

WEEKLY INCIDENT SUMMARY

Week ending Friday 29 May 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 commentary to Industry.

TYPE	NUMBER
Reportable incident total	37
Summarised incident total	4

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0037446 Underground coal	 <p>A dolly car at an underground coal mine was travelling down the drift with three ducksbills loaded on a flattop. The front ducksbill was secured to the flat top, but detached and slid off. The second ducksbill was unsecured and also slipped off the flattop. The dolly car was about 500 metres into the drift at the time of the incident. The first ducksbill slid to the bottom of the drift (approx. 1100m) while the second one stopped after about 150 metres. There was no one in the drift at the time of the incident.</p>	<p>Investigation of this incident by the Regulator is ongoing and further information may be published later.</p> <p>Procedures, relating to transporting loads via a drift conveyance, should be clear about the use of headboards and the proper securing of loads.</p> <p>Operators should ensure risk assessments for dolly car operations include all known hazards and that</p>



adequate controls have been implemented for identified risks.

Dangerous incident
IncNot0037323
Dredging operation

A sand dredge sank in the river at a sand mining operation. Nobody was on board at the time of the incident.

The cause of the incident will not be known until the dredge is recovered and examined. An initial investigation has identified the following possible causal factors:

- The anchor rope had worn a small hole in the front right pontoon - patched in Dec 2019 with a temporary fix.
- A small ingress of water continued, and a bilge pump was installed to control inflow.

The discharge hose from the bilge pump was routed through the top hatch on the pontoon,

Serious injury
IncNot0037445
Underground
coal mine

In preparation for the installation of an underground crusher, an operator was drilling a hole for a roof bolt when the drill steel snapped, causing the hand-held bolter to drop. The bolter hit the operator on the side of the face and knocked him to the ground. He was briefly unconscious and sustained a laceration to his face.

Prior to this incident, other rope threaded drill steels had broken during use, but no action had been taken by the mine to determine the cause.

hence the hatch was no longer water-tight.

The installation plans for the crusher were not correct and resulted in revised work plans. Mine operators must conduct adequate change management to ensure any new risks are identified and additional controls are implemented as required.

With any equipment failure, adequate investigation must be undertaken to ensure the failure is not repeated. Mine workers must be reminded that all damage or near misses must be reported so the incident can be investigated adequately.

Serious injury
IncNot0037436
Open cut
construction
materials

An apprentice was injured by a falling hopper wing on a mobile impact crusher. The crusher was being prepared to float to another location and when a hydraulic cylinder was pressed out, it was noticed that it was broken. The apprentice climbed up to assist in aligning a component, when the wing dropped and hit the apprentice on the back of the head and shoulder. The apprentice sustained a broken scapula and a gash to the back of his head.

No-go zones should be identified during risk assessments for the dismantling of plant.

Under no circumstances should any no climb on plant where securing pins and wedges have been removed during the dismantling process.



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)	
MinEx NZ	<p>Loss of control of vehicle – Fatality</p> <p>An ADT dump truck, operating in a quarry, left the haul road and fell approximately 12 metres landing on the quarry bench below, fatally injuring the driver.</p> <p>Details</p>
National (other, non-fatal)	
Queensland Mines Inspectorate	<p>Uncontrolled release of energy – Polyethylene pipe (Mines safety alert no.374)</p> <p>There has been a recent increase in reported incidents of coal mine workers being struck by polyethylene pipe as a result of stored energy being released suddenly and uncontrolled. These incidents have resulted in five individual receiving a fractured lower leg in separate incidents since 31 October 2018.</p> <p>Details</p>
DMIRS (WA)	<p>Pressure vessel failure injures worker</p> <p>In April 2020, a worker was transferring compressed air from one air receiver (pressure vessel) to a second air receiver that was mounted on a frame for transportation with a forklift. The second air receiver ruptured and broke away from the frame. Parts of the vessel struck the worker, causing an eye injury, hearing damage and other injuries.</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.

© State of New South Wales through Regional NSW 2020 You may copy, distribute, display, download and otherwise freely deal with this publication for any purpose, provided that you attribute Regional NSW as the owner. However, you must obtain permission if you wish to charge others for access to the publication (other than at cost); include the publication in advertising or a product for sale; modify the publication; or republish the publication on a website. You may freely link to the publication on a departmental website.

Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (June 2020) and may not be accurate, current or complete. The State of New South Wales (including Regional NSW), the author and the publisher take no responsibility, and will accept no liability, for the accuracy, currency, reliability or correctness of any information included in the document (including material provided by third parties). Readers should make their own inquiries and rely on their own advice when making decisions related to material contained in this publication.

DOCUMENT CONTROL

CM9 reference	DOC20/420677
Mine safety reference	ISR20-22
Date published	5 June 2020
Approved by	Chief Inspector Office of the Chief Inspector