



WEEKLY INCIDENT SUMMARY

Week ending Friday 20 November 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.

| ТҮРЕ | NUMBER |
|---------------------------|--------|
| Reportable incident total | 40 |
| Summarised incident total | 3 |

Summarised incidents

| INCIDENT TYPE | SUMMARY | COMMENTS TO INDUSTRY |
|--|--|---|
| Dangerous incident IncNot0038655 Underground coal mine | A worker sustained a head injury during a conveyor belt extension in an underground coal mine. Slack cable was being moved inbye on the primary monorail system (from transformer to DMU), outbye of the DMU monorail tow arm. The worker was found by other workers in a hunched over position and semiconscious. It is suspected that he was hit in the back of the head, as he could not recall what had happened. An inspection of the site showed interaction between the monorail cables, hoses and a structure stored on the ground. The cables were tangled around | Mine operators should develop a risk mitigation strategy for the task of conveyor belt extensions. Consider engineering controls such as ensuring monorail loops are raised in the area between the DMU pull arm and the boot end. Ensure exclusion zones are in place. Mine operators should also have a standard procedure for managing workers with head injuries affecting their level of consciousness. |

the structure and the structure had moved from where it had been stored.



Dangerous incident IncNot0038658
Coal processing

A major slump occurred on a coal stockpile. The slump migrated to three coal train wagons that were being loaded by manned front-end loaders. Coal slurry also flowed through to the rail tracks of several other wagons.

A manned front-end loader was close to the failed stockpile. No workers were on foot in the area at the time.



Mine operators should review their stockpile management documents and procedures and include:

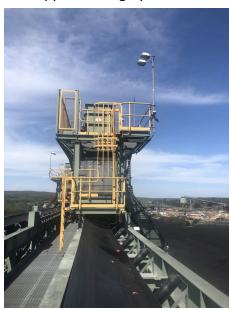
- design of the stockpiles
- surface profile of the stockpiles to manage water at various stages of the formation of the stockpile
- controls to prevent water accumulation on the surfaces
- measurement of stockpile water levels at various stages of stockpile formation
- TARPs for stockpile management to include references to water content in the stockpiles and rainfall events

Dangerous incident IncNot0038684 Coal processing

The tripper on a gantry conveyor inadvertently moved about 20 metres causing the front bogies to de-rail. There was an operator on the tripper at the head chute at the time. The operator was uninjured. The gantry conveyor belt wasn't tracking properly, and operators were attempting to realign the belt. Due to damage to a mile post limit supply cable, the belt was run with the mile

This incident is under investigation. Further information may be published at a later date.

marker disconnected at the switch. It appears that the belt was caught up and dragged the tripper along, rather than the tripper moving by itself.



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 Inspectorate (coal) | Methane detectors bypassed on explosive protected diesel engines – Safety Bulletin #189 The purpose of this safety bulletin is to provide information on recent reports and subsequent investigations by the Mines Inspectorate into incidents where methane detectors fitted to underground coal mine explosion protected diesel engine systems have been found to have been bypassed. 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

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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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