

Week ending 20 December 2017

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	40
Summarised incident total	5

Summarised incidents

Incident type	Summary	Recommendations to industry
Serious injury SinNot 2017-02013	A driller's index fingertip was crushed and amputated when the door of a blast hole drill rig was closed onto his finger. The operator had his hand resting on the door frame of the non-hinged side when another worker closed it. He was taken to hospital for treatment.	Workers are reminded to keep their hands clear of nip points and edges where objects could unexpectedly fall or close causing a crush injury.
Dangerous incident SinNot 2017-02007	A small fire was reported on a contractor's shotcrete machine. The fire occurred in the electrical (24 volt) componentry on the left-hand side of the machine and was extinguished using the aqueous film forming foam (AFFF). There was minimal damage to the machine and nobody was injured.	All mine operators should review their procedures associated with the introduction to site of contractor's equipment. All contractors should review how their equipment is maintained in a compliant state.

Dangerous incident
SinNot 2017-01992

A hire drill rig had completed drilling a hole as part of a shot pattern and was in the process of removing the steels from the hole and racking them in the carousel. The operator lifted the lead steel to the top of the mast and the steel disconnected at the saver sub causing the steel to fall about 2 metres, penetrating the drill deck adjacent to the operator's cab. The operator was not injured and reported the incident.

Mine operators should maintain and adjust alignment of drill heads and carousels for return of drill pipe to minimise the risk of decoupling when unsecured. Inspections of mobile plant should be plant model specific and include alignment and wear in drill masts and guides where applicable.

Dangerous incident
SinNot 2017-01988

The operator of a bobcat was picking up overflow spillage (mud, coal, magnetite) that was spread around the collection sump. The operator had picked up and loaded about 15 to 20 loads of wet muddy material into the collection sump before the incident. On the bucket load of the incident, the operator drove towards the collection sump and raised the bucket in the air (with material in the bucket), when he went to stop the bobcat rear wheels came off the ground and the windscreen made contact with the guard rail surrounding the collection sump causing the windscreen to smash.

Mine operators should review how hazards associated with the potential change in workloads are assessed and controlled.

Dangerous incident
SinNot 2017-01986

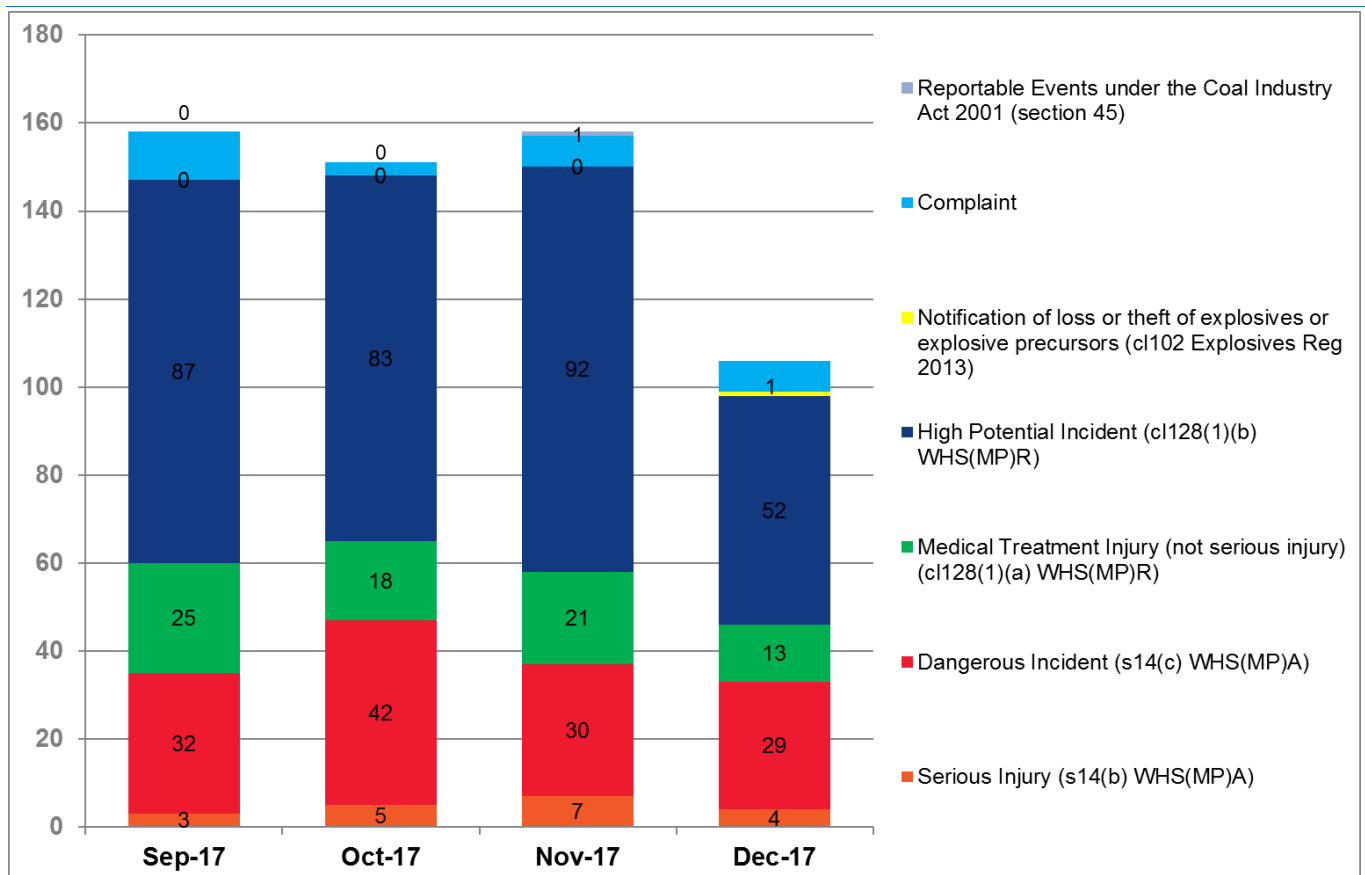
A haul truck was reversing into the pit dump behind a dozer that was positioned and working perpendicular to the haul truck. The dozer reversed into the haul truck making contact between the ripper frame on the dozer

Mine operators should review how the hazards associated with machine interaction are controlled. Such a review should consider:

- positive communications;
- proximity detection technology;

and a tyre on the haul truck. The wheel rim was scored and scuffed. No escape of air occurred from the tyre.

- job design (segregation)
- planning.



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.

Disclaimer

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

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Mine safety reference	ISR 17-50
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