

## Week ending 16 May 2018

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	41
Summarised incident total	12

### Summarised incidents

Incident type	Summary	Recommendations to industry
<p>Serious injury SinNot-2018/00747</p>	<p>A loader operator suffered three cracked ribs after falling 1.5 metres from a loader. He was standing on the top rung of the access ladder when he had a back spasm.</p> 	<p>Mine operators must ensure their health control plan includes control measures to ensure persons working at the mine are fit to carry out work without causing a risk to their own or others' safety.</p>
<p>Dangerous incident SinNot-2018/00738</p>	<p>A continuous miner driver was hit in the back and knocked over by rib spall. He was found by</p>	<p>When poor strata is identified, corrective actions should be taken in</p>

another operator. Poor ribs had been identified but had not been barred down.

accordance with procedures and mine's trigger action response plan (TARP) as soon as practical.

Mine operators must ensure that workers are provided with adequate information training and instruction in relation to hazards associated with ground and strata failure.

Mine operators should consider potential risks to unaccompanied workers operating remote control mining equipment.

Dangerous incident  
SinNot-2018/00727

While delivering sand to a mine, a second trailer overturned during tipping.

When approaching full height, the driver noticed the trailer leaning to the left and stopped tipping. The trailer continued to roll and overturned onto the ground.



Suitable areas and procedures should be in place to allow safe tipping of material arriving on site. In identifying risk controls in these procedures, consideration should be given to cross grades, material build up and wind.

Serious injury  
SinNot-2018/00719

A fitter degloved the tip of his finger. The fitter was in the process of removing a broken blow bar (about 100 kg) when it fell and jammed his finger. He was not wearing gloves.

Job task planning should consider risks arising from how heavy items are handled.

When assessing the handling of heavy items, workers



should seek assistance or use of mechanical aids.

Mines should have a system in place requiring supervisors to monitor personal protection equipment compliance, including gloves.

Dangerous incident  
SinNot-2018/00716

An electrician suffered several electric shocks when a second electrician carried out an insulation test on the cable they were working on. The electricians were at opposite ends of the cable and the electrician conducting the insulation test did not communicate his intended actions.

A procedure should be in place for the use of electrical test equipment, including the exposure to workers.

Clear communication is required between work parties and team members.

The potential impact of the task on other workers should be considered in procedures and risk assessments.

Serious injury  
SinNot-2018/00712

The owner/operator of an opal mine suffered spinal injuries when he fell down a shaft. He was fixing a ladder to the shaft wall when it gave way and he fell 6 to 9 metres. Emergency services were required to extract the injured person, who was taken to hospital.

Where a risk of falling is present, mine operators must minimise the risk of fall by providing adequate protection against the risk.

Mine operators must have safe systems of work to protect workers from the risk of falls. Emergency response and recovery plans should form part of this system.



Serious injury  
SinNot- 2018/00701

A worker suffered serious head injuries when he was hit by an unsecured bracket that fell while decommissioning a crane. The bracket, weighing 50 kg, fell about 10 metres from the top of the mast section. The bracket glanced off the hard hat of the worker.

Mine operators should have procedures in place to ensure lift plans and job safety procedures are correctly implemented throughout the duration of the task.



Items that pose a risk to workers should be secured to prevent injuries.

When objects can fall, appropriate no-go zones should be established to protect workers from falling objects.

No-go zones should be clearly communicated and delineated to all workers in the vicinity.

Dangerous incident  
SinNot-2018/00740  
SinNot-2018/00736  
SinNot-2018/00730  
SinNot-2018/00726

