NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 28 August 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	47
Summarised incident total	3

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Serious injury IncNot0038079 Underground coal mine	A worker was hit on the leg while helping to remove a power pack from a longhole drill. The work group entered the area to remove the power pack, which was on a trailer. The regular access road was blocked, which led to the load haul dump vehicle (LHD) approaching from the opposite direction. The trailer needed to be rotated 180 degrees in the roadway to hook up the trailer. During the rotation of the trailer, an operator entered the no-go area and was hit on the leg.	Workers have a responsibility to maintain safe work practices including following procedures for tasks. Workers should not enter designated no-go zones while they are in operation. Mine operators should ensure that workers are fully aware of no-go zones and that they communicate the requirement to adhere to work practices.

Dangerous incident

IncNot0038085

Open cut coal mine

Roads or other vehicle operating areas

A 30 tonne excavator conducting rehabilitation work was being walked backwards when one track rode up onto a rock pile, causing the excavator to overturn.

The operator suffered a bump on the head.

Equipment operators must maintain situational awareness and remain vigilant to manage the risk of machine rollovers.

This includes familiarisation with the work area by visually identifying hazards before starting work.

Dangerous incident

IncNot0038102

Open cut construction materials mine

A worker's arm became caught in the tail pulley on the main drive of a screening plant belt. The worker removed a guard to view the belt tracking and put his hand in to remove a rock.

The machine was at idle when the incident occurred.

We have recently published an Investigation Information Release about a similar incident.

Refer to: Worker's arm injured in belt press filter

Entanglement between moving parts is a foreseeable risk. Mine operators are reminded of their duty to identify hazards and manage risks to health and safety associated with the operation, maintenance and cleaning of plant.

Mine operators and workers must ensure that when guarding around plant is removed for maintenance or cleaning purposes, all energy sources are isolated.

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 29 July 2020, a miner was injured when his arm became entangled in a stacker conveyor belt. The miner was airlifted to a trauma centre, where he passed away a week later. Details
	International (other, non-fatal)
MinEx NZ	**Dump truck reverses into loader** A dump truck was reversing to tip its load over a tip head while a wheel loader was side-cutting material along the same face to create a windrow. The dump truck entered the tip head in a clockwise direction and, while reversing, he hit the loader bucket with the rear right side of the dump truck tray. There were no radio communications between the dump truck driver and the loader driver before or during the incident. No-one was injured. Details
	National (other, non-fatal)
ARTC (MinEx NZ)	**Working from height risks – Ladder use** An experienced rigger was using a ladder to climb to the top of a culvert to attach four hooks to perform lifting activities. As the rigger was climbing down the ladder, it slipped, causing the rigger to ride the ladder to the ground. This had the potential to cause serious harm to the rigger, who suffered minor injuries. Initial investigations identified a change occurred on site resulting in the rigger using a smaller ladder than used on the previous occasions. The smaller ladder was not secured, or footed, and resulted in reduced overhang at the top of the ladder and ability to be footed on stable ground. Details

ARTC (MinEx NZ) **Line of fire – Lifting operations**

Two experienced and competent workers were undertaking a routine lifting operation using a hydraulic vehicle loading crane. A sudden release of energy resulted in the lifting hook hitting the dogman in the cheek.

The dogman, who suffered serious injuries, was on the truck dogging the load and the crane operator was standing at ground level at the rear of the truck operating the crane.

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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