NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 15 May 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.

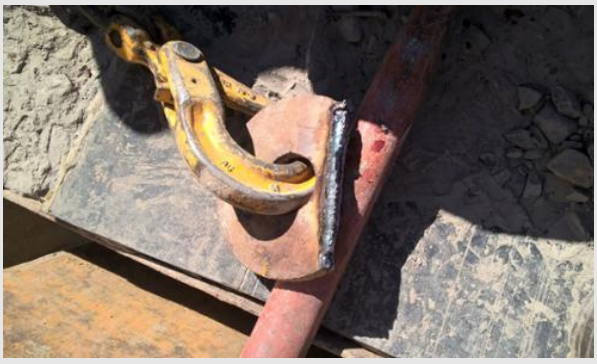
At a glance

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

TYPE	NUMBER
Reportable incident total	45
Summarised incident total	4

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Serious injury IncNot0037325 Open cut metals mine	A contractor was using an explosives mixing unit to load shot holes. He put his hand into the intake side of the hopper and the top of his finger was amputated. The unit does not have a mixing auger at the bottom. The mix goes through an air-operated valve, where emulsion is delivered to a pump. If there is a blockage, a scraper is normally used to break lumps and push the mix down the hopper walls. Occasionally this is assisted with water. The operator would normally turn the valve off and on during this process. The injured worker was not using a scraper, and put his hand into the bottom of the hopper where	Mine operators and contract companies should ensure their procedures and training packages include risks associated with how and where to place body parts around moving parts of plant or machinery. The risks associated with air-operated valves should be well understood by machine operators. These risks must be assessed and either mitigated or eliminated. Hard controls,

	the valve cut his finger. The unit is not supplied with a guard or screen to prevent this from happening.	such as guarding, to prevent operators accessing moving parts should be implemented wherever reasonably practicable. Soft controls only, such as procedures and work practices, are inadequate to control the risks associated with the moving parts of plant or machinery.
Serious injury IncNot0037349 Underground metals mine	A boilermaker was conducting repairs to a jaw crusher and welded a lug to the upper centre portion of the fixed plate before trying to lift it out using an excavator and lifting attachments. The plate appeared to be stuck so the lift was stopped, but tension remained on the lifting equipment. While standing on the crusher platform, the boilermaker leaned over to see what was preventing the plate coming free. At that point, the welded lug broke away and hit the boilermaker's hard hat, causing damage to the hat, which in turn caused an eight centimetre cut to the boilermaker's forehead. Without protection from the hard hat, the consequences could have been far more serious. 	Mine operators should review how workers and supervisors are trained in recognising the potential hazards associated with all energy sources including the stresses and strains introduced by lifting equipment on plant. This is especially important when there is the potential for unexpected stored energy to be released without warning. In this instance, the hazard introduced by welding a temporary lifting lug and connecting it to lifting equipment was not identified, therefore the risk of the weld failing was not assessed.

Dangerous incident

IncNot0037359

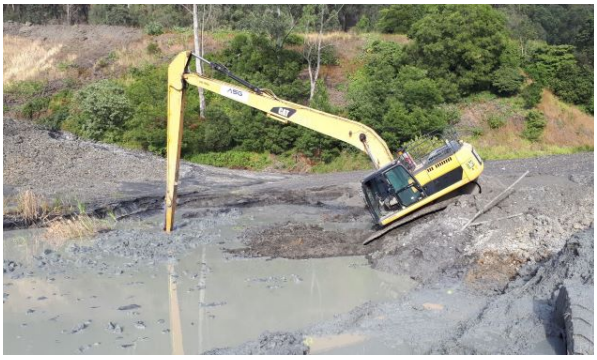
Quarry

Ground or strata

An operator was digging out a sediment pit with a long-reach digger when the ground at the front of the digger gave way and the digger tipped forward about 45 degrees.

The operator lowered the bucket to stabilise the digger and exited the machine.

The excavator was working from a constructed bench to remove sediment and load it into a haul truck.



Equipment operators must maintain situational awareness and remain vigilant to the risk of machine rollovers.

Suitable bunding should be in place to protect mobile plant from accessing edges of benches. If bunding is not installed, there should be adequate demarcation of the work area, so operators are aware of their positioning in relation to the bench edge.

Serious injury

IncNot0037358

Underground coal mine

A work crew was using a panther drill with an air leg to drill shot holes in a longwall dyke.

When drilling a hole just above ground level, the air leg was braced against the vertical face of the shearer drive rack bar. Due to the drill orientation and the air leg resting on the rack bar, an offsider placed his foot on top of the air leg to stop it from slipping.

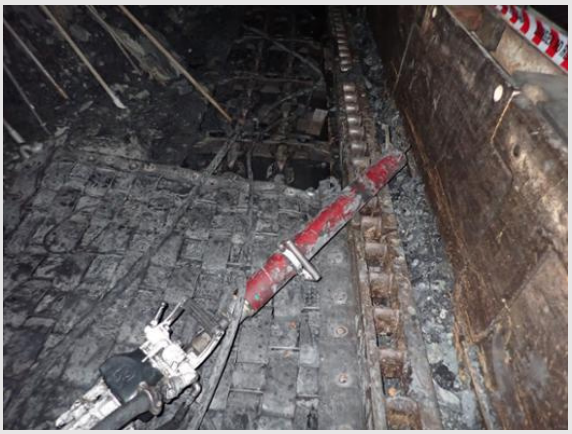
During drilling, the pusher leg feed control knob became caught on the rubber woven explosion mat that was laid over the AFC, resulting in activating the air relief button. This depressurised the air leg and it no longer had positive contact with the rack bar.

As the drillers pulled at the drill to free it, the relief button was released and repressurised the air leg, pushing it over the

When work tasks vary from existing standard procedures, workers and supervisors must identify any new hazards, assess the risk arising from those hazards and implement additional controls where necessary. No-go zones should form part of the job instruction when there is a risk from moving parts, such as an air leg.

top of the rack bar and pinning the offsider's foot against the AFC spill plate.

The hazards introduced by using the rubber matting and an unsecured airleg were not identified and therefore not risk assessed.



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	**Fatality – final report** A 50-year-old contractor employee suffered injuries at the Federal No 2 Mine on 27 February 2020. The worker was attempting to assist a truck driver to position a tractor and trailer to load a rock truck. The worker was standing in front of the wheels on the trailer's front axle and was hit by the trailer's wheels as the tractor and trailer moved forward. The worker died later that day from the injuries sustained. Details

MSHA	**Fatality alert** A miner entered a dredged sand and gravel bin, through a lower access hatch, to clear an obstruction on 2 May 2020. The miner was clearing the blockage with a bar, when the material inside the bin fell and engulfed him. Details
	National (other, non-fatal)
Queensland Mines Inspectorate	**Ladder failure – serious injury** In March 2020, a worker was seriously injured when a fibreglass ladder catastrophically failed. The worker was coming down a 120-kilogram load-rated, fibreglass, dual purpose, step ladder that was set up in its unfolded (straight) configuration when it snapped in two. The worker sustained a back injury after a two-metre fall. Details
Queensland Mines Inspectorate	**Fake RPE sold to mines – Mines safety alert No 373** It has come to our attention that current demand for respiratory protection has resulted in sub-standard or 'fake' respirators entering the industry that, despite being appropriately branded, have not been manufactured in accordance with a relevant Standard or equivalent international scheme (i.e. A/NZS, NIOSH etc). 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	
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