WEEKLY INCIDENT SUMMARY

Week ending Friday 08 May 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	36
Summarised incident total	5

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous Incident IncNot0037278 Quarry  Roads or other vehicle operating areas	A loaded, articulated haul truck was travelling down the main entry road of a quarry. The road was on a decline and was sealed. The driver tried to slow the truck using the retard brake, but the truck didn't slow sufficiently. The driver used the foot brake, but the wheels on the truck locked up, causing the truck to slide sideways and overturn. The driver was inexperienced, having only operated the truck for one week before the incident. The truck was travelling about 50km/h. The driver was not injured.	Mobile plant characteristics, including stopping distances, maneuverability and operating speeds for both the loaded and unloaded vehicle must be considered when developing control measures to manage the risks to operating vehicles. Mines should consider the use of speed limiting devices and the operating range of retarder systems. The risk of articulated trucks overturning has been highlighted to the industry by the Regulator

through the following publications:

- SB17-01 Industry reports more truck rollover incidents
- Articulated truck rollovers and falls from mobile plant

Dangerous incident

IncNot0037284

Underground coal mine

Ground or strata

While drilling contractors were drilling a ventilation shaft from the surface of an underground coal mine, they noticed a loss of return water from the shaft. Drilling was stopped.

It was identified that a bulkhead, installed underground to isolate the shaft construction from the mine workings, had failed. Further ground movement into the shaft void destabilised the drilling rig and platform, which partially collapsed into the collar of the shaft.

The Resources Regulator is carrying out a causal investigation with the cooperation of the relevant stakeholders. A preliminary report will be published soon.

Dangerous incident

IncNot0037285

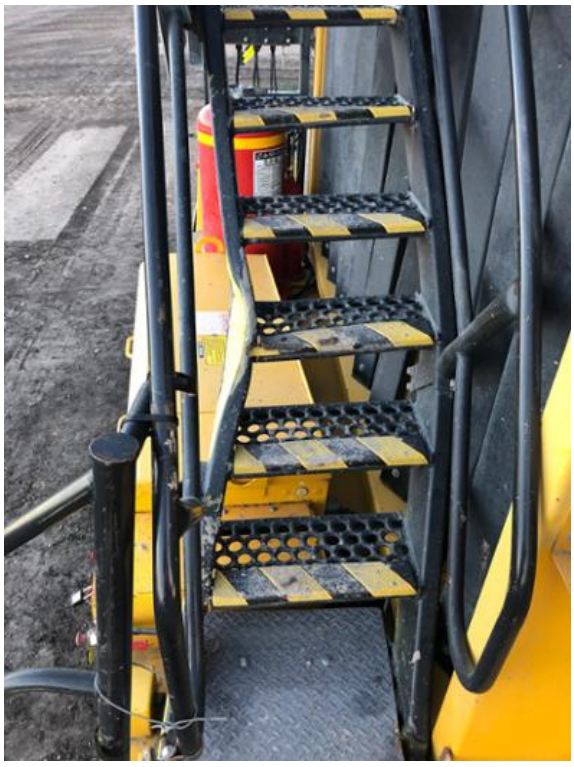
Open cut coal mine

Roads or other vehicle operating areas

A haul truck was parked in a loading queue with the headlights turned off because the light were distracting the excavator operator. Proximity lights on the truck remained on.

After a clean-up at the site, a dozer hit the haul truck on the left-hand side under the cab, damaging the ladder and bumper bar. Nobody was injured.

Neither operator reported the incident to the supervisor.



Dozer operators should always maintain situational awareness and pay attention to the movement and proximity of other machinery.

Refer to:

- SB19-10 Dozer incidents increase despite warnings
- SB19-01 Rise in dozer incidents putting operators at risk.

Incidents that cause harm to workers, or expose workers to serious risk, must be reported to the Regulator by law. Workers who do not notify supervisors of incidents may impede the work of the mine operator to manage the risk.

Serious injury IncNot0037316 Underground coal mine	A worker fell from the back of a ute while unloading ventilation tubes underground. There were three tubes on the tray. The worker was standing on top of an outer tube trying to remove the centre tube when the tube handle broke. The worker fell backwards over the side rail of the tray and onto the ground. The worker fractured his arm. The mine's procedure for this task states that a maximum of two tubes are to be carried on the tray. 	When a risk of falling is present, mine operators must assess the risk and minimise the risk of fall by providing adequate protection against falls. Elevated areas that have not been identified as work areas/platforms must not be used as a work area. When work situations vary from existing procedures, workers must identify the risk and implement additional controls.
Dangerous incident IncNot0037311 Metals processing plant	An apprentice electrician suffered an electric shock when installing a bypass switch in a 240Vac electrical circuit. An isolation was put in place upstream and the cable was cut. As the apprentice was stripping the cable, he felt a tingling sensation and the electrician confirmed the presence of about 100 volts. A downstream uninterruptible power supply (UPS) was not isolated when the work commenced and a back-feed from the UPS was believed to be the source of the 100V.	Any isolation procedure should consider all potential sources of hazardous energy. Electrical isolations should be especially mindful of back-feeds, stored charges, induction and stored energy in circuit breaker springs. Test for dead verification tasks should then be performed to address each of the potential sources before starting work.

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)
Queensland Mines (Coal) Inspectorate	**Workers injured in ignition event** Five coal mine workers suffered serious burn injuries during a gas ignition event on a longwall face in an underground mine near Moranbah. The workers were receiving hospital treatment for their injuries. The cause of the ignition event is under investigation. The mine was evacuated and secured to prevent people entering the mine until gas monitoring analysis and re-entry risk assessment determines it is safe to do so. 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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