NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 15 January 2021

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.

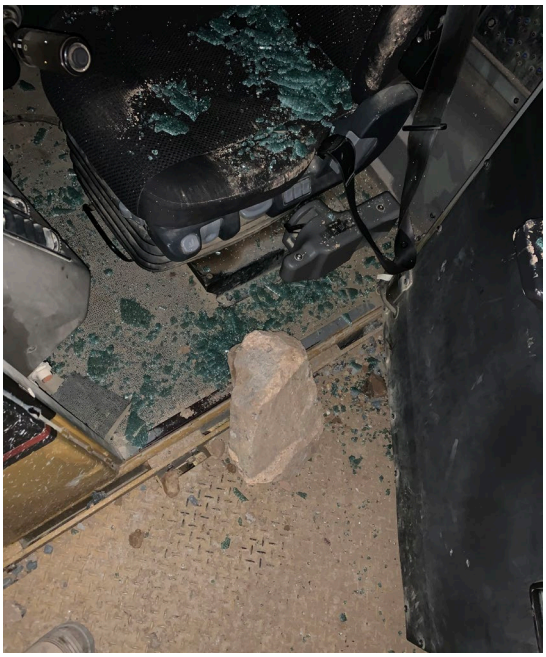
At a glance

High level summary of emerging trends and our recommendations to operators. Please note the reportable incident total is recorded for the period 9 January 2021 to 15 January 2021

TYPE	NUMBER
Reportable incident total	34
Summarised incident total	7

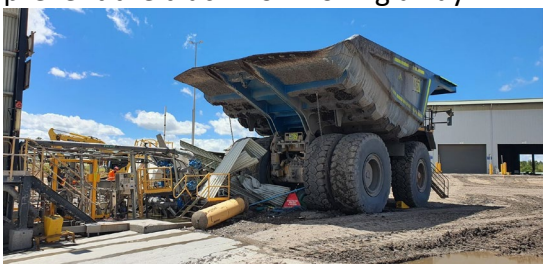
Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0038985 Underground metal mine	An operator was loading a truck at the oxide stockpile when a rock, weighing approximately 20 kilograms, came off the bucket and bounced through the truck side panel window, making contact with the operator. The operator received bruising to the upper arm.	Mine operators should ensure loader operators are trained in correct bucket loading practice and techniques, including loading perpendicular to the truck where appropriate. Mine operators should ensure that the most suitable plant is used to complete the loading. Introduction to site processes must be in place to ensure the correct equipment is used for each particular application.



Dangerous incident IncNot0038987 Underground metal mine	A work box detached from an integrated tool carrier and fell approximately two metres. It hit the ground and rolled 90 degrees onto its side, partially ejecting two mine workers who had been inside the work box. 	Mine operators must ensure that locking pins are in place on mobile plant used for work boxes. The locking pins should be used to give a positive/secure attachment. Mine workers involved in the task must verify that all locking pins are correctly engaged prior to use. Please refer to Safety Alert Elevated workbox falls from loader.
Dangerous incident IncNot0038989 Open cut coal mine	A truck was on the workshop deadline for a defect repair. After parking the truck, the operator exited the machine and the truck rolled backwards approximately 65 metres and collided with the pump at the wash bay. It has been identified that the park brake had not been applied. The mine also identified that the park up hump standard had deteriorated from recent	Where the ground is contoured to make vehicles fundamentally stable, mine operators must ensure the contours are to standard as per the procedure and are remediated if required. Park brake safety interlocks should be checked as part of pre-operational inspections and should never be used as the

wet weather events and failed to prevent the truck from rolling away.



primary means of applying the park brake.

Dangerous incident

IncNot0038998

Underground coal mine

A winder rope kinked approximately eight metres from the man car attachment point. The man car operator noticed the rope kink and the buildup of mud/dirt on the rope during operations.

From the primary investigation it was identified that the rope may have been run over by a vehicle with rubber tyres. Mines operating winders should have exclusion zones clearly defined. Workers must report damage to plant and equipment when it occurs.

