increased from 3.5% to 5.5% by 10.00 PM. Issues were raised relating to: Maintenance Spare parts Technical back-up Analysis of gas produced by the TB.	
80	5/1/98	12.00 AM	The ICM and the Consultant checked the niethod of GC use	'I-he SIMTARS operator was having difficulty. A second trained operator was recalled to duty. Training of operators of GC was again raised as an issue.	

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Descriptors

		5/1/98	8.00 AM - 12.30 PM	The DCI, Senior Mines Inspector (SMK), the ICM and the Manager conducted an inspection of the mine	This preceded the normal pre-shift inspection by Deputies. Meetings were held between the mine management, Incident Team and Inspectorate following the inspection.
=	82	5/1/98	8.30-1 1 .30 PM	The Deputies pre-shift inspections were conducted	The inspections were suspended due to trigger levels being reached and the mine was evacuated.
	83	5/1/98	1 1.30 PM	The Deputies were withdrawn from the mine	A linear increase in CO and H, at 5 c/t was observed and considered to be inexplicable. CO and 1-12 reached 700 ppm and 400 ppm respectively.

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Three hourly bag samples from 4, 5 and 7 c/t were resumed from one hourly, due to falling below the set trigger levels.

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84	84 6/1/98 3.00 AM The TB was suspected to be the cause of		-	The Consultant asked for a bag sample of the TB exhaust due to the unusual linear trend in CO and H2 at 5 c/t.	
			reaching trigger levels	Bag samples were taken from the exhaust of the TB. The result showed 1,300 H, and 2,200 CO.	
			2	Routine hourly analysis of the TB exhaust was instigated.	
				Subsequently, the TB was proven to be very sensitive to fuel pressure, incomplete combüstion occurring at high pressure, causing the appearance of CO and 1-12 in the exhaust.	
			5	The TB had been operating at 0.5% 02, 20 ppm CO. At 10 AM, the TB was observed to produce 0.5% 02 and 150 ppm CO. At that output, 1-12 was also present. A compromise was agreed where the TB output was 1.2% 02, 20 ppm CO and zero FL.	
				The TB operators were instructed to monitor the output and report to the Incident Team if 02 or CO moved from the agreed value $\pm 5\%$.	
			ϵ	5 .	
85	6/1/98	4.15 AM	The TB was shut down on	Moths blocking the condenser were believed to be cause.	
			overtemperature	Once the TB stopped the 1-12 and CO concentrations at 5 c/t began to decline.	
86	6/1/98	8.00 AM	The Deputies pre-shift	The men went underground at 10.30 AM.	
			inspection was conducted	A normal shift was worked.	

