Weekly incident summary
Mine Safety News
Emerging trends, reportable incidents and safety advice

NSW GOVERNMENT

NSW Resources Regulator

Week ending 8 March 2019

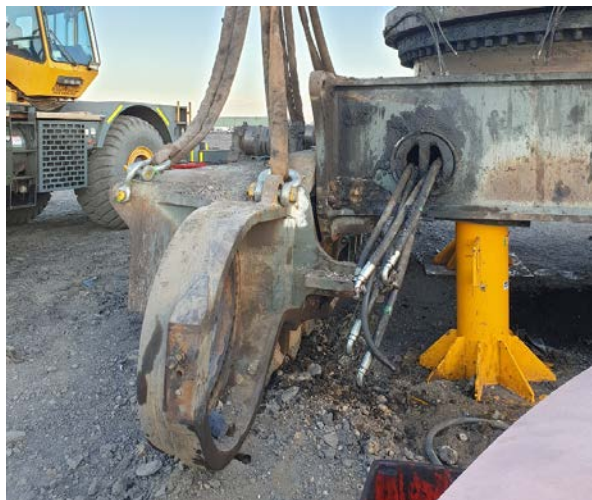
This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the NSW Resources Regulator: phone 1300 814 609 24 hours a day, 7 days a week.

At a glance

High level summary of emerging trends and our recommendations to operators.

Type	Number
Reportable incident total	50
Summarised incident total	4

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident IncNot0034077	A maintenance worker was hit in the face with pressurised hydraulic fluid. The worker was standing on a ladder to disconnect a hydraulic hose on an excavator track adjuster. The tracks were disconnected from the machine. However, there was residual pressure present in the accumulator which the worker had not identified. 	Mine workers must be trained and competent in isolation. Correct isolation includes the identification of all energy sources and the complete dissipation of the energy. Training must include all steps in the isolation process.

Dangerous incident IncNot0034039	A large haul truck was travelling at speed into a mine when the operator took a wide turn. To avoid a collision with an oncoming haul truck, the driver over-steered the vehicle, causing the front right-hand tyre to fail and the front of the truck to dig into the ground. The truck was driven another 15 metres at a speed of about 50km/h. Additionally, a rock fell off one haul truck onto the other haul truck, breaking the right-hand side windscreen. 	All mines must consider the hazard of speeding while driving. Engineering controls need to be considered to minimise this risk. The use of speed monitoring and alarms need to be considered and the appropriate action taken when speeding is identified.
Dangerous incident IncNot0034087	An operator was hit on the helmet and shoulder by a coal packer when it fell against mesh that was being removed for pillar extraction. The operator was sent to hospital for review and was released without injury. The rib broke into three packer sizes ranging from 850 x 300 x 200 mm, 600 mm x 300 x 200 mm and 500 x 300 x 200 mm.	When working methods are altered, mines must ensure change management is completed and all introduced risks are assessed. All change management processes must include training.

Dangerous incident IncNot0034076	An operator was walking along a designated gantry in a coal preparation plant when a piece of the walkway gave way and his foot went through it. No injury was reported.	Following the competition of structural integrity audits, repair work must be prioritised and continually reviewed to ensure implementation. If structures are deteriorating at a greater rate than expected, then these need to be reviewed as a priority.

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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