

WEEKLY INCIDENT SUMMARY

Week ending Friday 05 February 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	43
Summarised incident total	4

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0039128 Underground metal mine	A 10-metre high, four-metre diameter water clarifier tank at a paste fill plant buckled. 	The cause of this incident is yet to be determined. Further information may be published at a later date. Mine operators need to operate and maintain tanks to meet OEM recommendations. Mine operators should also be aware of the dangers associated with excessive build-up of solids in tanks.
Dangerous incident IncNot0039131	A worker was blasted in the face by compressed air while attempting to extend a two-inch air line. The worker	Unfixed pressurised hoses should not be worked on without isolating the energy source and

Underground coal mine

was connecting a pipe to a manifold that was being held by a second worker. The second worker unintentionally hit the ball valve, which allowed the compressed air to escape. The injured worker was hospitalised with facial injuries.



dissipating any stored energy. Operators should consider using gate valves in place of ball valves to isolate air flow.

Dangerous incident
IncNot0039161
Open cut coal mine



Ground or strata

A dump truck has dropped about one to two metres when the dump wall failed as the operator was tipping a load.



Mine operators must have safe systems of work in place to inspect dumps. These inspections must consider weathering effects, ground water and conditions that affect the dump wall stability. Refer to: [Safety Bulletin SB20-01 Failure of highwalls, low walls and dumps.](#)

Severe incident
IncNot0039162
Underground coal mine

A shuttle car driver sustained extensive injuries when he was pinned between the rib and the boom of a continuous miner. The driver was assisting the continuous miner operator with bolting. When completed, the shuttle car driver activated the radio mode handle from bolting mode to flit mode. The continuous miner operator has then reversed approximately one metre trapping the shuttle car driver.

This matter is under investigation and an information release will be published shortly. The incident serves as a reminder of the importance of establishing and maintaining no-go zones. The implementation of engineering controls to assist in maintaining no go zones must be considered during any risk assessment process. Mine operators,

supervisors and workers all have a role to play in ensuring no-go-zones are in place and adhered to in all circumstances.

Other publications of interest

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 (fatal)
MHSA	<p>Mine Fatality – On 19 January 2021, a mine worker backed a haul truck to the edge of a dump point that was over steepened by a loader removing material at the bottom of the slope. When the edge of the bank failed, the haul truck travelled backwards and overturned, landing on the roof of the cab. The worker was fatally injured.</p> <p>Details</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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