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GLOSSARY

ACMI Acting Chief Mines Inspector

adsorbed The process of gas entrapment in the pore matrix of coal

CFMEU Construction, Forestry, Mining & Energy Union

CH4 Methane

CMI Chief Mines Inspector

CO Carbon Monoxide

COZ Carbon Dioxide c/t Cut through

DAK Loudhailer communications system

DCI District Check Inspector

desorbed The process of gas release from the pore matrix of coal

Inspector of Coal Mines

DMM Deputy Mine Manager

EMS Environmental Monitoring System

GC Gas Chromatograph
GM General Manager

GMHMP Gas Monitoring Hazard Management Plan

millimetres

1-12 Hydrogen

Vs • litres per second LW Longwall m metres

MG . main gate

Ml Megalitres

MM Mine Manager

O, Oxygen

Passport Hand Held Monitoring Device

PED Personal Ernergency Device

PJB personnel transport
POC products of combustion

ppm parts per million

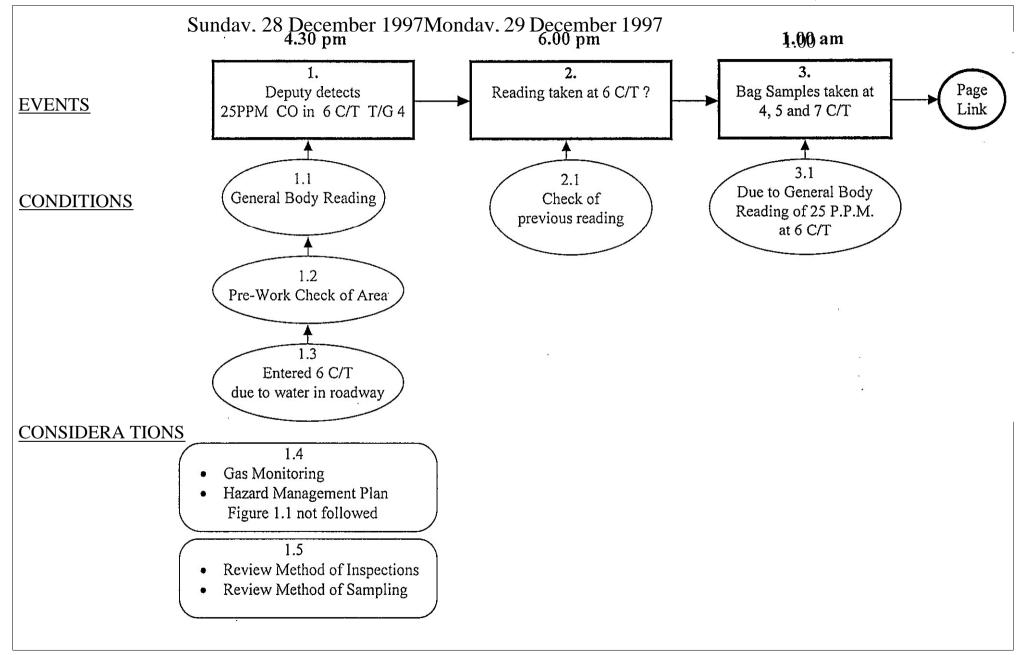
QMRS Queensland Mines Rescue Service

SCHMP Spontaneous Combustion Hazard Management Plan

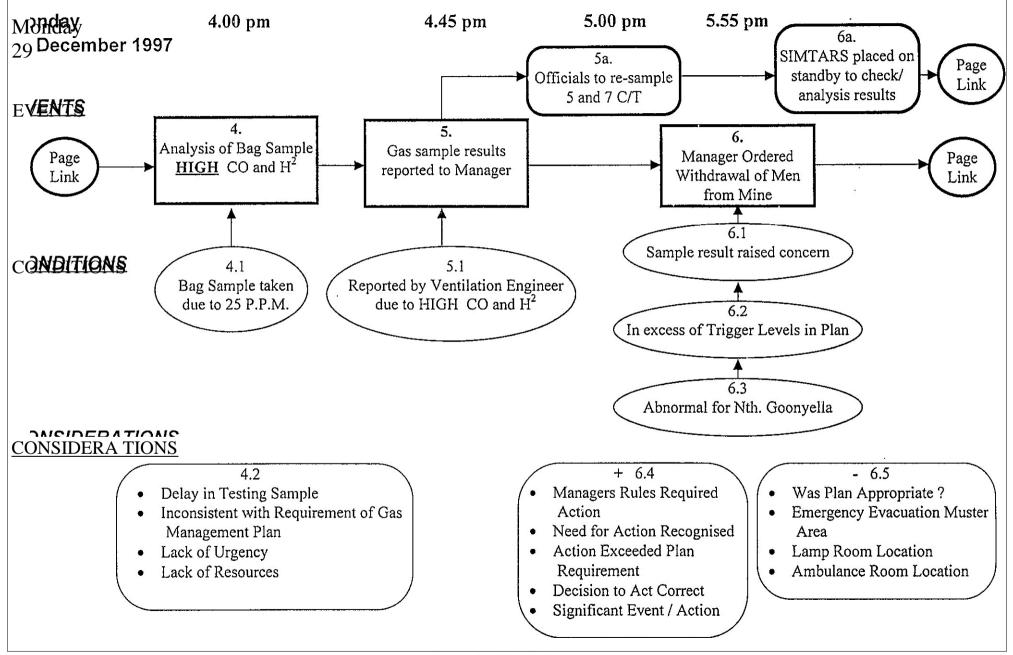
SIMTARS Safety in Mines Testing and Research Station

