Weekly incident summary

NSW RESOURCES REGULATOR

Week ending 25 January 2019

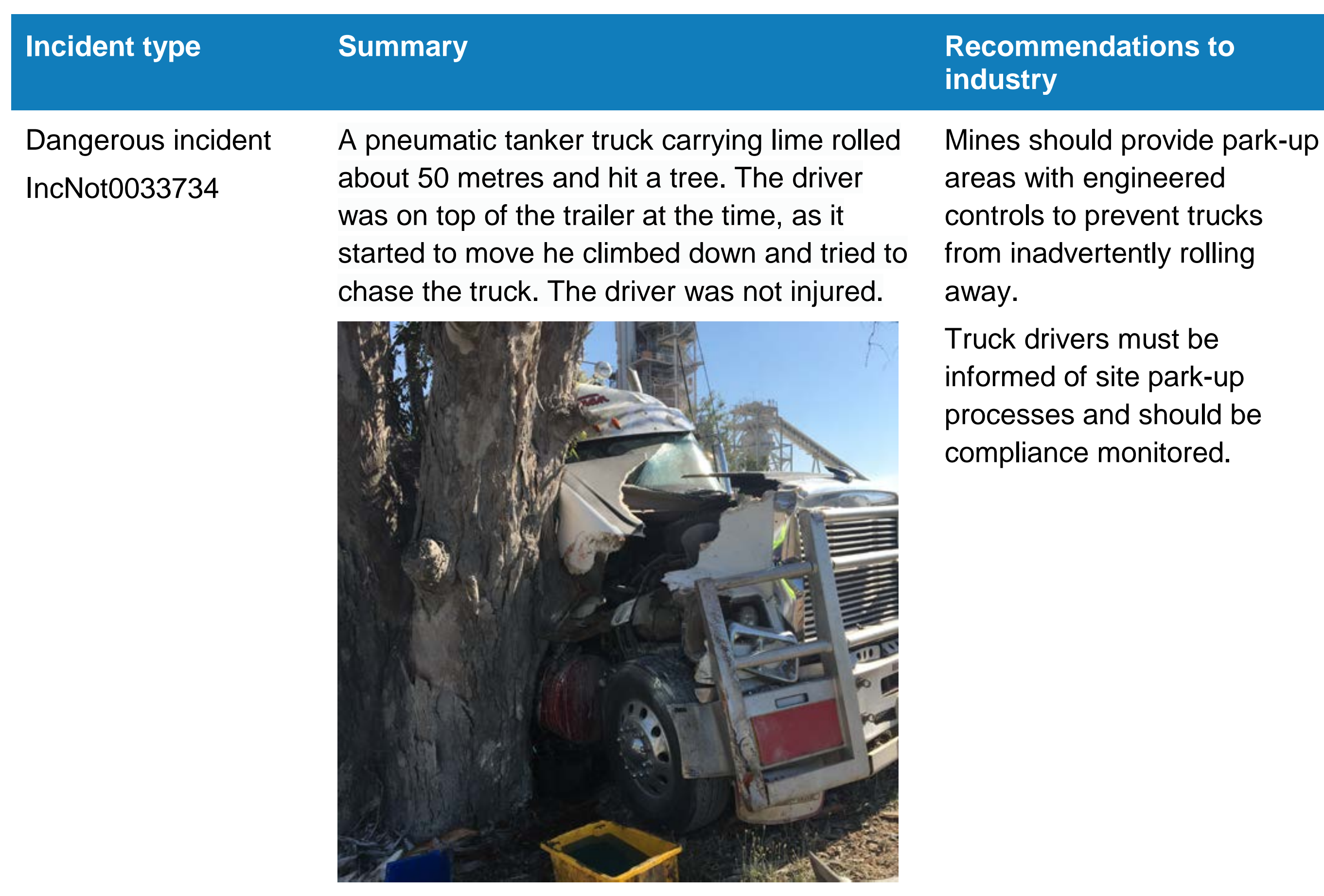
This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the NSW Resources Regulator: phone 1300 814 609 24 hours a day, 7 days a week.

At a glance

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

Type	Number
Reportable incident total	40
Summarised incident total	8

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident IncNot0033734	A pneumatic tanker truck carrying lime rolled about 50 metres and hit a tree. The driver was on top of the trailer at the time, as it started to move he climbed down and tried to chase the truck. The driver was not injured. 	Mines should provide park-up areas with engineered controls to prevent trucks from inadvertently rolling away. Truck drivers must be informed of site park-up processes and should be compliance monitored.

