NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 19 June 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	37
Summarised incident total	3

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0037567 Open cut coal mine	Workers were lowering a shovel cable from a cable tower in an open cut mine when the shovel tower rope broke and the cable fell to the ground. The cable tower rope was attached to the ripper of a grader to lower the cable and the cable was being pulled at an angle. It was dark and wet at the time of the incident. The shovel tower brake mechanism was thrown about 60 metres and hit a supervisor on the hand. The supervisor, who was standing about 3 metres from the tower, suffered hand fractures.	Operators are reminded of the need to follow documented procedures for tasks - to conduct a thorough risk assessment and to implement controls for identified risks, such as using fit-for-purpose equipment and establishing no-go zones. The identification and use of fit-for-purpose equipment must be completed and documented for every task. Safe standing zones, with a focus on remaining outside the line of fire for all foreseeable failures, must be established.

Dangerous incident

IncNot0037608

Underground metals

Fire or explosion

A loader, operating in remote mode, caught fire in the ventilation incline (exhaust side) while bogging at the bottom of a new ventilation shaft.

The loader's fire suppression system was activated, and three fire extinguishers were used but were unsuccessful in extinguishing the flames. All workers proceeded to refuge chambers and safely exited the mine.

This incident is under investigation and the cause of the fire is not yet confirmed. A preliminary investigation suggests there was a fault in the brake solenoid circuit that caused the brakes to overheat.

Further information may be published at a later date.

Dangerous incident

IncNot0037586

Open cut metals

A service truck was driving down the main ramp of an open cut mine when the brakes failed. In order to bring the truck to a halt, the driver turned the truck into the wall.

The driver received lacerations to his forehead and bruising to his face. The service truck is a modified flatbed diesel on-road truck.

Preliminary assessment indicates that the service truck was fit for purpose, however the driver, while assessed as competent on other vehicles, had not been assessed as competent for the service truck.

Mine operators must ensure that vehicle operators are competent

Roads or other vehicle operating areas

for the vehicles they operate and that they follow daily pre-start checks on vehicles.

A drive-through park brake test should be carried out daily as part of the pre-start check.

The service truck driver did not apply the park brake or the suppression brake during the incident.

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
	National (other, non-fatal)
DMIRS (WA)	**Workers tipped out of basket – Significant incident report (SIR) No 281** On 11 February 2020, a service crew was relocating a jumbo box and hanging an attached high voltage electrical supply cable. They were using an integrated tool carrier (ITC) with a work basket. A linkage failure on the boom of the ITC resulted in the two workers being thrown onto the ground. The workers suffered serious, but non-fatal injuries. Details
QMI (Coal)	**Incident periodical May 2020** Fall of ground #1 • Coal mine workers observed evidence of a fall of ground at the highwall. Good communication ensured that there was no impact to the safety of workers. The failure occurred in a controlled manner and within the defined exclusion zone. Fall of ground #2 • Drill operators, operating outside the exclusion zone, were forced to evacuate to safety as a highwall failed and material breached the exclusion zone.

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Line of fire #1

- A cylinder pin was being removed from an excavator boom. The plan was to use the tractive force of a 20-tonne Franne crane, applied via a fabric sling to an attachment point welded to the pin. The attachment point failed at the weld and the energy release in the sling caused the attachment to strike the windscreen. No workers were injured.
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Line of fire #2

- A worker sitting in a dozer narrowly escaped injury as the dozer window was hit by a projectile. A nearby (20 metres) tyre failure, released energy and ejected a 50 millimetre rock through the glass door of the dozer.

Worker seriously injured

- A worker suffered a tear to the ACL and a fracture while attempting to open a ventilation door.

Underground vehicle collision

- An unattended driftrunner was hit with the load being carried by a forward moving Eimco front end loader. The driftrunner had been left parked across the cut through, parallel to the road on the offside of the Eimco operator cabin. No-one was in the driftrunner at the time of the collision.

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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DOCUMENT CONTROL	
CM9 reference	DOC20/494261
Mine safety reference	ISR20-25
Date published	26 June 2020
Approved by	Chief Inspector Office of the Chief Inspector