

# WEEKLY INCIDENT SUMMARY

Week ending Friday 07 Feb 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	31
Summarised incident total	3

## Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0036665 Underground coal mine	An underground coal mine experienced a stress-induced coal burst caused by localised conditions (longwall approaching a stub, goaf hanging/canter levering.) No workers were in the immediate vicinity when the burst occurred.	<p>Predicting coal bursts is not precise so mine operators should consider that when an increased coal burst potential has been identified because of the presence of geological structure or changes in stress regimes, control measures should be implemented to reduce the likelihood of a coal burst occurring, and worker exposure should one occur.</p> <p>Refer to:</p> <ul style="list-style-type: none"> <li>■ <a href="#">IIR16-05 Austar coal burst</a></li> <li>■ <a href="#">Report into double fatality at Austar Coal Mine on 15 April 2014</a></li> </ul>

Dangerous  
Incident  
IncNot0036686  
Underground  
coal mine

A six-wheel tipper truck towing an axle trailer was tipping a load when the axle trailer tipped onto its side. The truck was unable to tip at the unloading area because of weather conditions. The operator was asked to tip on a bitumen roadway instead. No-one was injured or was in the area at the time of this incident.



The stability of articulated vehicles is a known risk, and mines should manage this. Consideration should be given to factors including:

- operating grades
- uneven surfaces (holes, rocks, foreign material)
- tipping loads
- loads hang-up
- load movement
- operations speeds.

Dangerous  
Incident  
IncNot0036690  
Open cut  
metal mine

Two workers were commissioning a pump discharge line in the mill when a poly joint failed, resulting in one worker being pushed against the side of the scissor lift. The worker suffered bruises and grazes.

Mine operators should review how the potential hazards associated with a discharge line are recognised and controlled.

Mine operators should ensure robust, safe work procedures are in place and workers are competent and aware of hazards associated with discharge lines.

## 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
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### International (other, non-fatal)

<b>MinEx NZ</b>	Water cart hits service vehicle
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After breaking down on a ramp and then being repaired, a water cart has collided with the rear of the service vehicle. There were no reported injuries.

[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.

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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (February 2020). However, because of advances in knowledge, users are reminded of the need to ensure that information upon which they rely is up to date and to check currency of the information with the appropriate officer of the NSW Department of Planning and Environment or the user's independent advisor.

### DOCUMENT CONTROL

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<b>Mine safety reference</b>	ISR20-06
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