NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 21 June 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 significant incidents and our recommendations to operators.

TYPE	NUMBER
Reportable incident total	26
Summarized incident total	3

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous Incident IncNot0034902	An underground nipper (4WD utility) reversed down a decline and parked on a grade about 6 to 8 metres away from an operating drilling jumbo. After the operator exited the vehicle, it rolled downhill approximately 6 metres. The vehicle's rear tray collided with the jumbo. The operator of the nipper confirmed that he had applied the hand brake and that he thought he had left the vehicle in gear. He also stated that he did not put any chocks behind the wheel, as per mine procedure. The incident scene was not preserved.	Mine operators need to comply with correct park-up arrangements, particularly when parking on a grade. Following any incident that is notified under Section 14 of the WHS (MPS) Act 2013, mine operator must ensure the requirements of Section 17 WHS (MPS) Act 2013 – Duty to preserve incident sites is complied with. All persons with safety management responsibilities on a mine site

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
	No injuries were sustained. The operator received a medical assessment and passed a subsequent drug and alcohol test.	must be made aware of these requirements.
Dangerous incident IncNot0034904	An underground nipper (4WD utility) was reversing out of a workshop onto a decline. As the operator reversed around a pillar, the left rear wheel of the vehicle travelled up the pillar wall and the vehicle overturned. Although the vehicle was a mines explosive vehicle, it didn't have any explosives onboard at the time of the incident. The explosive placards had been removed. The vehicle was being used because no other vehicle was available. No injuries were sustained. The incident scene was not preserved.	Vehicles should be operated at a speed that is appropriate to the prevailing conditions.
Serious Injury IncNot0034881	A work crew was installing secondary ground support using a handheld boring machine. Two workers were operating the borer. The workers, positioned either side of the machine, were leaning against the borer to apply force. The operator on the left-hand side of the borer lost his footing on wet ground and slipped. This movement caused his hair, which was tied back in a pony-tail, to become entangled with the rotating drill steel. The operator immediately stopped the borer. Hair from the right side of the operator's head was ripped out by the drill steel. The injured operator was assessed by the work group underground and transported to the surface for medical attention. The operator was transferred offsite for further medical attention. The incident site was immediately demarcated as a non-disturbance area.	Mine operators should review the adequacy of their safety management system with regard to managing the risks of entanglement with machinery. Long hair presents an elevated risk if additional controls are not implemented.

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY

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 7 March 2019, a 38-year-old miner, with 10 years of mining experience, received fatal injuries while he was working on the pad of a highwall mining machine (HWM). The miner was contacted in a pinch point between a post and a section of the HWM (i.e. push beam) that was being removed as part of the normal mining cycle. Details
	International (other non-fatal)
MinEX NZ	**Lacerated wrist removing rock spillage** A worker cut out a section of mesh using bolt cutters to remove rock spillage behind the mesh. While removing the rocks, a wedged rock quickly ejected, landing on his arm and forcing contact with the cut mesh. Details
	National (fatal)
WorkCover Qld.	**Conveyor fatality** In March 2019, a worker was fatally injured after becoming trapped in a conveyor belt system at a recycling facility. It is not clear at this stage what caused the incident. Investigations are continuing. Details
	National (other non-fatal)
WA DMIRS.	**Safe access to high-voltage powerline corridors** The Western Australia Department of Mines is concerned about the high degree of non-compliance with the procedures for access to overhead powerlines and powerline corridors on mine sites. There were 26 reported occurrences of contact with overhead powerlines from 2009 to 2018. 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.

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