NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 3 July 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	38
Summarised incident total	5

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0037646 Underground metals mine	During construction of a fresh air wall, a worker was trimming mesh from a raised work basket. A short piece of mesh, about 35 by 12 millimetres, dislodged and penetrated the eye of another worker below the basket. The worker underwent eye surgery. It was not known if he was wearing safety glasses at the time of the incident. 	No-go zones and safe standing zones for workers must be in place to manage the risk of falling objects and these should be included in work procedures. The importance of personal protective equipment (PPE) cannot be overstressed and it is essential that workers adhere to standard practices such as wearing PPE.

Dangerous incident

IncNot0037650

Underground metals mine

Ground or strata

A worker was hit on the hard hat by falling roof material while installing ground support. The worker believes he was knocked unconscious for about five minutes.

Procedures for ground support activities should provide instruction that no worker enters an area of unsupported ground. Mine operators must ensure that workers understand and follow the procedures through training and supervision.

Machinery should be designed and operated in a way that ensures the operator is not exposed to unsupported ground when accessing the boom with the dolly attached.

Dangerous incident

IncNot0037659

Open cut coal mine

Roads or other vehicle operating areas

A dozer was pushing on top of a windrow when a rock dislodged from the windrow and fell to the bench below. The rock landed on the catch windrow and came to rest next to the lighting plant.

There were workers in the vicinity at the time.

Work methods must consider the risk of falling material and the locations of people in the vicinity of the work area.

Before commencing pushing operations, dozer operators should inspect the work area to identify hazards, such as loose material, that could be dislodged and put others at risk of injury.

Mine operators should consider alternative methods of removing material build-up on sides of roads to eliminate the need to push material over windrows.

Dangerous incident

IncNot0037663

Underground coal mine

A rigid tipper truck rolled over after losing traction on an incline and rolling backwards.

The driver tried to change down gears but couldn't find the appropriate gear before the truck lost momentum and began to roll backwards. The driver attempted to stop the truck with the foot brake but had no response from the braking system. The truck rode up on the berm at the bottom of the incline and tipped onto its side. The driver was uninjured

Mine operators must ensure defect reporting and pre-start inspections are being used effectively to maintain safe operating plant.

Safety critical systems such as braking and steering systems should be inspected, maintained and tested in accordance with the manufacturer's recommendations.

Roads or other vehicle operating areas	and was able to exit from the cab. It was dark at the time of the incident. 	
Dangerous incident IncNot0037685 Open cut construction materials mine	A worker slipped backwards about 60 centimetres from the track of a mobile crushing screen. The worker was alone at the time and was unable to alert anybody for about 30 minutes.	The cause of this incident was unknown at the time of writing. The incident is under investigation. Mine operators are reminded that they must have systems in place for workers to contact others in the case of an emergency when working alone.

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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