WEEKLY INCIDENT SUMMARY

Week ending Friday 11 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	50
Summarised incident total	1

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0038226 Underground coal mine  Fire or explosion	Workers in an underground coal mine smelt something burning and noticed that the gearbox output shaft of a conveyor belt felt warm. They saw small embers in a build-up of material behind the coupling cover. An initial investigation indicates that the overloading of the gearbox may have occurred, resulting in oil overheating.	Mines should ensure that temperature monitoring is installed in locations where it is most likely to detect and alert an increase in temperature from component wear/failure or low oil levels. Conveyors should not be operated outside of original equipment manufacturers operating parameters such as load, temperature and oil specifications.

Areas where material can accumulate, such as under guards, should include methods to allow for inspection and cleaning. These areas should be included in routine maintenance inspections.

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	**Stope stability in opencast mines and quarries** A coal mine was heavily fined over a rock fall incident in 2017 that seriously injured a worker. The worker was operating an excavator in a pit when a 7-tonne rock fall hit his excavator. He suffered a broken neck and fractured skull and continues to experience ongoing health issues as a result of the incident. Details

	National (fatal)
Queensland Mineral Mines and Quarries Inspectorate	**Tipping near/over edges in underground mines** Queensland has had a number of incidents where loaders have been operating near unguarded vertical openings and have entered the void, resulting in operators losing their life. To assist operators to manage the risks involved with underground tipping operations, the Queensland Mines Inspectorate has developed and issued Guidance Note QGN 18. Western Australia experienced similar incidents in July 2020. Refer to SIR No.283.
	National (other, non-fatal)
Queensland Coal Mines Inspectorate	**High Potential Incidents (July 2020 incident periodical)** Details
Queensland Coal Mines Inspectorate	**Structural failure: Security of suspended objects – Safety Alert #378** While replacing a light in a CHPP, coal mine workers identified that the shackle on the light was badly worn. The shackle was the only support point. If the shackle had failed, the entire weight of the light would have been borne by the power cable. Details
Queensland Mineral Mines and Quarries Inspectorate	**Drawpoint management – Safety Bulletin #187** A recent review of mine practices found that there is significant variation in how effectively each mining operation assesses and deals with the risks associated with drawpoints and stope brows. Details
Queensland Mineral Mines and Quarries Inspectorate	**Mobile plant contact overhead, energised, powerlines – Safety Bulletin #188** Mines and quarries must implement effective controls that prevent mobile plant and equipment from entering the exclusion zones of energised overhead powerlines. These controls must be monitored for effectiveness and communicated to workers. 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	DOC20/758225
Mine safety reference	ISR20-37
Date published	18 September 2020
Approved by	Chief Inspector Office of the Chief Inspector