

# WEEKLY INCIDENT SUMMARY

Week ending Friday 26 July 2019

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	42
Summarised incident total	3

## Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous Incident IncNot0035137	<p>While a light vehicle was driving back to the assembly point from a drill site, it drove over an open edge. The front of the vehicle dropped over the edge, while the rear wheels remained on the bench.</p> <p>The two occupants of the vehicle were not injured.</p> <p>The vehicle was exiting the drill area at the end of shift. The driver used the same road they had driven on earlier that day. During the shift, an excavator dug through the ramp, leaving an</p>	<p>Mine operators should review the adequacy of their communication arrangements on shift.</p>

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
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open face approximately two metres in height.

The excavator operator was unaware that his work area was intersecting an active light vehicle track. This resulted in the track being excavated without the installation of any delineation markers or communication to the light vehicle operators.



Dangerous Incident  
IncNot0035193

A nine-kilogram dry chemical fire extinguisher, mounted on a CAT D11T Dozer (DOZ817), exploded. This resulted in the metal buckle from the retaining strap releasing and cracking the cabin window. There were no injuries to personnel.

Investigations are underway to try and understand the causal factors contributing to the catastrophic failure of the extinguisher.

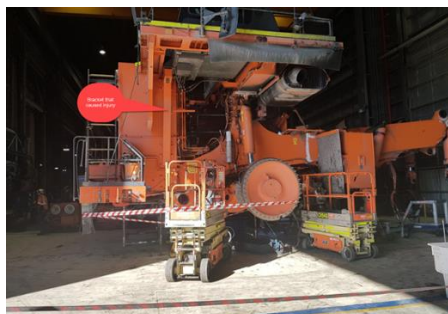


INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
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Serious Injury  
IncNot0035168

A contractor technician was raising himself in an EWP self-propelled scissor lift to change a hydraulic hose on a truck. He was looking up at the hydraulic hose location while raising the EWP with his right hand on the controls and left hand on the hand rail. He contacted his left hand with a bracket on the truck when he stopped raising the EWP. The technician was transported to hospital with a suspected broken hand. The technician was later transferred to the John Hunter Hospital to undergo surgery on his hand. He has since been released from hospital.

The EWP used in this incident was not fitted with two-handed controls. The operator was unaware that his hand was in a vulnerable position and there was no secondary handrail fitted that would have provided a higher level of safety.



**NSW RESOURCES REGULATOR PUBLICATIONS**

Safety Bulletin

[SB19-07 Configuration of work baskets](#)

Safety Bulletin

[SB19-08 Coupling disintegrates](#)

## 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
<b>International (fatal)</b>	
MSHA	<p><b>Worker dies from fall - Investigation report final</b></p> <p>A 46-year-old contractor with three years' experience, died on 7 March 2019 at 3.30am after falling three and a half metres from the top of a log washer. While the worker was tightening bolts on the log washer drive motor, his wrench slipped off the bolt head, causing him to lose balance and fall backwards. He fell through a gap between two log washers, striking a handrail before landing on an electrical cable tray. He suffered internal injuries and died at the hospital.</p> <p><a href="#">Details</a></p>
<b>International (other non-fatal)</b>	
MinEx NZ	<p><b>Faulty pressure gauge</b></p> <p>A subcontractor was performing splicing of a conveyor belt (joining the belt with pressure and heat) on a mobile crushing plant when a clamping bolt on the vulcaniser failed and part of the vulcaniser catapulted around five metres into the air. The part, weighing approximately 50kgs, landed on the back end of the contractor's van and smashed the rear window.</p> <p><a href="#">Details</a></p>
<b>National (other non-fatal)</b>	
WorkCover QLD	<p><b>Worker injured when tyre explodes</b></p> <p>In May 2019, a young worker suffered serious facial injuries when the split rim that he and another worker were performing maintenance on, exploded. For reasons yet to be established, it appears the tyre exploded while the workers were removing a tyre from a split rim on an earthmover. Investigations are continuing.</p> <p><a href="#">Details</a></p>

**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 (August 2019). 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

<b>CM9 reference</b>	DOC19/658598
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<b>Mine safety reference</b>	ISR19-29
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<b>Date published</b>	2 August 2019
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<b>Approved by</b>	Chief Inspector Office of the Chief Inspector
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