WEEKLY INCIDENT SUMMARY

Week ending Friday 09 October 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

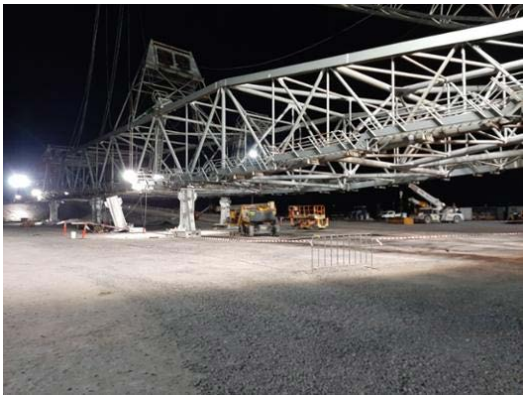
High level summary of emerging trends and our recommendations to operators.

TYPE	NUMBER
Reportable incident total	40
Summarised incident total	4

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0038433 Open cut construction materials	A worker climbed onto a redundant item of plant to attach a set of lifting slings to the excavator hook with the intention to lift and move the item. A decision was then made to remove the bucket from the excavator prior to the lift. Before the worker had removed the slings from the hook, the excavator moved causing the item of plant to shift. The worker attempted to jump from the item of plant but caught his foot and fell to the ground. The worker suffered a broken wrist.	Mine operators must have safe systems of work to protect workers from the risk of falls. Workers should remain situationally aware and not put themselves in a position where they are at risk of falling from a height. Appropriate work platforms should be considered when working at height. Methods of communication between workers must be clear, agreed upon and understood before the task is undertaken.

Dangerous incident IncNot0038431 Underground coal mine	A longwall fitter was replacing hoses on roof supports as part of a maintenance program. He removed the staple from a DA Ram POCV and was applying some force to remove the hose when he was struck on the palm of his hand by fluid under pressure. Initial investigation indicates that residual pressure was retained in the circuit. The bleed point was potentially contaminated with dirt which prevented full dissipation of fluid pressure.	Although procedures for the task were followed in this instance, the tool for the job was not functioning properly which put the worker at risk. Failure to identify residual pressure, and to bleed this pressure off appropriately is failure of a critical control. Refer to: SB 19–04 Workers injured by high pressure fluid

Dangerous incident IncNot0038419 Open cut coal mine	During a shutdown, workers were removing stands from underneath the boom of a dragline when the boom moved approximately 300 millimetres. The task was to remove the stands under the boom between the dragline house and the end of the boom. The incident occurred when workers were lowering the hydraulic cylinders on the third last stand located between B2 location and the dragline cabin. The B2 left stand fell over and the B2 right stand lost packing between the stand and the boom. 	It is essential that a task such as this have a documented procedure. The risk assessment for this task must be thoroughly undertaken and include all hazards, including detail about the removal of boom stands. All personnel involved in the task must understand the procedures and sign on to the JHA. Ensure there is enough packing between the ground and the base of the stand, and at the interface between the hydraulic cylinders and the boom. The boom should be monitored for movement during the build.
Dangerous incident IncNot0038413 Underground coal mine	While removing a drift winder rope, the head sheave plumber blocks failed, resulting in the head sheave falling to ground level from its position on the gantry, a vertical distance of approximately 15 metres. The sheave wheel fell into a demarcated no-go zone. A person was positioned in the line of fire when the pulley fell, but was not injured. Initial investigation indicates that the method of rope removal, using the mobile friction winder, inducted a horizontal load on the plumber blocks. This resulted in the plumber block feet failing and the head sheave working free.	Safe systems of work must be documented and provided by mine operators. Supervisors must ensure that the systems of work are understood and implemented by workers. Engineering design and expected forces must be calculated for all parts of the task to ensure equipment is designed for the expected duty. The risk of falling objects and the positioning of workers must be considered in the work methods.

Established no-go zones must be adequately sized to ensure workers are not put at risk from falling objects.

Other publications of interest

The incidents below 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	**Bar hits worker in the face** During assembly of a new screen on the crushing plant, a crane lifted the plant to allow the wheel assembly to be released. While a worker was attempting to remove the pin of the wheel assembly, the wheel assembly became jammed. The

worker used a bar to try and release the pin, and while pulling on the bar it slipped out and struck the worker in the face, chipping a tooth.

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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