NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 22 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 notifiable incidents and our comments to Industry.

TYPE	NUMBER
Reportable incident total	34
Summarised incident total	5

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0037381 Open cut construction materials  Roads or other vehicle operating areas	While unloading a trailer at a site dump, the trailer rolled onto its side when the third stage of the hoist ram was reached. The trailer tipped because of wet material hang-up. The trailer rolled towards the passenger side of the truck. The driver's cabin remained upright. 	The stability of articulated vehicles is a known risk. Following a succession of similar incidents, the NSW Resources Regulator published two safety bulletins with recommendations to help prevent truck rollovers. Refer to safety bulletins: ■ SB17-01 Industry reports more truck rollovers ■ SB18-07 Safe systems of work for mobile plant

Dangerous incident

IncNot0037386

Open cut coal mine

Ground or strata

A section of a 20-metre highwall failed at an open cut mine.

An excavator crew was about 200 metres from the fall at the time.

Following several incidents in which people and equipment have been exposed to significant health and safety risks as a result of highwalls, low walls and dumps failing, we have published a safety bulletin:

- SB20-01 Failure of highwalls, low walls and dumps

Operators should take note of the recommendations in this bulletin.

Dangerous incident

IncNot0037393

Open cut coal mine

Ground or strata

A dozer operator was pushing coal on a stockpile and was trying to dig out a bridge that had formed over a valve. The bridge unexpectedly collapsed, causing the coal to slump under the right-hand track of the dozer. The operator was unable to drive the dozer out, but decided to exit the dozer and walk from the stockpile.

Operators are reminded of the potential hazards associated with a dozer on a stockpile.

Importantly, the decision to exit the dozer placed the operator at heightened risk, because further movement of the stockpiled material could have resulted in him being engulfed.

Before starting work, supervisors and equipment operators should inspect and assess the work area to determine hazards, such as the potential for material bridging and subsequent collapse. Planning for the work must include identification of hazards, risk assessment and control.

Refer to:

- MDG28 Safety for stockpiles and reclaim tunnels

Serious injury IncNot0037398 Coal preparation plant	An operator was cleaning a belt press filter when he became entangled between a roller and the filter cloth. He could not free himself, and remained with his arm trapped by the rotating apparatus until released by a supervisor. The operator suffered arm fractures, a serious laceration to the top of his left forearm and an abrasive-type burn to his left lower forearm. 	Under no circumstances should guards be removed, or work carried out on rotating equipment without the equipment being shut down and correctly isolated before work commences. Where limit switches are identified as a control, mines should ensure that they are installed and operational.
Dangerous incident IncNot0037412 Underground metals	A contractor was cleaning the floor grate on top of a leach tank area using a high-pressure cleaner. During the cleaning process, a 1.5 centimetre cut was created by the high pressure water jet on a poly line that was sitting underneath the mesh floor. The line was a cyanide feed line and cyanide fluid sprayed from the cut pipe. The leaking cyanide sprayed for three to five minutes before the line was isolated. The operator had placed the head of the high-pressure washer below the grid mesh to remove some build-up on a beam. No-one was injured. 	A job safety analysis (JSA) was completed for this task but did not identify the risk of the lines underneath the mesh floor being compromised. The pressure cleaner operating pressure was reduced for the job from a maximum pressure of 2500bar to 690bar. The incident highlights the importance of contractors being provided with all relevant information before work begins. Appropriate labelling of the poly pipeline may have alerted the cleaning contractor to the existing hazard.

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 (other, non-fatal)
MinEx NZ	**Isolation failure** A worker was seriously injured by the release of pressurised hydraulic fluid into his face and eyes. The worker was conducting field maintenance on a mobile crusher when the incident occurred. 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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