Dangerous incident IncNot0033728	While operating on a clean coal stockpile, a dozer sunk into a void. The operator was able to safely exit the machine. 	The hazard of concealed voids exists on stockpiles and must be included in risk assessments, training and procedures for operators. Operators must be trained in identifying when the risk is present and how to control this risk. When designated equipment fitted with risk controls (in this case toughened glass and GPS) is swapped, the alternative machine must have controls to manage the risk to an equivalent level.
Dangerous incident IncNot0033707	A loader damaged an 11,000 volt cable was damaged in a quarry. The operator was using a loader to clean up when he dug into a bund. A cable was damaged and tripped the power to the site. 	All buried services at mine sites should be clearly delineated and marked on plans. Operators need to consider services in areas around infrastructure.

Dangerous incident IncNot0033683	A tractor rolled while it was undertaking rehabilitation work at an open cut coal mine. The operator was not injured. The tractor was towing a spreader loaded with gypsum when the operator drove down a slope. The tractor started to skid and as it slid it overturned.	When assessing the risk of vehicles and equipment operating on slopes and grades, the effect of any trailers and attachments used must be considered. When equipment is upgraded or replaced, any training, assessments and appointments must be updated to reflect the equipment being used.
Dangerous incident IncNot0033683	A group of workers were installing rock fall barriers on a highwall in an open cut gold mine. When completing the task, a piece of stone fell and hit a worker on the ankle.	Workers must have appropriate controls in place to manage the risk of falling material when working near highwalls.
Dangerous incident IncNot0033664	A loader was working on a coal stockpile when a fire occurred. The fire was localised to the air filter area. Investigations are continuing.	Any machines fitted with burn type diesel particulate treatment should have the risk of this process addressed in the fire risk assessment for the machine.

Dangerous incident IncNot0033659	A worker suffered a fractured leg and required surgery following an incident at an underground coal mine. A group of workers were recovering longwall roof support leg cylinders using a wire rope winder attached to a load haul dump. The rope was placed around a timber prop and during winching, it pulled out the timber prop, which hit the worker, breaking his femur.	Before completing a task, a risk assessment tool must be used and control measures identified. When the task involves towing or snigging, no go zones must be identified and communicated to ensure workers remain out of the line of fire.
Dangerous incident IncNot0033650	A road-registered truck being used as a water cart rolled over in an open cut coal mine. The operator was descending a ramp when the truck hit a windrow and rolled. 	Maintenance plans should be reviewed when on-road vehicles are routinely used in mine sites. Operators of mobile plant must remain focused on the task at hand and avoid tasks that may distract them from their primary duty of safely operating plant.

Other publications of note

These 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)
HSE in MinEx NZ	**Quarry operator sentenced after worker severely injured** A quarry operator has been fined after it failed to keep fixed guards in place on moving machinery, causing serious injuries to an employee's arm. Telford Magistrates' Court heard how, on 9 December 2016, a new employee of Tudor Griffiths Limited was injured on his first day working at the quarry. His arm became caught

	and dragged into the 'nip point' between the conveyor belt and rotating tail drum. The worker's injuries resulted in the need for multiple skin graft operations and has left him with permanent scarring on his arm. Details
MinEx NZ	**Arc flash from switchboard** A plant operator at a tertiary plant noticed low amp supply on his main computer for the tertiary plant. He went down into the room where all electrical switchboards were located to see what the problem was. As the operator reset the power supply, an arc flash occurred which startled the operator. He went to retrieve the fire extinguisher, but it was not required. Details
National (fatal)	
Qld Mines dept. (DNRME)	**Fatal incident as bulldozer overturns into pit** On Monday 31 December 2018 about 10.30pm, an experienced 49-year-old coal mine worker was fatally injured while he was operating a bulldozer at an open-cut coal mine near Dysart in Central Queensland. The bulldozer was traversing, with the blade not in contact with the ground, along a bench in an area where three bulldozers were pushing overburden material. The bulldozer operated by the deceased, for a reason yet to be determined, went over the bench's crest and rolled downwards about 20 metres. The bulldozer came to rest on its roof in an area of mud and water about two metres deep. Details
National (other, non-fatal)	
Qld Mines dept. (DNRME)	**Serious accident involving an articulated water cart** In September 2018 an operator loaded an articulated water cart and was moving up a ramp on a mine's tailings dam. The engine then stalled for unknown reasons, and the vehicle ran away backwards down the face of the tailings dam wall, overturning at the bottom and pinning the operator in the cab. The operator was hospitalised for assessment and treatment of fractures and bruising. 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.

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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