

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 24 July 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.

ТҮРЕ	NUMBER
Reportable incident total	38
Summarised incident total	2

Summarised incidents

	INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
ind Or Or Rc ve	Dangerous incident IncNot0037797 Open cut coal	one level of IE/HE from the holes and	The traffic management plan for the shot floor should clearly identify travel routes so that trucks do not inadvertently drive along the incorrect path.
	Roads or other vehicle operating areas	next path. After travelling the same path on five occasions that morning, the stemming truck operator has turned down the adjacent path. The operator did not see the detonator and booster on the ground and drove over it. No ignition of the explosives occurred.	Drivers should know the travel routes before entering the shot floor. To aid the drivers, demarcation of usable tracks should be clearly identified by using visible cues such as cones or signage. Mines should ensure effective supervision and auditing of compliance with documented traffic management plans.

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Dangerous incident IncNot0037817 Open cut coal



Roads or other vehicle operating areas

A light vehicle towing a trailer loaded with a dingo, ran out of power while pulling the trailer up a steep section of road. The trailer and vehicle rolled backwards down the road and both overturned one and a half times.

The driver was uninjured.

It appears the vehicle hubs were not engaged, and the operator was towing in 2-wheel high range.



Mines should ensure that vehicles and trailers are fit-for-purpose when being used to transport a load. The suitability of the towing vehicle to handle the trailer mass and the trailer load should be assessed.

Mines should check that their 'introduction to site' process is being properly applied and ensure that vehicle operators are competent to use the vehicle for towing purposes.

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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 9 July, 2020, a mine superintendent was electrocuted while attempting to reverse the polarity of a 4,160-VAC circuit by switching the leads inside an energised 4,160-VAC enclosure that contained a vacuum circuit breaker and disconnect. Details
MSHA	Fatality – Final report On 2 May, 2020, a 56-year-old front-end loader operator with over eight years of total mining experience, died when he was engulfed by material inside the number one hopper at a sand and gravel mine. The worker entered the hopper to clear a blockage caused by material in the hopper. Once inside, a large amount of material dislodged, engulfing the worker. Details
	International (other, non-fatal)
MinEx NZ	Severe weather events Recent heavy rain has caused ground instability, including washouts and slips over the North Island and Gisborne areas. Such weather and saturated ground inevitably impacts on many mine and quarry sites, making haul roads slippery and stockpiles and benches potentially unstable. 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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DOCUMENT CONTROL

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