NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 18 September 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	63
Summarised incident total	6

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0038233 Underground metals mine	A jumbo offsider sustained a serious crush injury to his foot when it was caught beneath a stabilising jack that was being lowered. The offsider was preparing to plug a pump cable into a cable receptacle on the jumbo while the stabilising jacks were being lowered.	Work procedures and controls must consider the risk of workers being in proximity to equipment. No-go zones and safe standing zones for workers should be implemented and communicated to all workers involved in the operation of plant. The use of proximity detection should be considered when completing risk assessments for working around operating equipment.

Dangerous incident

IncNot0038244

Open cut coal mine

An electrical tradesman had his head caught between a lift cylinder and the body of a haul truck. The tradesman was disconnecting an earth strap adjacent to POS34. The tray of the truck had been removed and the lift cylinder was chained to a lug. As the tradesman reached to disconnect the earth strap, the lift cylinder pivoted and pinned the tradesman against the truck. He sustained minor head injuries.

While the lift cylinder had been chained to a lug, there was enough slack in the chain to allow the cylinder to move when bumped.

Unintended movement of secured loads is an identifiable risk. Safe work procedures should clearly articulate the risk and outline the controls required to prevent unintended movement.

Mine operators should ensure that their work procedures for this common task include this particular risk and the necessary controls.

Dangerous incident

IncNot0038271

Open cut coal mine

A worker's index finger was severely crushed in the pivot point of a haul truck's emergency egress ladder. The truck was being washed down and the egress ladder was activated to allow access to air filter dust caps. The operator put his hands on the rails of the ladder to climb up, but when he put his weight on the bottom step the ladder closed at the pivot point where he had his hand crushing his finger.

Mine operators should review their procedures to determine if their training includes the hazards associated with potential pinch points and their identification.

Mine operators should consider reviewing the emergency egress handrail design in consultation with the OEM.

Dangerous incident

IncNot0038274

Open cut coal mine

A dozer tipped over when the operator drove the left-side track partially up a pile of side casted material. The dozer became unbalanced and slowly tipped onto its right-side track. The operator was able to exit the dozer and was uninjured.

Equipment operators must maintain situational awareness and remain vigilant to manage the risk of machine rollovers. When planning tasks and travel paths, supervisors must consider rollover hazards.

Refer to Safety Bulletin:

SB19-10 Dozer incidents increase despite warnings

Dangerous incident IncNot0038285 Underground coal mine	A mine worker severed the tip of one finger and received deep cuts to other fingers of his right hand while sliding an auger sleeve into an empty kibble. He and another worker were attempting to get the auger sleeve into the kibble, which had a cross brace on the top, making it awkward to manoeuvre. One worker lifted the auger sleeve to attempt to slide it under the cross brace and the other worker had his hand at the back of the auger sleeve to guide it into place. When one worker pushed the auger sleeve it slipped quickly off the top of the kibble crushing the other worker's hand between the auger sleeve and the kibble wall. 	Workers must be trained to identify potential hazards when undertaking unplanned tasks and be capable of assessing and controlling risks. Communication between workers jointly undertaking tasks is of paramount importance and the approach to any unplanned task should be discussed and agreed upon.
Dangerous incident IncNot0038238 Open cut industrial minerals mine	A worker showering in the amenities building received an electric shock when operating the water tap. Initial investigation shows that the inadvertent repowering of a redundant hot water tank and the ineffective earth	Mine operators must ensure installations meet the requirements of *AS/NZS3000 Wiring rules* with particular attention to the effectiveness of earthing and

	bonding of the plumbing and drainage pipework exposed the worker to a potential difference between the tap and the shower floor.	bonding of pipework and conductive materials in wet areas. Low impedance earth paths and the use of fast acting sensitive earth fault protection are paramount in the early detection and interruption of hazardous electric faults. Review the investigation report into a previous electrical fatality for further considerations: Fatality in a residence

NSW Resources Regulator publications

- Safety alert SA20-08 Drill rig contacts high voltage power line

Other publications of interest

These 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 (other, non-fatal)
Health and Safety Executive (UK)	**Failure to detect dangerous gas/vapour due to incorrect specification of sample tube** In a recent incident a gas detector failed to detect the presence of a flammable vapour. Hot work proceeded in the belief that there was no flammable vapour present. The subsequent explosion resulted in a fatal injury. Gas detection may be used in support of a risk assessment associated with, for example, hot work or confined space entry. It is important that the gas detection system used is suitable for the intended purpose and gives a sufficiently accurate and reliable indication of the presence of the hazardous material. Details

MinEx NZ	**Near miss – Failure to lockout (isolate)** A supervisor was exposed to unguarded nip points (while plant was running) and failed to secure himself as he climbed (working at height) to inspect the plant breakdown. The incident occurred when a supervisor attempted to observe the source of a bearing failure on a conveyor head drum. Details
	National (other, non-fatal)
Queensland Mines Inspectorate (Coal)	**Tailgate infrastructure contributes to longwall Methane exceedance – Safety Alert #379** Power to a longwall face was tripped by an automatic methane sensor located at the tailgate. The responsible ERZC (deputy) conducted an inspection to identify the source of the methane. During the inspection in the area of the tailgate shields, the ERZC detected greater than 2.5% of methane. 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	DOC20/781409
Mine safety reference	ISR20-38
Date published	28 September 2020
Approved by	Chief Inspector Office of the Chief Inspector