NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 23 October 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	43
Summarised incident total	4

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0038471 Underground coal mine	A worker was extending fibreglass ventilation tube in a maingate development roadway when, his head was sucked into the tube. He was able to free himself but suffered lacerations to his face. The ventilation line was approximately 20 metres from the fan.	Control measures and procedures in relation to installing ventilation tubes while auxiliary fans are in operation should include identifying: • safe operating ranges of auxiliary fans for workers installing the tube • determination of the VIV settings of the fan which is dependent on the length of ducting and sequence of development

		• the sequence of steps to take, in order to safely add ducting inline.
Dangerous incident IncNot0038475 Open cut coal mine	A dozer driver has connected with the bucket of an excavator as the dozer operator was doing a push across the face. The excavator operator placed the bucket on the bench for the dozer to push across the face. As the dozer pushed past the face, the excavator operator placed the bucket into the dig behind the dozer. The dozer operator reversed the dozer contacting the back of the bucket. No one was injured.  	Mine operators should remind all equipment operators of the importance of positive communication across all parts of the mine site. Dozer operators should make positive communications with excavators before entering any excavator swing radius. Mine operators should consider proximity awareness technologies for high interaction areas.
Dangerous incident IncNot0038503 Underground coal mine	Three mine workers were travelling through an outbye section of the mine when they smelled smoke. They doubled back and discovered a flat return roller emitting smoke and sparks on the outbye side of the drivehead of the belt.	Mine operators must ensure that stringent monitoring and quality control of maintenance and repair activities are undertaken to prevent fires on conveyors. Enough time and resourcing must

The workers turned off the belt and went to find an extinguisher. When they returned to extinguish the fire, they observed a six to eight inch flame at the end of the roller.

be allocated for inspection, maintenance and repair of conveyors considering the length and complexity of the conveyor system.

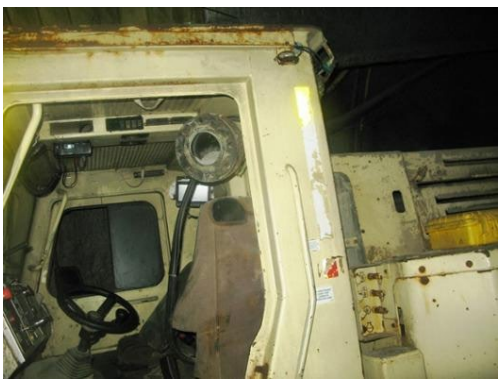
Maintenance frequency of rollers and pulleys must consider areas of high tension in the conveyor system.

Dangerous incident

IncNot0038460

Underground coal mine

An agitator truck was reversing up a decline when a four inch polypipe pushed in the back window of the cab. The truck was keeping to one side of the path to avoid a drain on the other side. It appears that the corner of the cab caught the end of a disconnected sandfill poly line which then travelled across the back of the cab and pushed the window in. The glass did not shatter. The operator was uninjured.



Open-ended, low-hanging pipes are an easily identifiable hazard and present an unacceptable risk to vehicle operators. Mine operators should have controls in place to eliminate/mitigate risks that can arise from such a hazard, such as hanging the pipes at a height where they do not align with the travel path of a vehicle.

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	**Confined space – Safety Alert** Between 2017 and 2020, three miners were fatally injured after entering confined spaces to clear material and obstructions. These confined spaces included a sand and gravel bin, a sand-filled hopper, and a cone crusher. All three miners were engulfed by falling material. Details
MSHA	**Mine fatality** – On 9 October 2020, a contractor was changing the nozzle on a hydroseeder and accidentally engaged the hydroseeder's clutch while the nozzle was pointing towards him. The material sprayed from the nozzle struck him, causing him to fall backward and strike his neck on the hydroseeder handrail. Details
MSHA	**Mine fatality** – On 13 October 2020, a miner died after being struck by a battery-powered scoop. He had parked his shuttle car in an intersection and was exiting when a scoop went through a ventilation curtain in an adjacent crosscut and struck him. Details
	International (other non-fatal)
MinEx NZ	**Cutting edge falls and injures worker** A worker was changing the cutting edge on a loader bucket. As he removed the last bolt the cutting edge fell to the ground, bounced, and struck him on the leg, causing a graze and a bruise. Details
	National (fatal)
SafeWork NSW	**Truck driver crushed by excavator bucket** A truck driver was fatally crushed while unloading a 400-500 kilogram excavator sieve bucket from a semi-trailer. The bucket was lashed to the semi-trailer. When the chains holding the bucket were released, the bucket slid and toppled off the

	truck, crushing the worker between the bucket and a bridge beam on the ground next to the truck. Details
	National (other non-fatal)
Mineral Mines and Quarries Inspectorate QLD	**Incident periodical – August -** significant safety incidents that have occurred recently in the mineral mines and quarries sector. 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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