NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 26 August 2022

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	41
Summarised incident total	4

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0042841 Open cut coal mine	A worker was installing an 8 metre cable bolt with a hand-held bolter on the offside of a longwall belt. The worker failed to notice that the bolt was not fully inserted into the hole and the nut had cracked and continued the rotation of the bolter. The nut travelled the full distance of the thread and once at the end of the thread, the hand-held bolter started to rotate. The worker's left hand came free of the handle, but they maintained grip with their right hand rotating towards the rib. The worker let go of the bolter and raised their right arm to protect their face and in the process hyper extended	Mine operators and contractors should ensure that risk controls associated with rotating hand-held bolters are documented and implemented by workers. This should include operating in restricted areas and where the operating height of the bolter may affect the worker's ability to control the bolter if it begins to rotate.

	their arm, dislocating their right shoulder and suffering an elbow laceration.	
Dangerous incident IncNot0042847 Underground coal mine	While lowering a drill rig at the end of the bolting cycle on a continuous miner, an operator heard a loud bang and was sprayed with hydraulic oil. The worker was not injured. The guard brace was broken, causing it to move. When the drill rig was lowered, the rotary actuator clashed with the guard, which pushed the auxiliary manifold backwards. This in turn, squashed and split a hydraulic fitting.	The integrity of guards should be checked as part of the maintenance inspections of continuous miners. When guarding and other components are damaged, inspection and testing for clearances and clash points should be completed.
Dangerous incident IncNot0042849 Open cut coal mines Ground or strata failure 	The edge of a dump failed, causing a slump of about 80 metres in length. No vehicles were operating on the edge at that time. 	Mines should review their dump trigger action response plans (TARPs) because of continued wet weather. Water management practices around dumps should also be audited and reviewed. Geotechnical assessments of dumps should be undertaken when dump material changes or the dump design is modified.
Dangerous incident IncNot0042874 Open cut coal mine Roads or other vehicle operating areas	A light vehicle narrowly avoided a collision with a haul truck at a T-intersection. Two haul trucks were approaching the intersection from different directions. The light vehicle driver was concentrating on the truck approaching on the right, which was turning into the lane adjacent to the light	Light vehicle operators need to maintain constant vigilance when driving on haul roads. It is imperative that drivers check for vehicles both left and right at T intersections before proceeding through a corner.

vehicle. The light vehicle failed to notice the truck on their left, requiring the truck to brake to avoid a collision.

The design of intersection must consider height of windrows and positioning of lights that may affect the visibility of drivers.

Mine operators should include worker fatigue monitoring and response technology as a part of their fatigue risk analysis.

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)
NZ MinEx	A grader was undergoing maintenance repairs in a workshop. After being dropped off at the workshop to pick up the grader, an operator decided to clean the exterior windows of a grader. While standing on the third rung of a 5-step A-frame ladder (less than 2 m), the operator fell and hit their head on the concrete workshop floor. The operator suffered a skull fracture,

	intercranial bleed and head laceration and was transported to the hospital for further assessment and care. Details
	National (other, non-fatal)
WorkSafe Victoria	On 4 August 2022, a side discharge conveyor on a screening plant at a quarry collapsed suddenly while operating. The supporting structure failed at the midpoint, instantly causing the discharge end of the conveyor to collapse. A steel diversion chute had been retrofitted to the discharge end of the conveyor several months before the incident. Clay material had also built up inside the chute. The extra weight of the steel chute and built-up material caused the failure. The steel diversion chute was not supplied, installed or checked by the manufacturer of the plant. No employees were injured in the incident. 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.

© State of New South Wales through Regional NSW 2022 You may copy, distribute, display, download and otherwise freely deal with this publication for any purpose, provided that you attribute Regional NSW as the owner. However, you must obtain permission if you wish to charge others for access to the publication (other than at cost); include the publication in advertising or a product for sale; modify the publication; or republish the publication on a website. You may freely link to the publication on a departmental website.

Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (September 2022) and may not be accurate, current or complete. The State of New South Wales (including Regional NSW), the author and the publisher take no responsibility, and will accept no liability, for the accuracy, currency, reliability or correctness of any information included in the document (including material provided by third parties). Readers should make their own inquiries and rely on their own advice when making decisions related to material contained in this publication.

DOCUMENT CONTROL	
CM9 reference	DOC22/243855
Mine safety reference	ISR22-33
Date published	2 September 2022
Approved by	Deputy Chief Inspector Office of the Chief Inspector