NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 06 November 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	35
Summarised incident total	3

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0038585 Open cut coal	Workers were using a crane to lift and lower light poles from their foundations. After attaching a chain to the bottom of a pole, a worker was to use an elevated work platform to attach a sling mid-way up the pole before lifting. However, before this happened, the crane operator tensioned the chain, causing the pole to lift from its foundation and topple over. No persons were injured.	Light poles should remain bolted in place until all slings and lifting equipment are in position so that the pole cannot fall when bolts are removed. Mine operators should have documented procedures for the task. Supervisors and workers should ensure that the procedures are followed throughout the duration of the task. It is vital that all parties actively involved in the task clearly communicate their intentions to others.

		No-go zones should be delineated and clearly communicated to all workers in the vicinity.
Dangerous incident IncNot0038584 Underground metals	An operator was using a scaling bar to attempt to free up a jammed drill rig carousel after a drill steel had become stuck. While pushing on the bar the operator lost his grip. The bar sprung back and hit him in the lower jaw causing a severe laceration. 	Operators need to remain situationally aware and avoid trying to apply solutions to problems that have not been risk assessed. Force should not be applied to plant with tools that are not fit-for-purpose.
Dangerous incident IncNot0038570 Underground metals 	While tramming with a loaded bucket from the stockpile to the crusher, a loader collided with the driver's side of a light vehicle. The vehicle was moved sideways with such force that the passenger side tyres were pushed off the wheel rims. The driver and passenger were fortunate to escape injury.	Lack of positive communication has been the root cause of many incidents, including fatalities. Mine operators must consider higher-order controls including proximity detection. Effective protocols and procedures should be in place to ensure that positive communication between all operators is achieved. Supervisors must monitor the

Roads or other vehicle operating areas

correct use of these protocols on a continual basis.

Refer to:

Safety Bulletin 18-06 Lack of positive communications

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	**Worker falls exiting loader** A worker was washing the roof of his loader, standing on the step near the back of the cab. Once he finished, he climbed backwards down the ladder (with 3 points of contact). When he reached the bottom step his foot slipped and he fell backwards, hitting his head. Details

National (other, non-fatal)

NT WorkSafe	**Dual lift operations with forklifts not recommended** In late September 2020, workers at a Northern Territory worksite attempted to move a 10-meter jib weighing almost 4 tonnes. The Franna crane normally used to move the jibs was offsite, and a decision was made to dual lift the jib using slings and two forklifts. During the lift, one of the forklifts positioned at the base of the jib rolled, pushing the jib forward. The uncontrolled momentum of the jib tipped the second forklift sideways. The forklift operator was wearing the seatbelt at the time, which prevented the worker from falling out of the cabin and potentially into the path of the tipping forklift. 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	
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