NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 10 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	44
Summarised incident total	4

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0037725 Underground metalliferous mine	A worker was removing an accumulator from a raise boring rig on the surface laydown area. During this activity, he suffered a fluid injection injury to his left-hand ring finger. The worker was admitted to hospital and underwent surgery. 	Mine operators are reminded that effective isolation and energy dissipation are critical risk controls when working on high pressure fluid systems. Methods for dissipation of energy must be established and communicated for work on each part of a high pressure system. Refer to: SB13-01 Fluid injections result in surgery SB12-03 Fluid power isolation failures

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
		SA09-04 Hydraulic injection near miss SA06-16 Fatal high-pressure hydraulic injection MDG-41-Fluid-power-systems MDG-40 Guideline for hazardous energy control
Dangerous incident IncNot0037724 Open cut coal mine	A 5T overhead crane was being used to remove an access ladder from a dozer. The operator was using the smaller hook on the crane. While taking up the slack on the slings and chains being used, the ladder was pulled free of its mountings and swung around, knocking over a stepladder which a worker was standing on. The worker jumped off the ladder and landed safely on the ground. The crane operator was unfamiliar with the 5T crane and the speed of movement of the smaller crane hook. The crane hook moved faster than anticipated when load was applied to the ladder which was still bolted to the dozer. 	Workers must be trained and competent in the use of equipment that is under their control. All potential failures must be identified when determining safe standing zones, including unplanned movement. The risks of unplanned movements should be communicated to all workers during no-go zone identification.

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0037723 Underground metalliferous mine  Fire or explosion	The operator of a loader in an extraction drive observed a flame coming from the muffler box on the loader. The operator stopped the machine and used a fire extinguisher to suppress the flame. The flame reignited and was extinguished again. The automatic fire suppression system was manually activated to cool the machine. The apparent cause was fuel leaking from a crack in the internal fuel tank into the diesel particulate filter (DPF) box. The loader had previously contacted a wall, but the damage to the fuel tank was not identified at that time. 	This incident is under investigation and further information may be published at a later date. Following damage to any piece of equipment, thorough inspection and recommissioning must be undertaken to ensure all defects have been identified and repaired. Refer to: Preventing fires on mobile plant
Dangerous incident IncNot0037725 Underground coal mine  Roads or other vehicle operating areas	A drill steel was caught in the articulation point of a load haul dump vehicle (LHD) and was flung out, striking the operator on the cheek. The drill steel and a roof bolt had been left on top of the LHD. The operator suffered two fractures to his cheek bone.	All equipment transported on mobile plant must be secured and only stored in designated storage areas. Operators should ensure they check for any loose materials on the machine and remove them before operating the LHD.

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 (other, non-fatal)
MinEx NZ	**Bucket falls from excavator** An operator of an excavator with a quick hitch and bucket attached, lifted the boom of the excavator and propelled the bucket five metres towards a nearby worker. Fortunately, the bucket missed the worker, and no-one was injured. The locking pin was not inserted into the quick hitch. 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.

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