NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 4 September 2020

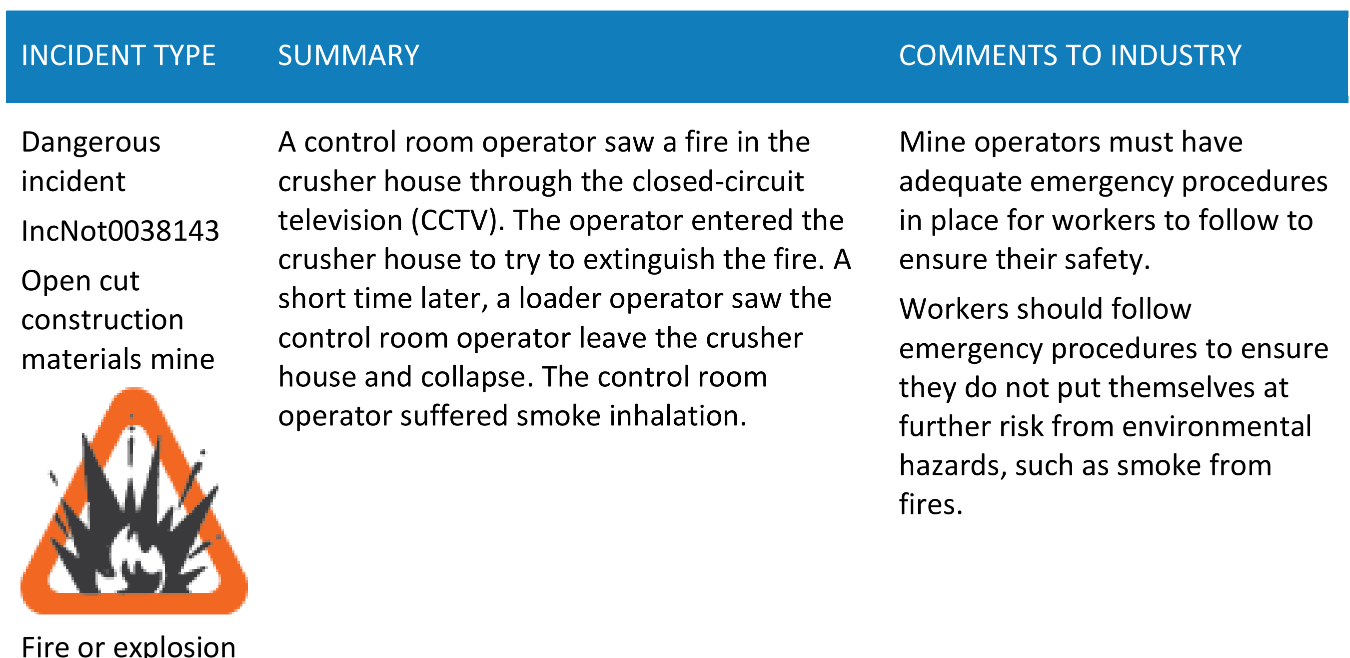
This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the NSW Resources Regulator: phone 1300 814 609 24 hours a day, 7 days a week.

At a glance

High level summary of incidents and our comments to operators.

TYPE	NUMBER
Reportable incident total	45
Summarised incident total	5

Summarised incidents



INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0038143 Open cut construction materials mine Fire or explosion	A control room operator saw a fire in the crusher house through the closed-circuit television (CCTV). The operator entered the crusher house to try to extinguish the fire. A short time later, a loader operator saw the control room operator leave the crusher house and collapse. The control room operator suffered smoke inhalation.	Mine operators must have adequate emergency procedures in place for workers to follow to ensure their safety. Workers should follow emergency procedures to ensure they do not put themselves at further risk from environmental hazards, such as smoke from fires.

