

# WEEKLY INCIDENT SUMMARY

Week ending Friday 09 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 | 23     |
| Summarised incident total | 3      |

## Summarised incidents

| INCIDENT TYPE  | SUMMARY  | COMMENTS TO INDUSTRY   |
|--|--|--|
| Medical treatment injury<br>IncNot0039605<br>Metals processing | A worker sustained a laceration to his foot when a grinder he was using fell and cut through his boot. The worker was deburring a pipe when the die grinder caught the internal edge of the pipe causing it to chatter in a circular motion. The worker lost his grip on the grinder, causing it to fall on his foot. The grinder was still operating at the time of the incident. | The risks associated with grinders are easily foreseeable. As a minimum control measure, grinders should be fitted with a dead-man's switch. In the occasion that a grinder comes free from the operator's grip, it ceases to operate. |
| Dangerous incident<br>IncNot0039601<br>Underground metals mine | A jumbo operator's off-sider sustained lacerations to his leg and arm when he was struck by flyrock. The operator was mechanically scaling the face with a 45 millimetre bit, when the bit entered an unidentified blast hole. The blast hole contained explosive residue which  | A risk assessment should be undertaken to identify blast hole remnants prior to commencing scaling work. Mine operators should consider using a scaling bit that is larger in diameter than a blast hole bit to eliminate the risk     |



Fire or explosion

initiated the explosion. The offsider was standing towards the rear of the jumbo at the time of the incident.



of the bit entering an unidentified blast hole remnant.

Dangerous incident  
IncNot0039590  
Open cut coal mine



Roads or other  
vehicle operating  
areas

A service truck overturned when the operator lost control of the vehicle while descending a ramp. The road surface was wet following recent dust suppression watering. The operator was able to exit the vehicle and was uninjured. The truck had approximately 20 kilolitres of fluid on board and a capacity of 32 to 34 kilolitres.



When developing control measures to deal with the risks associated with articulated service trucks, plant characteristics, including stopping distances, manoeuvrability and operating speeds, both the loaded and unloaded vehicle must be considered. Movement of fluid in tanks mounted on mobile plant can significantly influence the centre of gravity and overall stability of the vehicle. Consideration should be given to tank shape, baffling and compartmentalisation to control fluid surge. Mine operators should provide operator training specific to wet roads and ensure drivers are made aware of dust

suppression activities on roads. Operators of articulated trucks need to remain situationally aware and drive to the conditions.

## 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   |
|---|---|
| <b>International (other, non-fatal)</b> |   |
| <b>MinEx NZ</b>                         | <p><b>Worker walks behind operating loader</b></p> <p>A loader completed loading a truck with gravel, after which, the truck driver walked over to the loader and collected his docket.</p> <p>As the driver walked back to his truck, he got a phone call and went “walkabout” while on his mobile phone. While distracted on the call, he walked directly behind the operating loader. The loader operator saw the driver on foot and took evasive action to prevent a high potential collision.</p> <p><a href="#">Details</a></p> |

**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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| DOCUMENT CONTROL             |   |
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