

WEEKLY INCIDENT SUMMARY

Week ending Friday 21 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.

TYPE	NUMBER
Reportable incident total	28
Summarised incident total	6

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Serious injury IncNot0036767 Open cut coal mine	An operator was accessing a haul truck via the stairs when the handrail gave way and the operator fell sideways to the ground, about one to one-and-a-half metres. The operator suffered a broken wrist and broken leg.	Mines are reminded of the need to identify, assess, manage and rectify defects that affect the safety of plant or structures. The Regulator has commenced an investigation into this incident. An initial investigation report will be released in the next two weeks.

Dangerous incident
IncNot0036749
Open cut coal mine

An excavator was working across the face. A dozer was cleaning up and entered the swing radius of the excavator while it was placing a bucket of material in a truck. As the excavator bucket cleared the truck, it hit the lift cylinders on the dozer.

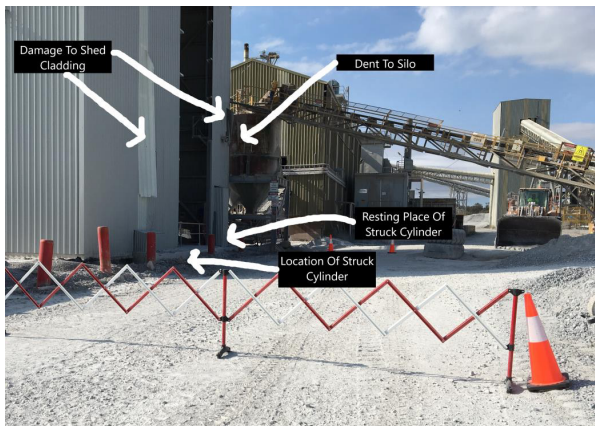


Effective communication protocols and procedures should be in place to ensure that positive communication between equipment operators is achieved. The proper use by operators of these protocols is monitored on a continuous basis.

Refer to [Safety Bulletin 18-06 Lack of positive communications](#)

Dangerous incident
IncNot0036753
Open cut minerals mine

A loader was feeding a hopper, as it reversed it hit a red cylinder that was buried upside down. The cylinder was one of several that were being used as bollards for a collision barrier for a building. The cylinder was punctured, causing a pressure release that propelled it into the air where it hit buildings, before landing on the ground.



In developing control measures to manage the risks of interaction between mobile plant and fixed structures, mines should ensure that the control itself does not introduce a new level of risk.

Under **no circumstances** should gas cylinders be used for anything other than their intended use.

Dangerous incident
IncNot0036760
Open cut coal mine

While installing a body pivot bush on a dump truck using a hydraulic puller, a section of threaded bar failed. The threaded bar, nut and spacer were ejected in different directions.

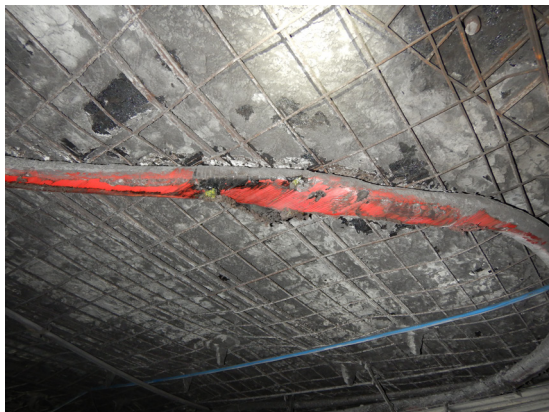
The threaded bar landed about 5 metres away. The nut and spacer landed about 12 metres away in an adjacent workshop bay. No-one was injured.



Mechanical engineering control plans must set out the control measures for risks associated with the unintended release of mechanical energy by considering safe work systems for people dealing with plant or structures - including the isolation, dissipation and control of all mechanical energy sources from plant or structures.

Dangerous incident
IncNot0036762
Underground coal mine

A longwall powered roof support was being transported out of the mine when the top of the support canopy contacted a high voltage cable that was looped across the roadway. Power was lost to inbye parts of the mine.



When developing control measures to manage the risks of roads or other vehicle operating areas, consideration must be given to the potential for interaction between mobile plant and fixed structures, including overhead and underground power lines, tunnel walls and roofs.

Factors for consideration include:

- roadway height and width
- load height and width
- location of cables and other services suspended from the roof.

Dangerous incident
IncNot0036772
Open cut coal mine

A haul truck reversed into a shovel while self-spotting on the offside. The truck body penetrated the housing of the shovel. No one was injured.



Operational procedures for truck loading need to identify adequate controls for operators to use to guide them when self-spotting under shovels. Regular verification of the implementation of these controls should be undertaken by supervisors.

Dangerous incident
IncNot0036782
Open cut coal mine

A person suffered an electric shock from a welder while applying the earth clamp to a work piece.



People involved with welding activities should remain insulated from the welding job. Welding gloves are not electrical insulators and if they are damp, they can enhance the effect of an electric shock.

Refer to the following publications for guidance

- [Safety Bulletin SB19-03 Welding-related electric shocks increase](#)
- [NSW Resources Regulator Information Sheet No.2: Basic welding practices](#)

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	<p>Coal/non-metal mine fatality final report</p> <p>On Thursday, August 29, 2019, at 6.30pm, a 25-year-old section foreman, with six years of mining experience, died after a section of rib fell on him.</p> <p>Details</p>
MSHA	<p>Coal/non-metal mine fatality final report</p> <p>On Thursday, September 5, 2019, at 2.50pm, a 39-year-old continuous mining machine (CMM) helper died when a battery-powered scoop struck him.</p> <p>Details</p>
National (fatal)	
DNRME Qld	<p>Tyre fitting fatality</p> <p>On Sunday 12 January 2020, a 33-year-old old contract tyre fitter was fatally injured while changing a large, wheel assembly (tyre and rim) on a rear axle expanding low loader at an open cut coal mine in Queensland's Bowen Basin. The tyre fitter was found trapped underneath a wheel assembly.</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.

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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (March 2020). However, because of advances in knowledge, users are reminded of the need to ensure that information upon which they rely is up to date and to check currency of the information with the appropriate officer of the NSW Department of Planning and Environment or the user's independent advisor.

DOCUMENT CONTROL

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