NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 28 February 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.

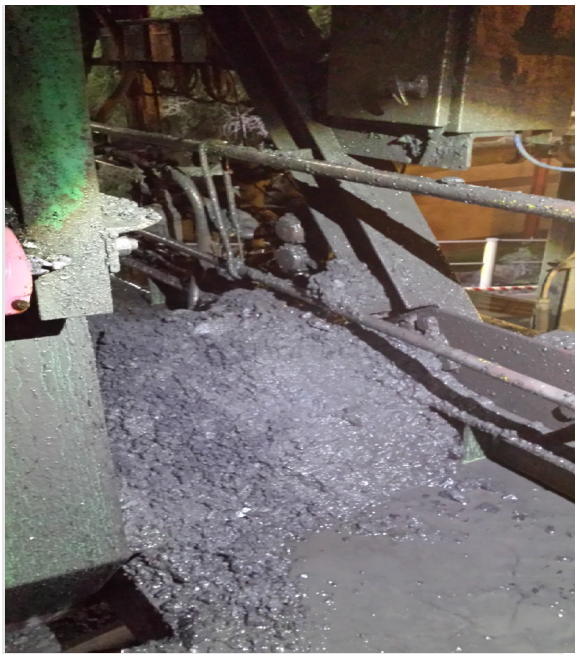
At a glance

High level summary of emerging trends and our recommendations to operators.

Reportable incident total	41
Summarised incident total	4

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0036795 Coal processing plant  Inundation or inrush of any substance	An operator was responding to a blockage in a feeder under a coal loading bin. The operator cleared the blockage and normal feed resumed. Shortly after, wet material flowed out of the feeder chute and hit the operator in the chest, knocking him off his feet. The operator suffered bruising. The plant was processing difficult material that needed the addition of water to keep it moving through the plant. This event was preceded by an upstream blockage in a sizer that was hosed out.	When developing the control measures to manage the risks of inundation or inrush of any substance, mines must consider: ■ failure or blocking the flow channels ■ the potential for the accumulation of water, gas or other substances, or materials that could liquefy or flow into other workings or locations.



In addition, mine operators should have a written procedure for the task of clearing a blocked chute and they should ensure workers adhere to the procedure.

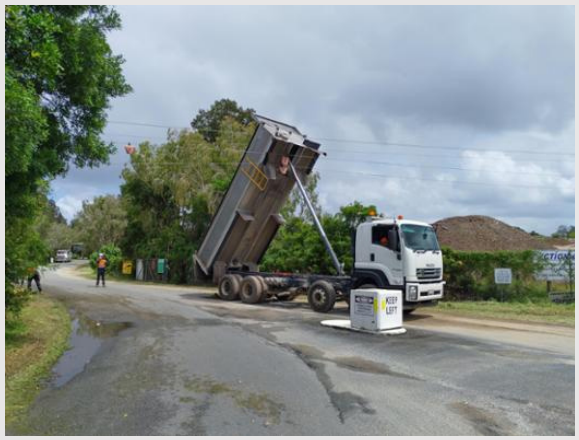
Dangerous incident

IncNot0036801

Construction materials mine

Roads or other vehicle operating areas

A tipper truck hit overhead power lines while exiting a sand plant. The driver reported that he had lowered the body and that the body had raised again, by itself. The driver did not suffer an electric shock.



The reason the truck body was in the raised position is to be established.

Refer to:

- Safety bulletin SB15-05 Plant contacting overhead powerlines and structures

Dangerous incident

IncNot0036820

Construction materials mine

Roads or other vehicle operating areas

A truck driver tipped a full load of material and then moved the truck forward about a metre but the tailgate did not release from the tipped mound.

The driver walked to the tailgate and put his head between the tailgate and truck body to see if something was preventing the tailgate from releasing. As he did this, the tailgate swung forward, hitting the side of the truck operator's head and causing his head to become caught between the tailgate and truck body.

The driver suffered head lacerations.

This incident is the subject of an investigation.

The NSW Resources Regulator investigated the death of a truck operator in 2016, who suffered fatal head injuries from a swinging tailgate. Two similar non-fatal incidents occurred in quick succession, leading to an awareness campaign to bring this hazard to the attention of industry. Nobody should place any part of their body between an unsecured tailgate and the truck body. This message should be reiterated to all truck operators, including contractors, on all mine sites.

Workers should be trained to recognise the hazards associated with gravity, and the controls that should be used.

Refer to:

- Safety Alert SA20-03 Tailgate hits worker's head
- Investigation report into fatality involving truck tailgate

Serious injury

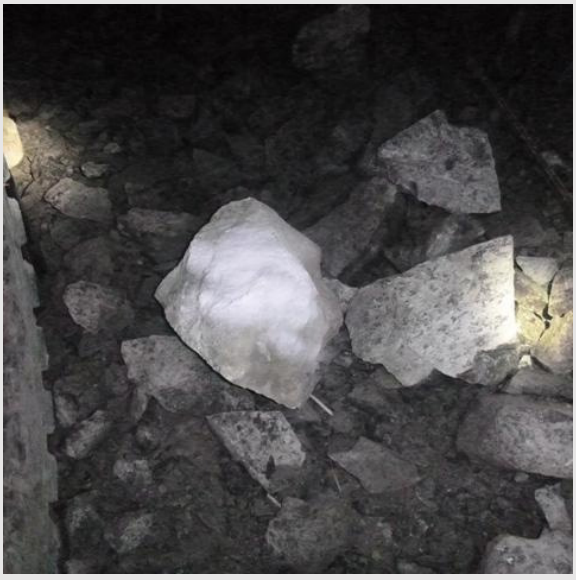
IncNot0036829

Underground metals mine

Ground or strata failure

A worker was assisting a Jumbo operator who was bolting a pillar incline. After the worker manually scaled the roof area (removed loose material), he began installing retaining caps resin capsules. He dropped a cap and bent over to pick it up. When he did this, a rock fell from beneath the mesh and hit him on the back of the head. The rock was about 50 centimetres in diameter and weighed about 20 kilograms. The worker lost consciousness briefly.

The worker's hard hat absorbed some of the impact.



Control measures to manage the risks of ground or strata failure include:

- using appropriate equipment and procedures for scaling
- the design, installation and quality of rock support and reinforcement.

Work methods must consider the risk of falling material and locations of people.

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	**Coal mine fatality** On 10 February 2020, a mine examiner was operating a personnel carrier down a mine intake slope. Evidence indicated the personnel carrier struck the left rib while travelling down the intake slope. The mine examiner was found unresponsive near the bottom of the slope, lying beside the personnel carrier. Details
	International (other, non-fatal)
MinEx NZ	**Plant operated without guarding** A worker removed the rear guarding on a feeder to remove rocks. After removing the rocks, the worker failed to replace the guarding. Details
	National (fatal)
WorkSafe VIC (in MinEx NZ)	**Hot works cause quarry fire** WorkSafe Victoria recently issued a safety alert about the risks associated with hot works, after a hopper liner and screen caught fire at a quarry. 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	
CM9 reference	DOC20/176176
Mine safety reference	ISR20-09
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Approved by	Chief Inspector Office of the Chief Inspector