Dangerous incident

IncNot0039012

Small mine

An excavator, tasked with building a ramp into the pit, was widening the area when a section of wall (topsoil and sand), approximately five metres high, has fallen out and smashed through the window on the excavator door allowing glass and soil into the cab to approximately ankle level. No one was injured.

Mine operators must have safe systems of work in place to inspect highwalls, low walls and dumps. These inspections must consider weathering effects, ground water, and conditions that affect stability. Following several incidents, where people and equipment have been exposed to significant health and safety risks as a result of highwalls, low walls and dumps failing, the NSW Resources Regulator published Safety Bulletin SB20-01 Failure of highwalls, low walls and dumps. Operators should take note of the recommendations in this bulletin.

Dangerous incident IncNot0039031 Underground coal mine	A fitter was in the process of checking a loose fitting on a shuttle car boom lift cylinder when the relief valve activated and sprayed hydraulic oil onto the fitter. The shuttle car was isolated at the time with the boom chocks in place.	Mines operators should review how workers and supervisors are trained to recognise the potential hazards associated with all energy sources. All hydraulic systems must be protected for over-pressure events. When designing pressure relief systems, consideration must be given to all applications and situations in which the equipment is used.
Dangerous incident IncNot0039039 Underground coal mine 	An idler bearing caught fire on a longwall conveyor outbye of the boot end. The mine has identified that a bearing failed prematurely on one side of the idler, which caused the bearing lubricant to ignite due to heat from friction.	Mine operators are reminded of their obligations under clause 29 of the Work Health and Safety (Mines and Petroleum Sites) Regulation. Belt conveyors must be inspected by a competent person once every shift, and as soon as reasonably practicable after belt shutdown (to detect hazards such as the presence of overheating, smouldering or other condition likely to cause fire). Particular attention must be paid to high tension areas and areas of temporary misalignment for the premature failure of rollers.

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
	International (fatal)
MSHA	**Mine fatality** – On 23 November 2020, a miner was electrocuted while troubleshooting a disconnect box for the classifier drive motor. The worker had

	the electrical disconnect box open and the main power supply was not deenergised. Details
MSHA	**Mine fatalities** – On 14 December 2020, two miners died when a back failure occurred in a large four-way intersection. The miners were pumping sealing grout in the intersection when blocks of salt and anhydrite fell from beneath a slickenside onto the miners. Details
MSHA	**Mine fatality** – On 15 December 2020, a miner was fatally injured while changing the rear tire on a front-end loader. The worker was underneath the front-end loader when it fell. Details
	International (other, non-fatal)
Safequarry	**Dredge worker injured by stored energy** A conveyor belt contractor working onboard a UK marine aggregate dredger was struck in the face by a chain under tension, while engaged in turning the longitudinal belt, which had flipped during operation. Details
Safequarry	**Close inspection of shovel loader identifies serious fault in rim** During an inspection carried out by an engineer on a Komatsu WA 320 Loading Shovel at an asphalt plant, it was noted that there was a crack travelling from the holes of each wheel stud. At first glance, it looked like the paint work had cracked, but after cleaning the area with a pressure washer and upon closer inspection, it was confirmed that this was a crack in the rim itself. Details
	National (other, non-fatal)
DMIRS (WA)	**Safety management of electrical arc flash hazards – Information sheet** This information sheet is designed to assist in developing safety measures to control arc flash hazards at mines. Details
Resources Safety and Health Queensland	**High potential incident summary - October 2020** Details

(MMQ Inspectorate)	
Resources Safety and Health Queensland (CM Inspectorate)	**Tyre explosion following lightning strike – Safety alert no.383** A coal mine worker in the crib hut for the pre-start meeting, saw lightning strike a truck in the park-up area. Shortly afterwards, the position 5 tyre on the truck exploded. Details
Department of Natural Resources Mines and Energy (QLD)	**Coolon Lighting – emergency battery packs deformation: Petroleum and gas Safety alert no.97** Coolon lighting and solutions have become aware of a potential safety issue with some of their emergency battery units or emergency battery packs (EMP's) 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	DOC21/28166
Mine safety reference	ISR21-02
Date published	23 January 2021
Approved by	Chief Inspector Office of the Chief Inspector