NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 26 June 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 incidents and our comments to operators.

TYPE	NUMBER
Reportable incident total	27
Summarised incident total	3

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0037626 Underground coal mine  Ground or strata	Following a goaf collapse, a considerable volume of air was expelled outbye along the return roadways of a partial pillar extraction operation. But instead of the air returning via the same pathway, it was drawn at considerable velocity from the intake side of the workings. This caused several workers to be knocked to the ground.	Mine operators should consider the potential impacts of secondary goaf formations when extraction is occurring in, and around, areas of structured geology. An assessment should be carried out of these areas by a suitably qualified geotechnical engineer, with their recommendations considered when developing and/or reviewing the manner and sequence of extraction.

Dangerous incident

IncNot0037610

Underground metals mine

Roads or other vehicle operating areas

A loader was towing a skid-mounted sub-station that was fitted with temporary wheels.

The sub-station was being towed from underground to the surface.

After exiting the portal on the surface, the skid detached from the loader and rolled about 50 metres before striking a scrap steel area.

Mine operators should review their procedures to determine if their training includes the potential hazards associated with towing.

When connecting a trailer to a towing vehicle, ensure that the trailer is securely attached and held in position. Safety chains or similar should be attached between the trailer and the towing vehicle.

Driving at a low speed is not an adequate control when towing a trailer that is not securely attached to the towing vehicle.

Dangerous incident

IncNot0037618

Underground coal mine

An underground mine worker was hit in the face by a drill steel, causing a laceration to the left-hand side of his nose and cheek. The worker was attempting to extract a drill steel that was stuck in a concrete floor.

The worker attached a sling to the steel and used a chain block to try to pull the steel free. The drill steel was almost released, but the tip of the steel was caught on the lip of the hole.

Mine operators should review how workers and supervisors are trained to recognise the potential hazards associated with all energy sources including the stresses and strains introduced by lifting equipment.

This is especially important when there is the potential for stored

The worker positioned himself to manually pull on the steel but failed to release the pressure being applied by the chain block. As he pulled on the drill steel, it released and hit him.

energy to be released without warning.

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	**Recent increase in 'falling from heights' incidents – Safety Alert** Twenty-eight workers have died after falling from heights over the past 10 years. Deaths from falls have increased from 8% to 19% of mining fatalities in the past two years. The most common tasks leading to incidents were: • working without fall protection on top of trucks, in aerial lift baskets and while accessing and egressing other mobile equipment • while performing maintenance on crushers, screens, conveyors, and other milling equipment. 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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