NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 29 July 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

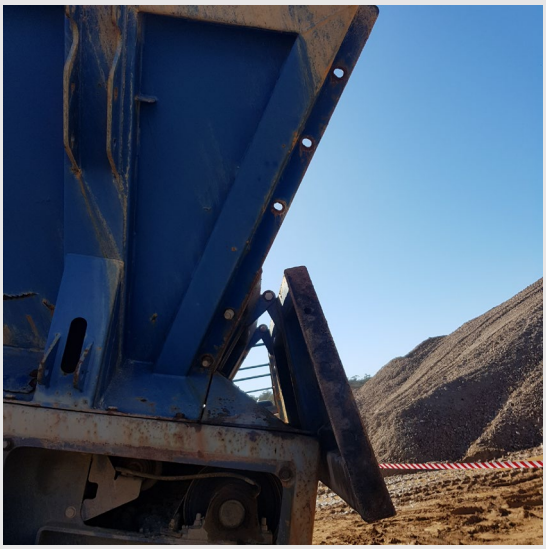
High level summary of emerging trends and our recommendations to operators.

TYPE	NUMBER
Reportable incident total	49
Summarised incident total	2

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0042669 Open cut coal mine Roads or other vehicle operating areas 	A dump truck was queued, waiting to be loaded. The operator put the truck in neutral and began to get something from a bag. The truck started rolling forward. The truck rolled 10 m and collided with the dovetail of another truck. No-one was injured.	Management plans and vehicle operating procedures invariably specify separation distances between mobile plant and require vehicles to be parked fundamentally stable. Vehicle operators must comply with correct queueing and park-up arrangements. Mine operators should consider installing interlocks or warning systems for park brakes on other mobile equipment. Refer to: Safety Bulletin SB13-02 Unplanned movements of vehicles - too many near misses.

Dangerous incident IncNot0042705 Construction materials	A worker was disassembling a hopper from a mobile crusher in a quarry. The worker removed one side and was removing the rear plate that was held in place by 5 bolts. The worker believed that the section would still be held in place by the 2 lower bolts. However, the worker failed to identify that the section was hinged. When the third bolt was removed, the section swung down, hitting the worker's shoulder. The worker suffered soft tissue injuries and a suspected fractured vertebrae.	Supervisors should ensure that workers have access to procedures before commencing tasks and ensure that they understand the risks and controls associated with that task. Workers have a legislative duty to care for their own health and safety and that of others (s28 *Work Health and Safety Act 2011*). One of the duties is to cooperate with any reasonable policy or procedure. Procedures are developed to help protect workers from injuries or illness. Where a procedure exists for a particular task, workers should follow the procedure. Any deviation from a procedure should first be discussed with a supervisor and appropriate risk control measures put in place.



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)
Resources Safety & Health Queensland	A 14 mm synthetic fibre rope failed when the breaking strain was exceeded during installation of a new conveyor belt. When the rope failed it whiplashed, striking a worker in the face. As a result of the accident, the worker had surgery to remove one of his eyes. Details
Resources Safety & Health Queensland	The Petroleum and Gas Inspectorate (PGI) conducted a noise health risk assessment across several drilling and completion plant and activities to determine a baseline for noise hazards. The principal health-related effect of noise exposure is hearing loss. Damage to hearing depends on the frequency, loudness and length of noise exposure. Noise induced hearing loss is painless, progressive, permanent and preventable. By controlling the noise within the lease, the benefit extends to environmental noise management e.g., improving landholder relations. Details
Resources Safety & Health Queensland	During routine servicing of a dozer, the machine was being relocated out of the workshop when the right-hand final drive locked up and subsequently failed, splitting the outer case. Two bolt heads sheared off (projectiles) from the outer casing of the final drive, travelling approximately 4.6 m, and impacting into a nearby toolbox. The machine locked as it began reversing and was unable to move forward or backwards. The operator jacked the machine up to see if it would rotate. During this attempt to move the track backwards, the right final-side drive casing split, ejecting the bolt heads. The technique to remove the plugs contributed to the incident. The plug was struck prior to being loosened and removed using an impact wrench. 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	DOC22/213883
Mine safety reference	ISR22-30
Date published	5 August 2022
Approved by	Deputy Chief Inspector Office of the Chief Inspector