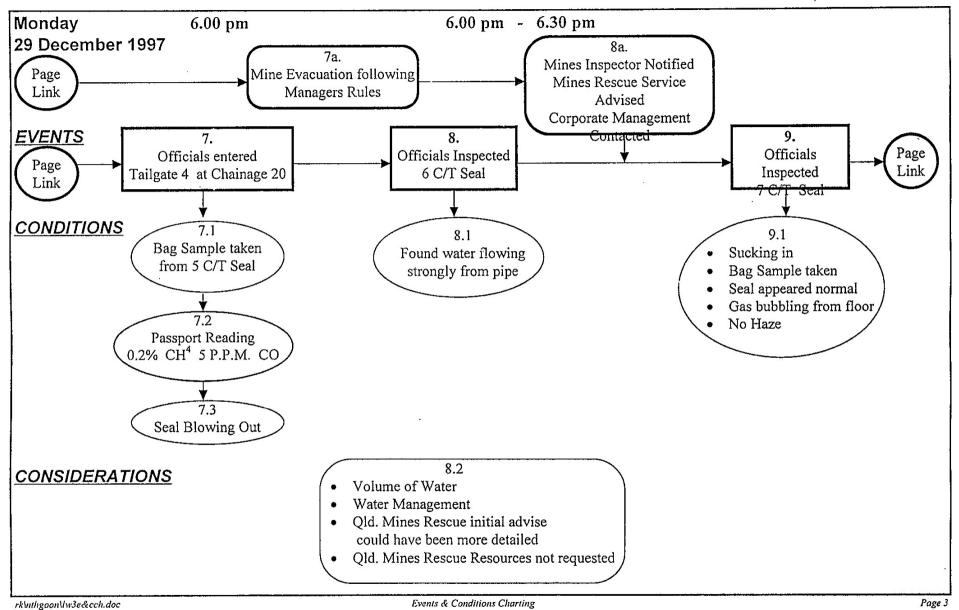
SMI Senior Mines Inspector

SMRS Southern Mine Rescue Service



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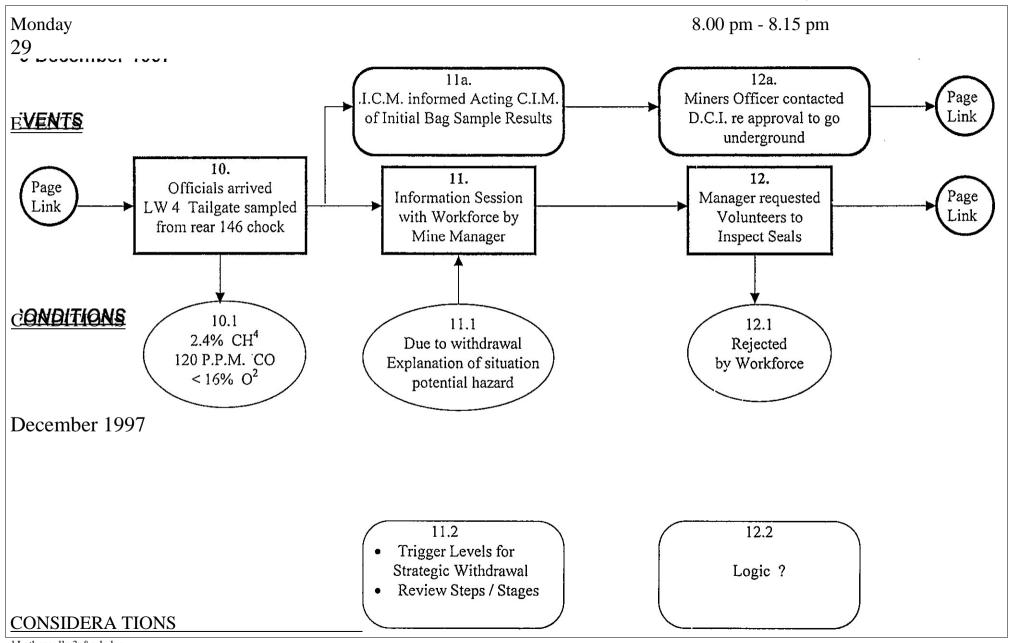