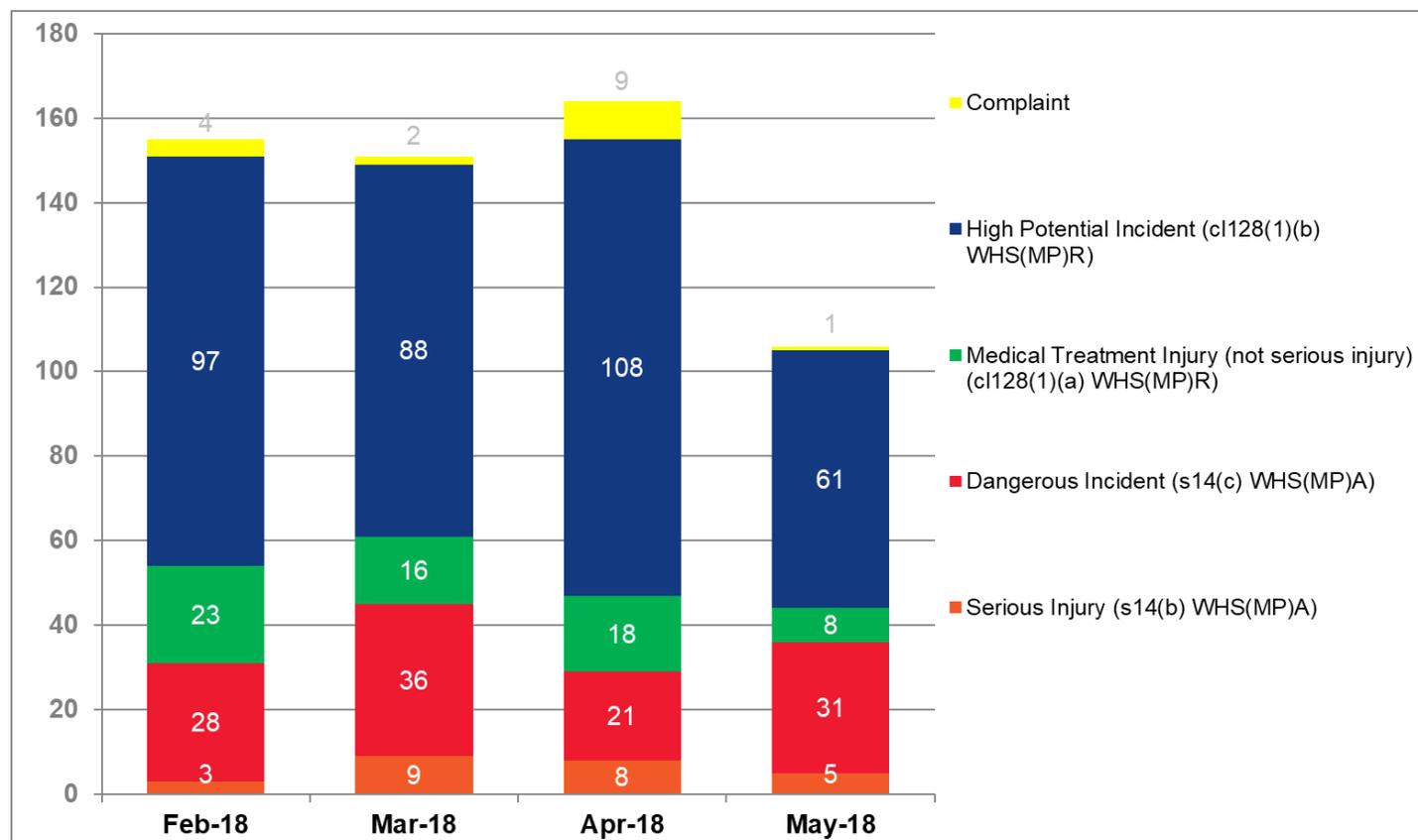
Multiple mines have been notifying the regulator of ongoing spontaneous combustion incidents.

All coal mine operators, including open cut mines, are reminded that the new Work Health and Safety (Mines and Petroleum Sites) Regulation 2014 clause 179 (h) requires 'spontaneous combustion' to be notified to the regulator.

<p>Dangerous incident SinNot-2018/00739</p>	<p>Spontaneous combustion was developing at a mine site and reported to the regulator. Oxidised coal was put into the dump.</p>	<p>Mines must have a principal hazard management plan for fire and explosion.</p> <p>For all coal mines, this should incorporate a system for the identification, management and control of spontaneous combustion, where it has been identified the risk of spontaneous combustion potentially exists.</p> <p>Workers must be provided adequate information training and instruction in relation to this system.</p>
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**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.



## Recent publications

- [SA18-09 CMI 425 Amp flameproof restrained receptacle recall](#)
- [IIR18-04 Dangerous incident at Chain Valley Colliery](#)

### 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.

### Office use only

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