NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 8 July 2022

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.

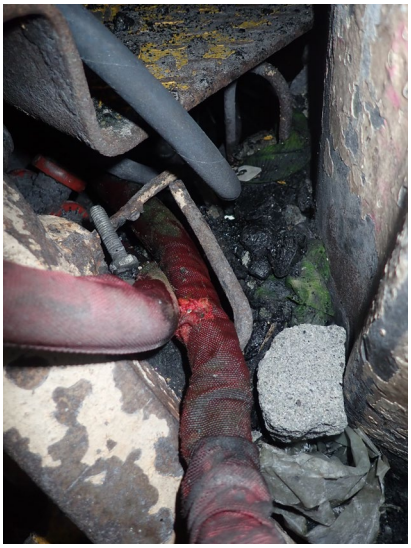
At a glance

High level summary of emerging trends and our recommendations to operators.

TYPE	NUMBER
Reportable incident total	43
Summarised incident total	4

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0042489 Underground coal mine	A worker was standing on a roof support when a high set hose failed on the adjacent support. The worker was struck with fluid on the arm. The mine uses a fluorescent dye additive in the longwall fluid. An inspection with a black light revealed emulsion in a pre-existing abrasion on the worker's arm. The worker was later cleared of injury when	Mine operators must develop and adhere to strict inspection and maintenance standards to avoid hose failure due to damaged and aged hoses. The life cycle of hydraulic hoses must be managed. High-risk hoses should have hose replacement schedules documented in the mines' maintenance systems. For further information refer to: MDG-41-Fluid-power-systems



Dangerous incident
IncNot0042491
Underground metals mine
Ground or strata

While charging an up-hole stope, workers were at an explosives hole charging unit when a brow failure occurred.
The failure was estimated at 20 tonnes, with some material breaching the bund.
Nobody was injured.

Underground mines should confirm workers are not exposed to the risk of strata failure by reviewing:

- the adequacy of their strata support at brow points
- monitoring arrangements
- associated trigger action response plans (TARPs)

Refer to:
Fall of ground risks at NSW underground metalliferous mines

Dangerous incident
IncNot0042496
Underground metals mine
Roads or other vehicle operating areas

A rear dump operator entered a tip head but could not establish positive communications due to 2-way congestion. The operator did not attempt positive communications and started to back up, hitting the ripper on the dozer. The truck operator thought the dozer was moving out of the way.

These types of accidents are becoming far too common in the NSW mining industry.
As a minimum, mine operators should put effective measures in place to monitor compliance to positive communication requirements and take action to correct as necessary.

A recent Resources Regulator campaign focused on the risk of collisions involving heavy mining equipment.
Refer to: Vehicle incidents - heading in the wrong direction

High potential incident
IncNot0042512
Underground metals mine
Roads or other vehicle operating areas

A diamond drill rig rolled over while maneuvering into a new drill site underground.
The operator was reversing into position when the rig slipped into a gutter and rolled over onto its side.
No-one was injured.

Equipment operators must maintain situational awareness and remain vigilant regarding the risk of machine rollovers.
When planning tasks and travel paths, workers and supervisors must consider rollover hazards such as cross grades, windrows, drains and potholes.

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
	National (other, non-fatal)
Resources Safety & Health Queensland	A CAT 789 haul truck backed position 5 and 6 wheels through a safety berm on an overburden dump during a night shift. After teetering for a brief period at the tip head, the truck rolled side-over-side for two complete revolutions, before finally coming to rest 26.7 m below on its wheels. The driver suffered injuries that required hospitalisation overnight. Between the supervisor inspection at the start of the shift and the time of the incident, the standard of the tip head had deteriorated significantly. The tip head was not to standard, being too narrow and misaligned, resulting in the truck backing up at an angle to the edge. Details
Orica	**Product Bulletin 5 JULY 2022** Safe use of Orica's electronic detonators. Avoiding misfires and unplanned detonation. 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.

DOCUMENT CONTROL	
CM9 reference	DOC22/193340
Mine safety reference	ISR22/27
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Approved by	Deputy Chief Inspector Office of the Chief Inspector