WEEKLY INCIDENT SUMMARY

Week ending Friday 18 October 2019

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.

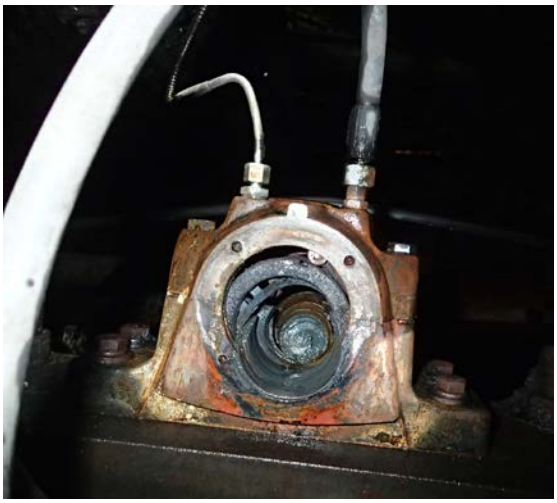
At a glance

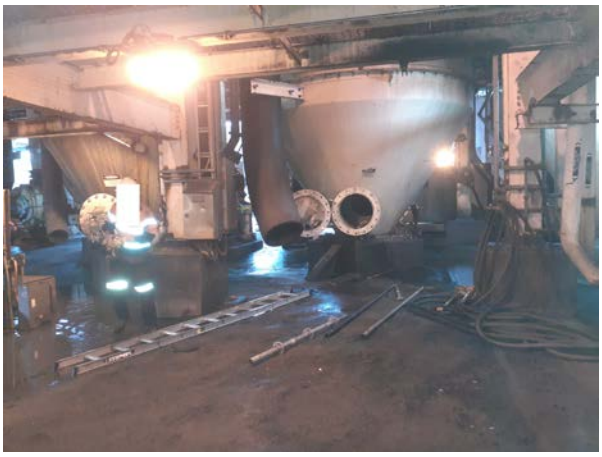
High level summary of emerging trends and our recommendations to operators.

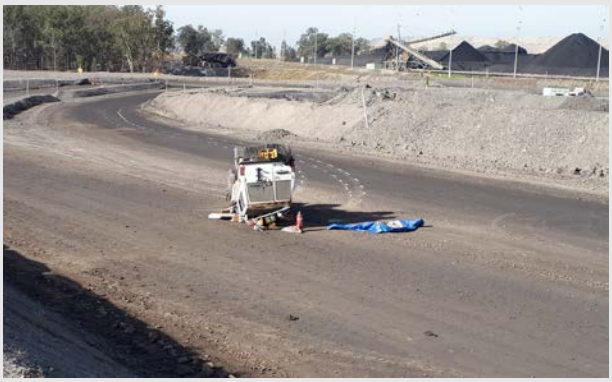
TYPE	NUMBER
Reportable incident total	40
Summarised incident total	6

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0035799	A worker at an underground coal mine suffered an electric shock while standing next to a shuttle car. The worker had one hand in contact with the rib mesh and the other hand touching the shuttle car. An investigation identified that the trailing cable may be non-symmetrical. Further testing of the cable will be carried out at a repair facility.	The electrical engineering control plan for a mine must set out the control measures to manage risk to health and safety from electricity at the mine. Reeling or trailing cables used in the hazardous zone must comply with the requirements of WHS (MPS) Regulations.
Workplace fatality IncNot0035801	A worker has died while operating an excavator. Initial assessment by ambulance officers was that the worker suffered a heart attack.	This matter is under investigation. Further information will be published in due course.

Dangerous incident IncNot003535793	A daily inspection identified a hot bearing in a tension pulley at a tripper drive on an underground coal mine conveyor belt. The belt was immediately shut down, belt tension was removed and the pulley was doused with water. Temperature monitoring did not detect the high temperature. 	The mechanical engineering control plan for a mine must set out the control measures to manage risks arising from fires being initiated or fuelled by plant. In developing these control measures, mine operators must take into account the prevention, detection and suppression of fires on conveyors. Mines must have a system to identify and change-out rollers. People conducting inspections must be aware of the increased risk of roller failure at high tension sections of belt.
Dangerous incident IncNot0035842	A worker at an exploration site felt unwell and reported having 'pins and needles' sensations. He was transported to hospital and it later confirmed that he had a stroke. The worker was recovering in hospital.	It has been reported to the regulator that doctors believe it was a medical event and is not work-related.
Dangerous incident IncNot0035827	During a shut-down at a coal preparation plant, two workers were erecting scaffold in an enclosed sump at a wash plant. At this time about 3000 litres of water was released from an overflow at the top of the plant. The level of water in the sump rose dramatically causing the workers to quickly exit the sump as the water rose above the egress point. One worker suffered knee injuries.	Mine operators need to be vigilant to ensure that all hazards are identified and appropriate controls are in place to prevent risks to workers while plant maintenance is being carried out. Consider the possibility of a second means of egress from confined spaces and ensure emergency protocols are in place to reduce the consequences of an inrush event.



Dangerous incident IncNot0035831	A light vehicle with three occupants was returning from the pit at a surface coal mine when it rolled onto its roof on the main access road. Two of the occupants exited the vehicle unharmed while one had to be stabilised before being removed from the vehicle. It appears that speed was a causal factor in this incident. 	Mine operators should review how road rule compliance is assessed and drivers should be reminded to travel at speeds suitable for the conditions.

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	**Metal/non-metal mine fatality** On 15 June 2018, a worker fell from a man basket when the weldment securing the basket to the shovel failed. The worker died of his injuries on 27 June 2019. Details
MSHA	**Mine fatality (final report)** On 24 June 2019, a contractor fell beneath the wheels of a tractor-trailer that was stuck in the sand. The contractor was walking toward the side of the truck as it was being extracted with a bulldozer. He fell and died at the scene. 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	DOC19/908322
Mine safety reference	ISR19-41
Date published	25 October 2019
Approved by	Chief Inspector Office of the Chief Inspector