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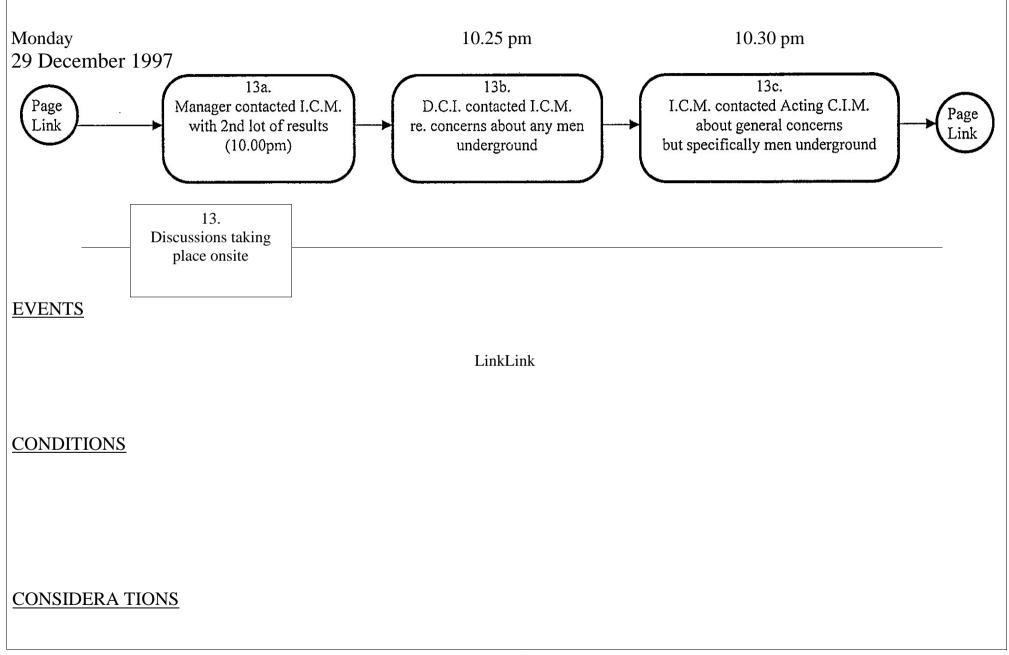
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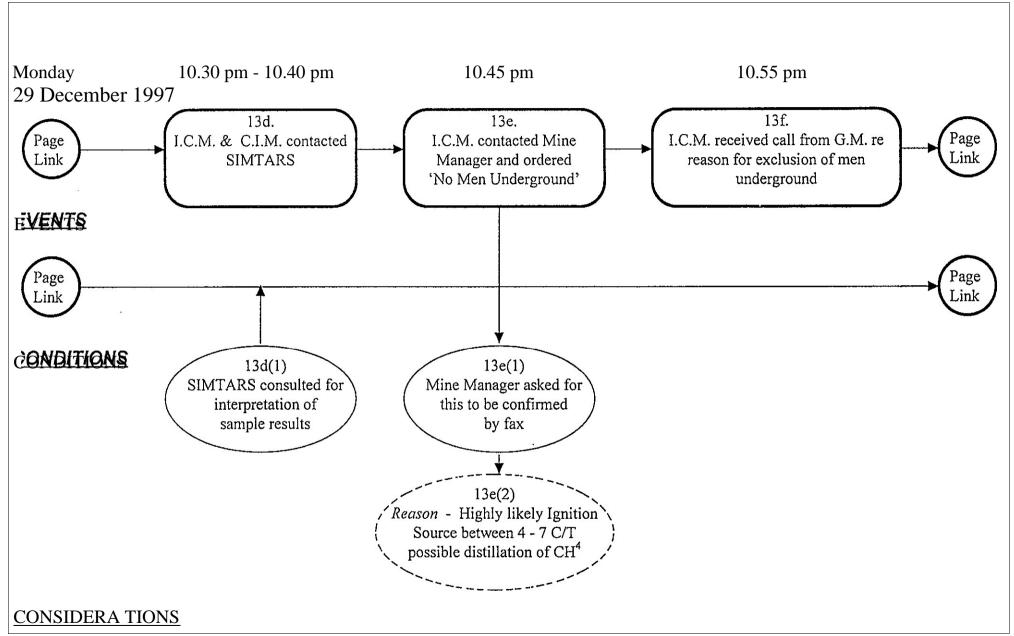