Dangerous incident IncNot0038155 Open cut construction materials mine Roads or other vehicle operating areas	After tipping a load, a haul truck operator drove about 30 metres with the tray of the truck raised. The tray hit the walkway of a conveyor structure. 	Mine operators should ensure that tipping trucks are fitted with visual or audible warning devices and/or a device that will automatically stop or inhibit the movement of the truck while the tray is in the raised position. Refer to safety bulletin: SB15-05 Plant contacting overhead powerlines and structures
Dangerous incident IncNot0038161 Underground metals mine	A 120mm^2 steel wire armored cable was run out and hung to a roof, suspended on steel hooks. Workers who were tasked with terminating the cable were pulling it to achieve enough slack when the cable suspension hooks failed, allowing the full length of the cable to fall to the ground.	Identifying hazards and assessing risk is of paramount importance for the safety of workers. Detailed planning for all jobs should be completed prior to the start of a task. When work deviates from the original plan, a risk assessment must be completed, and the plan revised. It is foreseeable that pulling heavy cable that is hanging from hooks presents a level of risk that must be controlled.
Dangerous incident IncNot0038162 Underground metals mine 	A Jumbo operator and a nipper were working on a stope that had previously been rock filled when they noticed the floor starting to slump. The floor slumped about three metres. A preliminary investigation suggested water from the Jumbo seeped through the floor and moved fine material into a larger void, resulting in the slump.	Procedures for backfilling stopes should include adequate controls and verification to ensure that the ground is consolidated no voids remain that could lead to slumping.

Ground or strata		
Dangerous incident IncNot0038123 Underground metals mine	Electricians working underground were installing a high tension cable from an integrated tool carrier basket. A rope connected from the end of the cable was tied to the mid rail of the basket. As the integrated tool carrier trammed to pull the cable, tension in the rope has overloaded the mid rail of the basket, causing it to fail. The rail hit an electrician on the torso.	If workers deviate from standard procedures for a task, the work must be managed through a change management process. If no procedures have been developed for the task, then the task should not be undertaken until an appropriate risk assessment has been carried out. The force applied when pulling material needs to be known so that fit-for-purpose equipment can be used. Lifting or pulling equipment should only be used in accordance with manufacturer's instructions and for the intended purpose.

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)
MSHA	**Working in proximity to belt conveyors – Safety Alert** There have been eight fatalities involving belt conveyors in the mining industry since 26 January 2017. Six involved miners working near moving conveyors, while two involved maintenance of an idle conveyor. All these fatalities could have been prevented with proper lock-out/tag-out and blocking against motion before working. The most recent fatality, involving a miner coming into contact with a moving conveyor, is under investigation. Details
MinEx NZ	**Worker falls off dozer** A mechanic was standing on the track of a dozer to remove the seat to access a hydraulic hose that had burst. The seat was very heavy and too much for one person to carry. The mechanic slipped and fell from the dozer track fracturing his shoulder. Details
	National (fatal)
DMIRS (WA)	**Adequacy of windrows (bunds) for vehicle impact – Mines Safety Bulletin No. 179** Since January 2018, more than 180 interactions with windrows (or bunds) have been reported on Western Australian mine sites. These involved vehicles breaching windrows, with incidents resulting in injuries to workers and one fatality. Details
DMIRS (WA)	**Manned loader falls into open stope – fatal accident** In July 2020, an operator was driving a load haul dump (LHD) in an underground mine when it fell over the edge of an open stope. The LHD fell approximately 25 metres and the operator sustained fatal injuries. Details

	National (other, non-fatal)
QMI (Coal)	**Structural failure: Overburden drill mast – Safety Alert #376** On 19 August 2020, a carousel wear plate, weighing about one kilogram, fell from a height of 12 metres from the drill mast and landed on the deck of the drill near the cab door. The mines inspectorate is aware that this is not an isolated incident, having raised safety alerts on similar incidents previously. Details
QMI (Coal)	**Continuous miner mounted rib protection systems – Safety Alert #377** On 27 July 2020, two coal mine workers suffered serious injuries from rib spall while working on a continuous miner in a development panel heading. The incident occurred as the workers were installing roof support and extending ventilation tubes. An inspection of the site revealed that the machine mounted rib protection system installed on the continuous miner did not provide an effective control for this hazard. Details
The National Road Safety Partnership Program **(NRSPP Australia)**	**DIDO and fatigue** The drive-in-drive-out (DIDO) lifestyle has its perks but comes with significant challenges also. These challenges include, altered sleeping patterns, time spent commuting form home to the worksite, long, intense and frequent work shifts and isolation from family and friends. All these can contribute to an increased inability to cope, leaving many workers to deal with psychological and social problems. Fact sheet and poster
Queensland Mineral Mines and Quarries Inspectorate	**High Potential Incidents summary – July 2020** 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.

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