NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 11 December 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	42
Summarised incident total	2

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0038802 Underground metals mine	During the filling of a cement silo an over-pressurisation resulted in deformation of the silo. As a result, bridge clamps connected to another silo snapped and one fell to the ground landing approximately three metres from a person. The two pieces of the bridge clamp that fell weighed 1.6 kilograms and 1.5 kilograms. No one was injured. Preliminary investigation suggests that a blockage in the dust extraction hose prevented the pressure relief valve from working.	This incident is under investigation and further information may be published later. Mine operators should review their maintenance programs for silos and ensure that their dust extraction hose system allows for easy removal to check for blockages. Consider fitting individual relief valves to each silo tank and installing overhead protection for operators filling the silos.

Dangerous incident IncNot0038828 Underground coal mine	A driller's offsider had the tip of his finger amputated when it was crushed between a drill bit and hammer shroud. The driller was lowering the hammer bit onto a trolley on the rod trailer when the offsider slipped on the wet surface causing his left hand to slip between the bit and hammer shroud. The weight transferred to the trolley, causing the gap between the bit and hammer shroud to close, resulting in the crush injury.	Mine operators and contract companies should ensure their training includes identifying potential pinch points and their associated hazards. Consider: • eliminating, or where this is not possible, controlling the hazards that could result in hand injuries. This may require operators to install effective guarding.

- alternative methods to remotely move drill rods and drill bits onto the trolley on the rod trailer
- separating the stabiliser from the hammer bit to reduce the weight of the drill bit assembly
- Improving work area floor surface to reduce soft/wet areas.

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 8 November 2020, a bulldozer operator was killed when his bulldozer backed over the edge of a highwall. Details
MSHA	**Mine fatality** On 23 November 2020, a miner was fatally injured when the battery-powered scoop he was operating ran over a section of pipe in the roadway. The four-inch plastic pipe entered the operator's compartment and struck him. Details
	National (other, non-fatal)
Queensland Mines Inspectorate (coal)	**High potential incidents – October periodical** 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	DOC20/1032294
Mine safety reference	ISR20-50
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Approved by	Chief Inspector Office of the Chief Inspector