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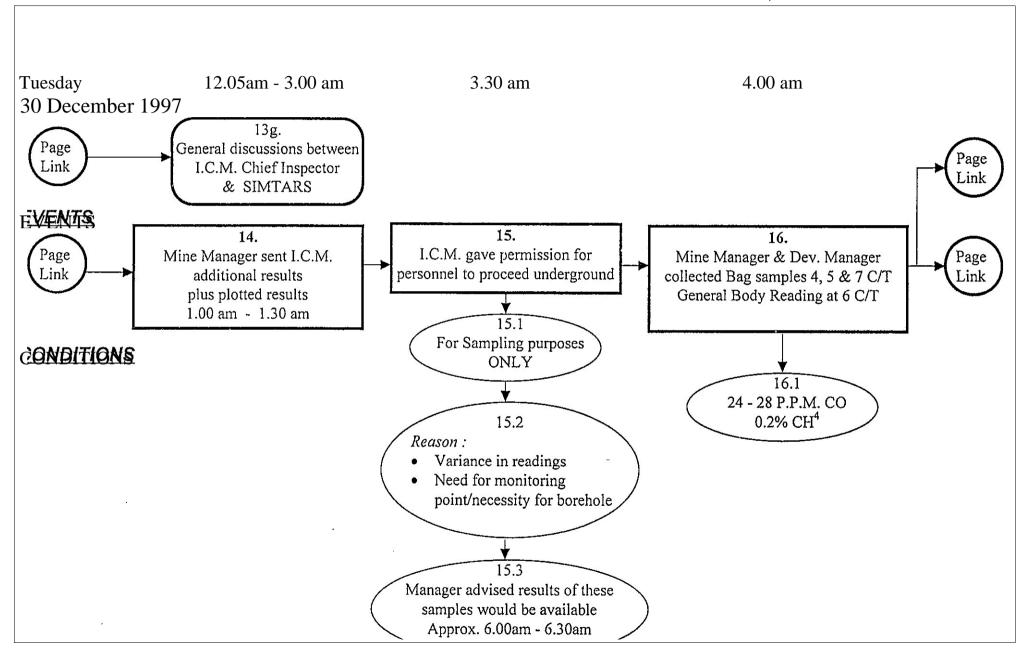
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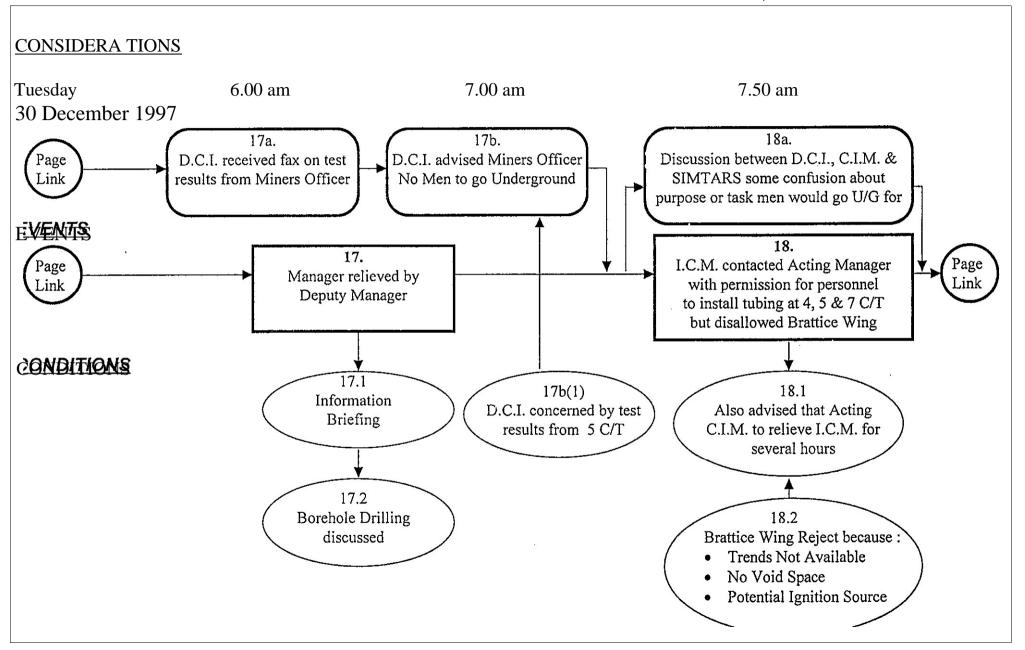


