NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 17 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	32
Summarised incident total	5

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0037148 Open cut coal mine  Roads or other vehicle operating areas	A dozer operator was cleaning up a bench floor at night when it backed over some large rocks and rolled onto its side. The operator was not injured. 	Following the investigation of several incidents in which tracked dozers overturned, the NSW Resources Regulator identified a range of contributing factors and published a safety bulletin. Recommendations on managing risks to dozer operators can be found in safety bulletin SB19-01 Rise in dozer incidents putting operators at risk

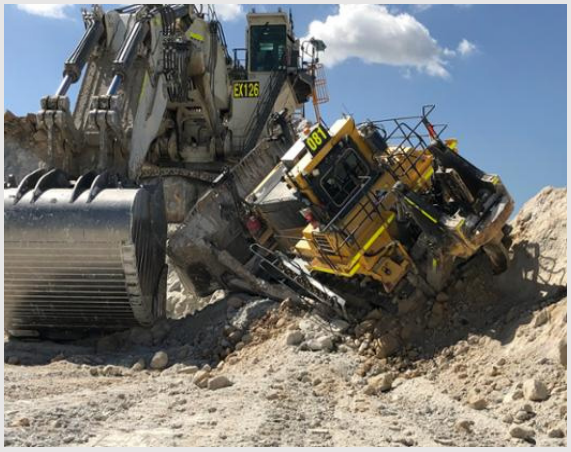
Dangerous Incident

Open cut coal mine

IncNot0037158

Roads or other vehicle operating areas

A dozer carrying out preparation work slid off a walk back and working bench near an excavator. The dozer operator appears to have misjudged the corner and driven off the edge. The dozer operator was not injured.



Refer to the recommendations provided in the previous dozer rollover incident above.

Dangerous Incident

IncNot0037154

Open cut coal mine

Roads or other vehicle operating areas

A dump truck went through a windrow when backing into a corner of the dump. The ground failed, causing the truck to overturn.

Preliminary investigations suggest that the controls identified to manage the risks associated with using weathered material at the dump may not have been adequate and some of those controls were not implemented.

While 10 metre lifts were planned for the dump, on the outside edge where the tip head failed, the rill face was approximately 20 metres high.

Mines must have systems in place to ensure dumps are operated and maintained as per the original design with adequate TARPs in place if circumstances change.

Dangerous Incident

IncNot0037172

Underground metals mine

Fire or explosion

A fire occurred underground at a metalliferous mine. All workers were evacuated and accounted for. No injuries were reported.

A site assessment conducted by the Regulator confirmed that the fire occurred in a large pile of rubbish material, near an underground meal room. While the source of ignition has not been conclusively determined, a significant number of cigarette butts were present among the rubbish. The site has a no smoking policy.

Dangerous Incident

IncNot0037185

Underground metals mine

A mill operator suffered an electric shock when opening a door at a surface crusher building. He made contact with the door's proximity switch and suffered an electric shock to his left hand.

A preliminary investigation suggests a diminished ingress protection (IP) rating of the proximity switch, together with the fact the area was wet, allowed the operator to be shocked when he touched the switch.

Electrical equipment that has an IP rating is critical in wet areas and should be maintained as fit-for-purpose throughout its life cycle.

Mines that have control voltages to field devices above extra low voltage (ELV) should review how they manage the risk of electric shock, including the modification of field control circuits to ELV.

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 (fatal)
MSHA	**Mine fatality** A miner was splitting and sorting rock in a quarry when lightning was observed in the distance. The miner was seeking shelter when he was struck by lightning. Details
MSHA	**Safety alert** On 5 March 2020, an operator was using a Caterpillar D8T bulldozer on a coal surge pile near a load-out feeder location when the surge pile collapsed, engulfing the bulldozer and trapping the operator inside the cab. The operator was uninjured because the bulldozer was equipped with: ■ high-strength glass that prevented coal from entering the operator's cab, and ■ two self-contained self-rescuers (SCSRs) which provided the equipment operator, enough breathable air throughout the two-hour rescue effort. Details
	National (other, non-fatal)
DNRME Qld	**Frictional ignition events (underground coal)** An underground coal mine experienced two frictional ignition events on a longwall face. The events occurred about eight days apart, with both being extinguished successfully. In both incidents the shearer was in the process of cutting through a geological structure (a down throw fault) on the longwall face. Additional controls introduced to manage the hazard after the first event proved inadequate to prevent a reoccurrence. A formal investigation by the mine's inspectorate is being conducted. 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	DOC20/307190
Mine safety reference	ISR20-16
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