NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 30 April 2021

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	50
Summarised incident total	4

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Serious injury IncNot0039769 Underground coal mine	A worker received crush injuries to two fingers when their hand was caught in a pinch point while operating a roof bolting rig. The worker was wearing gloves when her fingers became caught between the feed carriage end plate and the carriage retainers. The gloves had to be cut to free the worker's fingers. The worker sustained degloving of the end of her left ring finger and the tip of her little finger. A polyurethane flap had been fitted to prevent access to the pinch point, but this proved to be an inadequate risk control.	Mine operators should ensure that training of persons involved in roof bolting includes the identification of pinch points and associated hazards. Adequate controls should be put in place to control the risks. Operators should ensure that the installation of 'lobster' attachments does not introduce new, unidentified pinch points without risk controls.

Dangerous incident IncNot0039733 Open cut coal mine	While lifting a four tonne excavator slew ring from the ground, the lifting sling snapped when the slew ring was upright, allowing the ring to fall back to the ground. The lifting sling was rated for a two tonne lift and an inappropriate slinging technique was used for the lift. More appropriate lifting equipment was available at the time, including rubber sections to wrap around the load. No one was injured.  	Workers have a legislative duty to care for their own health and safety and that of others (s28 Work Health and Safety Act 2011). One of the duties is to cooperate with any reasonable policy or procedure. Procedures are developed to help protect workers from injury or illness. Where a procedure exists for a particular task, workers should follow the procedure. Any deviation from a procedure should first be discussed with a supervisor and appropriate risk control measures put in place.

Dangerous incident
IncNot0039770
Open cut coal mine

Roads or other vehicle operating areas

The tray of a haul truck collided with the lift arm and handrail of a front-end loader, putting the loader operator at risk. The haul truck was backing under the loader, however, the operator's view was obscured by dust and he lost sight of the loader. The loader operator had earlier switched to offside loading due to visibility issues with dust and lighting. No one was injured.

The consequences of vehicle operators not establishing positive communications with other vehicle operators can, and has been, fatal. Despite the prevalence of site procedures, operator training and the introduction of assistive technology, many operators continue to ignore the importance of following basic procedures. The continuous repetition of a task does not negate their responsibility to establish positive communications every time a task is repeated.

Serious injury
IncNot0039717
Underground coal mine

A worker sustained a punctured lung when he was struck in the chest by a poly pipe. While moving a pipe trailer into a roadway, a pipe has moved rapidly and struck the worker in the chest.

This incident is under investigation and further information may be published later.

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	**Potential fluid injection injury** A mobile plant operator and a fellow worker were in the process of starting the plant when a small oil leak was noticed in a hydraulic hose near the cabin. During the process of fault finding one of the workers suffered an impact injury on his left thumb pad, from a spurt of hydraulic oil 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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