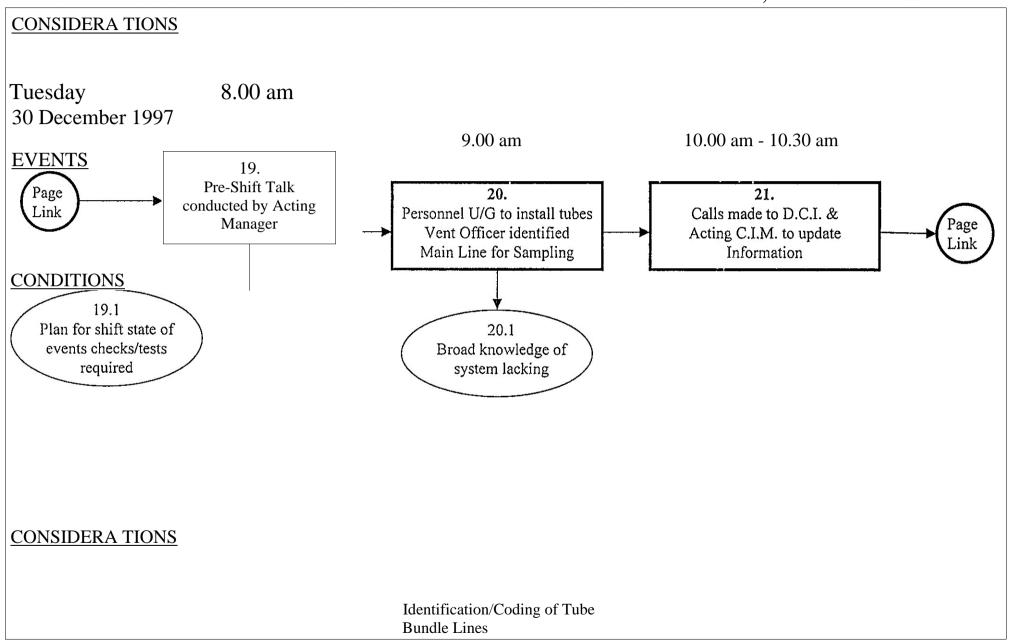
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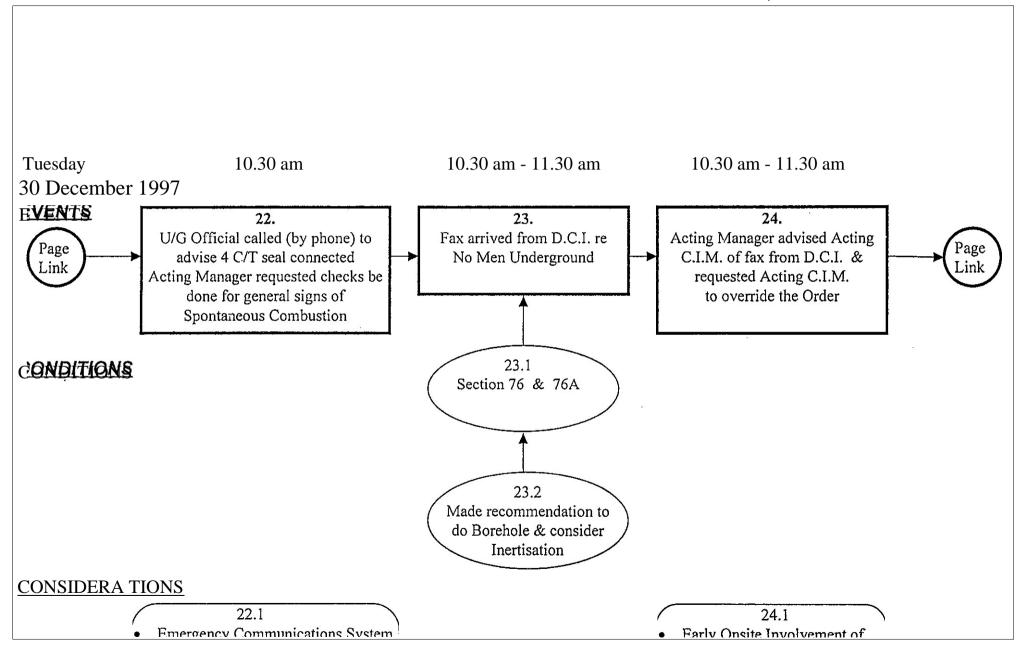


