

# WEEKLY INCIDENT SUMMARY

Week ending Friday 3 April 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 emerging trends and our recommendations to operators.

TYPE	NUMBER
Reportable incident total	38
Summarised incident total	4

## Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous Incident IncNot0037079 Underground coal mine  Fire or explosion	While laying out idler rollers for maintenance, workers smelled smoke. They found a conveyor drive gearbox anti-run back had failed and was on fire. The flame was about 300 millimetres high. They turned off the belt and used two fire extinguishers to put out the fire. 	Mine operators should review their maintenance strategies for anti-run back devices with particular reference to lubrication.  When developing control measures related to conveyors in underground coal mines, mine operators must take into account Australian Standard AS 4606-2012, Grade S fire resistant and antistatic requirements for conveyor belting and conveyor accessories.

Dangerous  
incident  
IncNot0037069  
Underground coal  
mine



Ground or strata  
failure

A small coal burst occurred on a longwall face during production. The shearer was cutting into the main gate in full remote mode. The area was identified as a high potential coal burst zone associated with a dyke running through the area. No workers were exposed to the ejected material.



This incident highlights the benefits of implementing robust controls to mitigate the risks of coal burst events. The Resources Regulator has published reports on specific coal burst incidents as well as a report on compliance with legislative requirements in relation to ground and strata failure. The 2019 report recommended that:

- Mine operators should review their trigger action response plans (TARPs) for mapping, inspection and monitoring results to improve the response time to major changes in the mine environment that may affect ground stability.

Refer to:

- [Compliance priority outcome - Ground and strata failure](#)
- [Investigation Information Release IIR16-05 Coalburst on longwall face](#)
- [Investigation report - Major rib burst in an underground coal mine](#)

Dangerous  
Incident  
IncNot0037081  
Underground coal  
mine



Fire or explosion

A longwall had cut one shear on afternoon shift before stopping production for about 1.5 hours to replace a roller on an outbye conveyor. During the stoppage, two longwall operators smelled something burning before another operator found a 75 millimetre flame underneath the cable tray at the back of pan 5 in the maingate. The area was hosed to extinguish the fire and cool the area.

Heat, due to friction between the AFC bars and sigma section, is believed to be the causal factor.

Mine operators should be mindful of the potential for excessive conveyor chain tension to increase frictional energy. The effectiveness of chain tension monitoring systems should be reviewed and cooling mechanisms considered.

Dangerous  
Incident  
IncNot0037093  
Underground  
metals mine

A boilermaker suffered an electric shock while in contact with welding equipment in an underground workshop.



Mine operators should verify that workers carrying out welding activities have identified appropriate earthing points, their personal protection equipment (PPE) is dry and they are appropriately trained.

Welding machines must be isolated when not in use.

Refer to:

- Safety Bulletin [SB19-03 Welding related electric shocks increase](#)

## 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
	<b>International (fatal)</b>
<b>MSHA</b>	<p><b>Mine fatality – final report</b></p> <p>A 30-year-old truck driver/quality control person, with one-year-and-eight-months of total mining experience, was fatally injured on 8 January 2020. The worker died when he fell into a lime surge hopper and became engulfed by the material.</p> <p><a href="#">Details</a></p>
<b>MSHA</b>	<p><b>Safety Alert – Electro-hydraulic lifts</b></p> <p>Damaged or defective welds on aerial lifts have caused several fatalities in the mining industry.</p> <p><a href="#">Details</a></p>
<b>MSHA</b>	<p><b>Mine fatality – final report</b></p> <p>A 69-year-old front-end loader operator with more than 37 years of total mining experience, died from aspiration pneumonia on 8 January 2020. The worker suffered injuries and was hospitalised as a result of an accident on 30 July 2019. He was operating a front-end loader when the bucket hit the ground, causing the front-end loader to abruptly stop. The force of the impact resulted in the operator, who was not wearing a seat belt, to strike the front window, which caused serious injury, including paralysis to his arms and legs.</p> <p><a href="#">Details</a></p>
	<b>International (other, non-fatal)</b>
<b>MinEx NZ</b>	<p><b>ADT rollovers continue</b></p> <p>An articulated dump truck (ADT) was travelling empty down a reasonably steep haul road when the truck started to accelerate. The operator applied the exhaust retarder and then the brakes, but neither action slowed the ADT down.</p> <p>The operator tried to run the ADT into a bund, however lost control of the truck. The truck rolled onto its right-hand side. The operator was not injured.</p> <p><a href="#">Details</a></p>

**National (other, non-fatal)****DNRME (Qld)****Track press cylinder failure – Mine safety alert No 371**

A serious incident occurred while coal mine workers (CMWs) were undertaking track repairs on a Hitachi EX1900 excavator at a mine site. The workers were preparing to use a 360-tonne track press. While aligning the track press in preparation to press out a track pin, the pressurised cylinder head plate failed catastrophically.

[Details](#)

**DMIRS (WA)****Inspection and maintenance of handrails – Mine safety alert No 173**

During inspections, handrails are frequently found in poor condition or not fit for purpose, including handrails that have collapsed in areas where they need to protect people from falling. This is especially notable where structures are prone to corrosion such as above tanks, in saline or moist environments or are adjacent to vibrating equipment and mobile plant work areas.

[Details](#)

**DMIRS (WA)****Operator crushed between handrail and ladder – Significant incident report No 280**

A bulldozer operator sustained serious injuries to the leg after being crushed between a hydraulic access staircase and handrail that were attached to the bulldozer. The bulldozer operator had just completed a pre-work inspection of the job site with the lead hand and was accessing the bulldozer via the stairs, when the stairs began to raise unexpectedly. The operator attempted to get clear of the moving stairs by jumping to the platform alongside the operator's cabin but was trapped between the handrail and the moving staircase.

[Details](#)

**DMRIS (WA)****Paste wall failure – Significant incident report No 279**

Two workers at an underground mine were approaching a paste retaining wall during paste filling, when the wall catastrophically failed. An inrush of fluidised paste entered the drive inundating the workers, who escaped by climbing up the wall mesh.

[Details](#)

**DNRME (Qld)****Mobile plant – Access entrapment**

A high potential incident involving machine access occurred at a mine in the northern Bowen Basin on 28 March 2020. A maintainer was completing post service checks, while seated in a grader, with the cabin door open. The grader was fitted with a dynamic rotating access ladder. On completion of testing, the maintainer initiated a machine shutdown, and the ladder activated, swinging up.

The maintainer was caught half out of the cabin when the ladder struck his foot, pinning him to the walkway. In this incident, the maintainer was able to activate the emergency stop.

[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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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (June 2020). However, because of advances in knowledge, users are reminded of the need to ensure that information upon which they rely is up to date and to check currency of the information with the appropriate officer of the NSW Department of Regional NSW or the user's independent advisor.

## DOCUMENT CONTROL

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