NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 21 August 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	37
Summarised incident total	2

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0038029 Underground metals mine	During shaft-lining operations, a winch cable snapped, resulting in a shotcrete hose-reeler moving about two metres and hitting the back of the shaft-lining rig. Up to 700 kilograms was suspended from the shaft-lining rig at the time. The lining rig weighed about 12 tonnes and was on the ground near the shaft opening. The cable reeler weighed about two tonnes and was behind the lining rig.	Winch ropes should be regularly inspected during all tasks. Triggers for rope replacement should be determined according to the task, the rating of the ropes and the risk associated with rope failure. Mines must identify all risks associated with rope failure and implement controls to protect workers in the event of a failure, such as safe standing zones and remote operation.

Plant that has the potential to move under strain should be secured in position where possible.

Death IncNot0038051 Underground coal mine	A worker was found unresponsive in a load haul dump machine (LHD) on the main travel road at an underground coal mine. Attempts to revive the worker were unsuccessful. The LHD was running at the time the worker was found.	This incident is under investigation and the cause of death is unknown at the time of publication. Refer to incident at Springvale Mine.

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** On 18 August 2020, a 21-year-old labourer, who was employed at a mine, entered a cone crusher to remove a blockage in the material chute. While he was inside the crusher cone an amount of material flowed from the chute, engulfing his legs and lower torso. He was extricated by emergency services and flown to hospital. He died later the next day. An investigation into the incident is continuing. Details

	National (other, non-fatal)
DNRME (Qld)	**Managing gas on open cut coal mines – Mines safety bulletin no.186** Coal mine workers at open cut sites are often not aware that flammable and toxic gases may be present and pose a significant risk during normal mining activities at open cut operations. Details
Queensland Mines Inspectorate (Coal)	**Methane ignited by friction generated during rib bolting – Safety Alert No.375** During the installation of a steel rib bolt, frictional contact between the rotating steel bolt and a steel rib mesh strand generated enough heat to ignite methane that was present behind the plate at the installation point. 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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Mine safety reference	ISR20-34
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