Installation

Local knowledge of System/Layout

Methods

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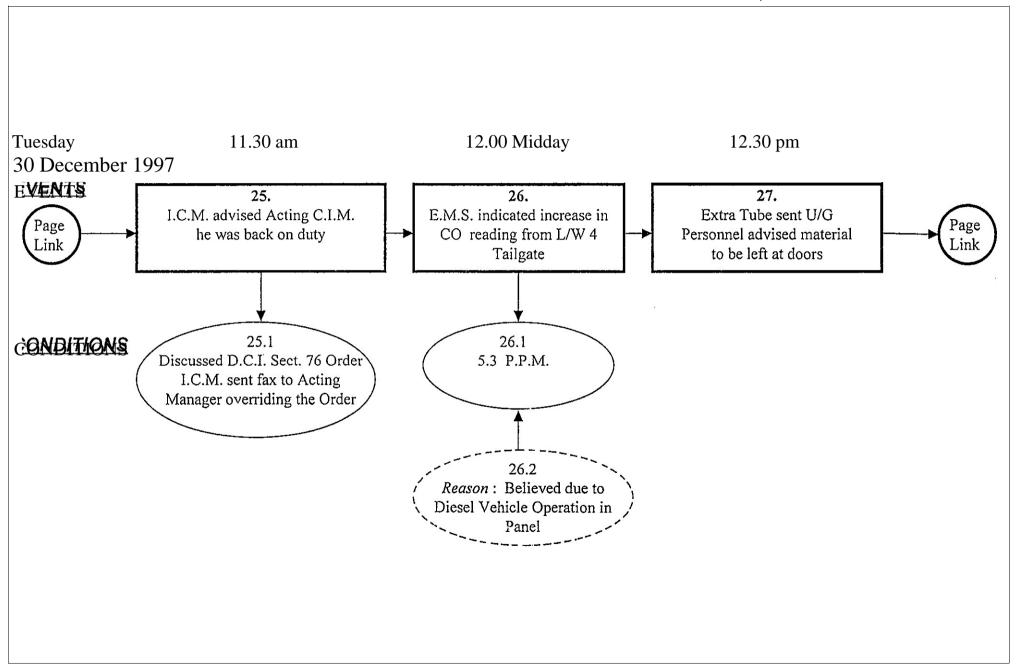
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Extended Emergencies
Lists of Available Resources

