NSW GOVERNMENT

NSW Resources Regulator

# WEEKLY INCIDENT SUMMARY

## Week ending Friday 19 November 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.

| TYPE | NUMBER |
|---|---|
| Reportable incident total | 41 |
| Summarised incident total | 2 |

## Summarised incidents

| INCIDENT TYPE | SUMMARY | COMMENTS TO INDUSTRY |
|---|---|---|
| Medical treatment injury<br>IncNot0041117<br>Underground coal<br>Ground and strata<br>  | A worker was leaning down, placing a monorail beam on the floor. A piece of rib material about 0.5m x 0.5m x 0.2m fell from the rib striking him across the shoulders and neck. The worker suffered a fractured vertebra.<br>The incident was reported by the mine operator as a medical treatment injury (WHS(M&PS) Reg 2014 cl128(1)(a)). In reviewing the incident details, Resources Regulator inspectors formed the view that the incident met the requirements of a dangerous incident (WHS(M&PS) Reg 2014 cl179). Investigations are ongoing. | Mines must ensure roadway are driven, and strata support installed to design, including roadway dimensions. Systems should be implemented to monitor compliance to design.<br>Workers must be vigilant for loose and unsupported coal that is not directly influenced by strata support. When a hazard is identified it should be made safe such as barring down or installing additional support.<br>Mines must have in place systems for the management of dangerous incidents as defined in cl179 Work Health and Safety |

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| | | (Mines and Petroleum Sites) Regulation 2014. Statutory officials should be trained in the implementation of these systems. |
| Dangerous incident<br>IncNot0041107<br>Underground coal | During bolting operations on a continuous miner, a worker was sprayed with hydraulic oil that released under pressure from the bolting rig.<br>The operator was standing about one metre away, operating the controls of the other bolting rig. The worker was cleared of any fluid injection injuries. | Maintenance procedures should confirm that oil pressure in circuits is in accordance with the original manufacturer's recommendations.<br>Pre-use inspections should include checks for damage that may impact the integrity of fluid power systems and components.<br>For further information refer to:<br>MDG-41-Fluid-power-systems |

# 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 (other, non-fatal)** |
| **MinEX NZ** | **Articulated dump truck (ADT) - Mechanical failure**<br>As an ADT was braking downhill, the 'whole tray was thrown up onto its side'.<br>Details |
| | **National (other, non-fatal)** |
| **Resources Safety and Health, Queensland (coal)** | **Safety alert #401 – Pressurised steering accumulators sent off site**<br>Two accumulators from the steering system of a Komatsu 830E rear dump truck were sent from a mine to the original equipment manufacturer (OEM) for servicing. Through its own procedures, the OEM discovered that it was still pressurised. There wasn't any notification or tagging to warn about remaining pressure.<br>Details |

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| **Resources Safety and Health, Queensland (coal)** | **Incident Periodical (August 2021)**<br>Recent high potential incidents; learnings and recommendations.<br>Details |
| **Resources Safety and Health, Queensland (coal)** | **Safety alert #402 - Introduction, inspection and maintenance of gas detecting and monitoring equipment**<br>Incidents have occurred while undertaking maintenance tasks associated with gas monitoring systems.<br>1. An incident occurred at an underground coal mine in which a longwall CH4 sensor was being relocated from a powered roof support to another location along the faceline. When the sensor was disconnected, the tripping circuit failed to operate.<br>2. An incident occurred at another underground coal mine in which an ERZ/NERZ boundary sensor went into a fault condition due to the failure of the uninterruptible power supply and the tripping circuit failed to operate.<br>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** | DOC21/1036540 |
| **Mine safety reference** | ISR21-46 |
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| **Approved by** | Deputy Chief Inspector<br>Office of the Chief Inspector |