

WEEKLY INCIDENT SUMMARY

Week ending Friday 24 May 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 emerging trends and our recommendations to operators.

TYPE	NUMBER
Reportable incident total	21
Summarised incident total	2

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0034713	NSW Resources Regulator inspectors have identified that mine operators are reportedly 'unaware' of the requirements of the Work Health and Safety (Mines and Petroleum Sites), Regulation 2014, which says that mines are required to notify the Regulator of exceedances of respirable dust and crystalline silica.	Amendments to the Work Health and Safety (Mines and Petroleum Sites) Regulation 2014 came into effect on 13 April 2018. These amendments included the addition of clause 128 (5) (q)(r), which requires mine operators of all mine types to notify the Regulator where respirable dust or crystalline silica levels exceed prescribed limits.

Operators must ensure they report all incidents to the Regulator by the appropriate means within the prescribed time limits. A guide to the Regulation changes can be found on our [website](#).

Dangerous incident
IncNot0034645

A dozer was preparing an access and windrow at an open cut coal mine at night. The operator became disorientated and inadvertently trimmed over the rill face. The operator was able to bury the blade into the rill material and halt the machine. The mine's emergency response team retrieved the operator, who was uninjured.

When working at night, work areas must be inspected, and potential hazards must be identified and communicated to relevant workers. Suitable windrow and lighting should be installed to define the work area.



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
National (other non-fatal)	
DNRME QLD	<p>Electrician suffers 100V electric shock and burns</p> <p>In March 2019, an electrician was fault-finding in a vent fan control panel during night shift. He was wearing 1000V Class 0 rubber gloves and attempted to remove a plastic cover to access control relays. The cover fell to the floor of the panel and adjacent to a control transformer (1000V/110V). He reached down to retrieve the cover and his glove caught on the sharp edges of exposed terminal lugs of the control transformer, which punctured the rubber glove.</p> <p>He suffered an electric shock when the current arced between two exposed cable terminals through the puncture holes in the gloves. He was able to remove himself from the panel and drove to the workshop. He was taken to hospital and has undergone multiple surgeries.</p> <p>Details</p>

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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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (May 2019). However, because of advances in knowledge, users are reminded of the need to ensure that information upon which they rely is up to date and to check currency of the information with the appropriate officer of the NSW Department of Planning and Environment or the user's independent advisor.

DOCUMENT CONTROL	
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