Events & Conditions Charting

Incident Team

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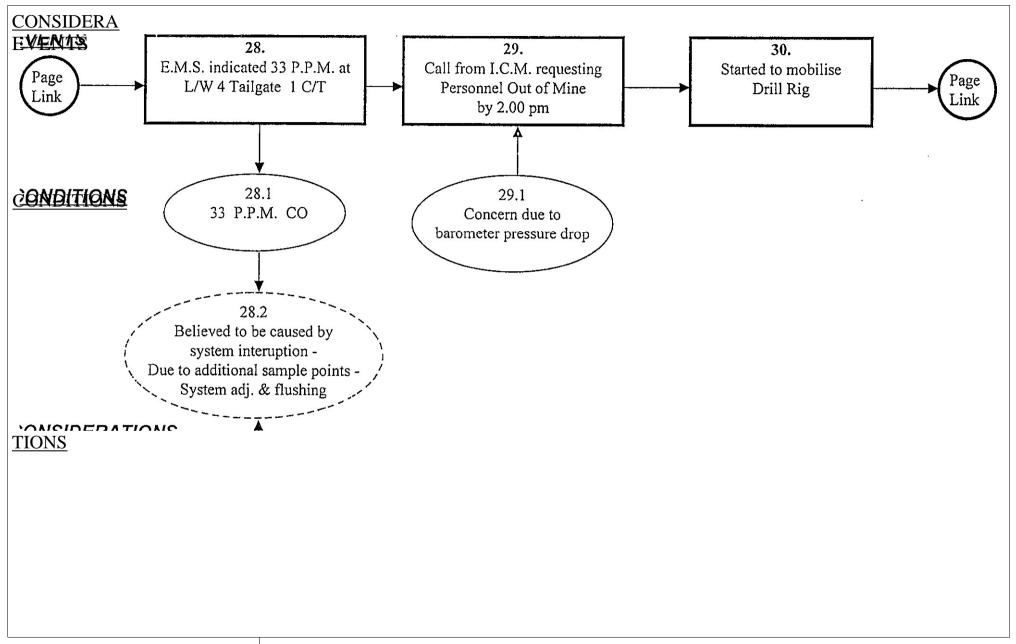


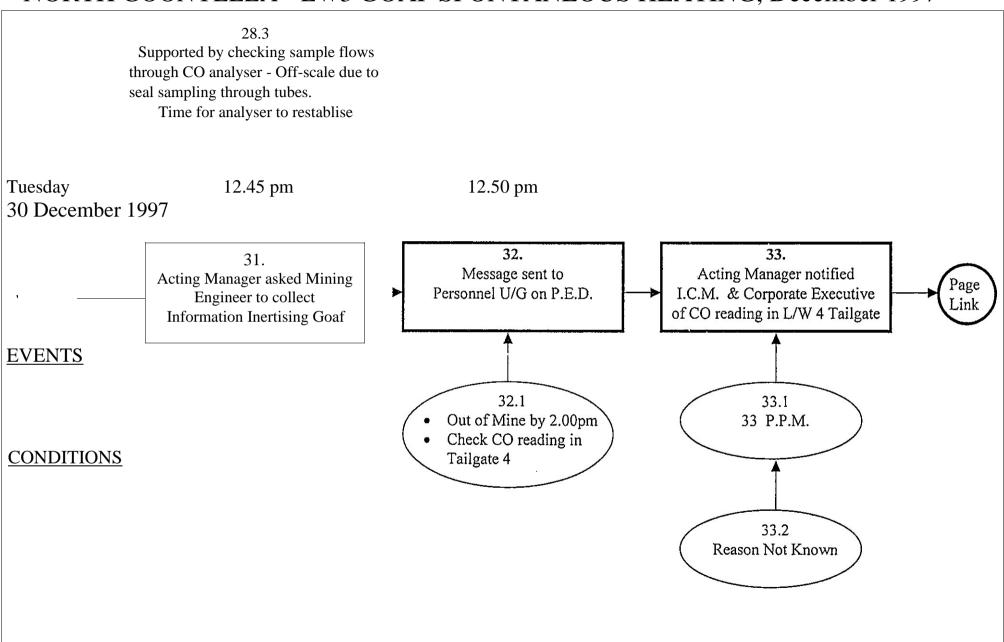
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CONSIDERA TIONS			
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