NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 31 July 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.

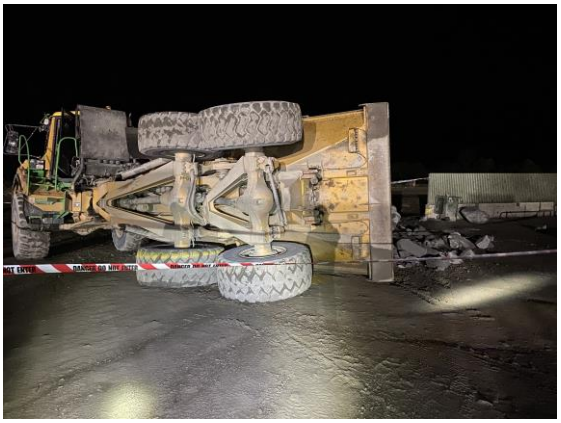
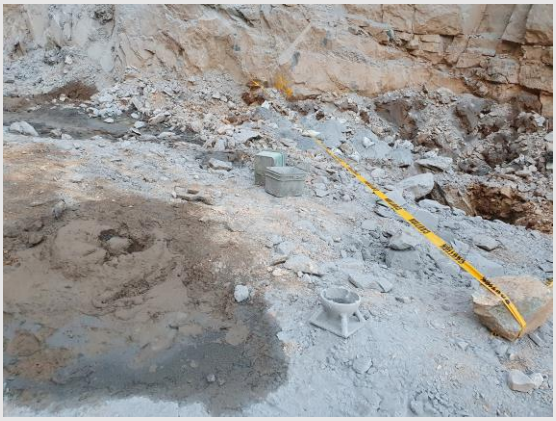
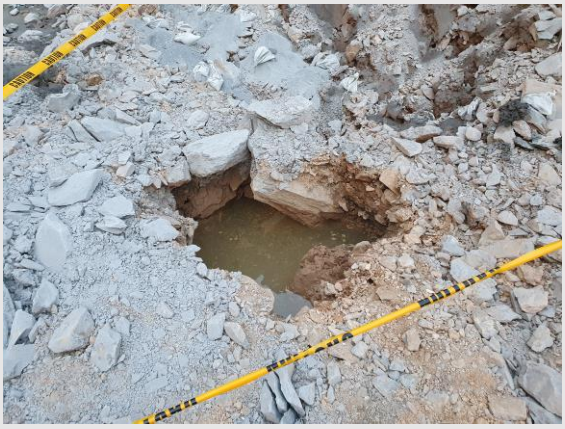
At a glance

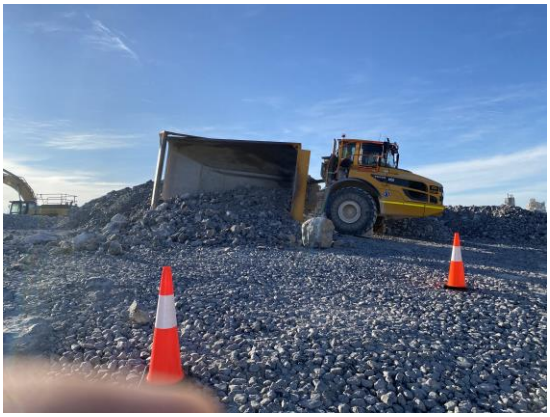
High level summary of incidents and our comments to operators.

TYPE	NUMBER
Reportable incident total	36
Summarised incident total	4

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0037860 Underground metals  Roads or other vehicle operating areas	A loaded articulated haul truck rolled over while going around a corner. The truck had been parked up in the workshop while the operator was on a crib break. Following the crib break, the driver and a passenger (bogger operator) were returning to work in the truck, when the trailer body rolled over while going around a corner. The cabin remained upright and nobody was injured. Speed is being considered as a contributing factor. The investigation is ongoing.	The stability of articulated vehicles is a known risk that needs to be managed by mines. Consideration should be given to factors such as (but not limited to): • speed of operation • operating grades • uneven surfaces (holes, rocks, foreign material) • tipping of loads • hang-up of loads • movement of loads. The risks associated with the rollover of mobile plant was the subject of our compliance priority program in 2018.

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
		Refer to the following outcome report for more information: Articulated truck rollovers and falls from mobile plant
Dangerous incident IncNot0037853 Open cut metals  Ground or strata	A small void (600 x 800 millimetres) opened up in the cap material that runs along an old previously mined stope. Grade control drilling was being conducted about four metres from the void and it is believed the vibrations from the drilling caused the void to slowly open up. Nobody was in the vicinity of the void at the time and it was monitored from the time it had started to open.  	Mines are required to have a Principal Hazard Management Plan for ground or strata failure and to ensure that the plan is implemented as designed. The stability of back fill material and old workings must be considered during open cut mining around old workings. A system to update the incoming shift supervisor of TARP risk changes, active TARPs and geotechnical hazards should be in place so that relevant information can be relayed to all workers.

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0037889 Open cut industrial minerals  Roads or other vehicle operating areas	A dump trunk carting rocks to a run-of-mine (ROM) pad reversed onto a rock pile from a previous tip, causing the tub of the truck to overturn. The cabin remained upright. 	See comments for earlier overturned trailer incident in this publication.
Dangerous incident IncNot0037847 Underground coal  Ground or strata	A coal burst occurred at a longwall mining operation. No gas was released. The longwall was operating in full remote mode, due to TARP requirements with the presence of a dyke on the Longwall face, increasing the risk of coal burst. The coal burst was identified when an e-stop was activated on a shield causing the shearer to stop. The crew reviewed video recorded at the time of the incident and saw the coal being ejected.	This incident highlights the importance of implementing controls, such as remote mining operations, when the potential for coal burst has been identified. The careful evaluation of factors known to be associated with coal bursts was a key aspect of this operation activating controls to eliminate the risk to workers from an identified principal hazard.

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	**Drill rods fall from underground strata** A loader was reversing from the face in an underground operation when diamond drill rods dropped rapidly from the last row of ground support (3.5 metres from face) and struck the face. Details
	National (other, non-fatal)
Mineral Mines and Quarries Inspectorate (Qld.)	**Worker entangled in conveyor tail drum (Significant Incident Report no.82)** On Tuesday 19 May 2020, a worker was seriously injured at a quarry when his left arm became entangled in the rotating tail drum of a conveyor belt. Prior to the accident, the conveyor had been stopped to enable the clearing of rock spillage from the tail drum area. The injured worker was attempting to clear rock from the nip point where the return side of the belt meets the tail drum, when the conveyor was briefly energised (jogged) by another worker from the plant switchboard located some distance away. The conveyor belt was cut in order to free the injured worker. Details
Mineral Mines and Quarries Inspectorate (Qld.)	**Incident Periodical (June) - Mineral Mines and Quarries Inspectorate** Details
Coal Mines Inspectorate (Qld.)	**Incident Periodical (June) - Coal Mines Inspectorate** 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	
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