NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 10 June 2022

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	35
Summarised incident total	5

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0042315 Underground coal mine Roads or other vehicle operating areas	While tramming backwards and parallel to a bench edge, a dozer operator lost sight of the edge and slid off the bench.  	Situational awareness is a key control when operating mobile equipment. Workers should be trained in the importance of this control and include it in their pre-task risk assessment. Ancillary systems such as GPS guidance, dispatch systems and two-way communication should only be used when it is safe to do so.

Dangerous incident
IncNot0042319
Underground metals mine
Roads or other vehicle operating areas

Dozer incidents continue to be an issue on mine sites.
When working near edges, operators should allow for failure of soft material when positioning their machines.
Mine operators must ensure that the recommendations in the following safety bulletins are considered when developing plans for dozer operations.
Refer to:
Safety Bulletin SB19-01 Rise in dozer incidents putting operators at risk

Safety Bulletin SB19-10 Dozer incidents increase despite warnings

Dangerous incident
IncNot0042330
Open cut coal mine

A boilermaker suffered minor burns to their neck and ear and singed facial hair while carrying out hot work.
The task involved cutting into a void, cutting out and rewelding a plug that had cracked. The boilermaker had completed all preparation and struck a test arc when an unknown substance ignited.

All hot work activities must identify and control all flammable substances in the immediate work area.
Work areas must be adequately ventilated as well.
A safety alert will be published regarding this incident.

Dangerous incident IncNot0042345 Underground metals mine	The body of an articulated dump truck overturned when the rear wheels rode up onto a previously tipped load. The operator had not raised the tub before it overturned. 	The stability of articulated vehicles is a known risk that needs to be managed at mines. Factors that truck operators must consider include (but are not limited to): • speed of operation • operating grades • uneven surfaces (holes, rocks, foreign material) • tipping of loads • hang-up of loads • movement of loads. The risks associated with the rollover of mobile plant was the subject of our compliance priority program in 2018. Refer to the following outcome report for more information: Articulated truck rollovers and falls from mobile plant Refer to: Safety Bulletin SB17-01 Industry reports more truck rollovers Safety Bulletin SB18-07 Safe systems of work for mobile plant
Dangerous incident IncNot0042382 Underground coal mine	During routine dust sampling of a development crew, the deputy exceeded the occupational exposure limit for respirable quartz. At the time of sampling, the continuous miner was cutting 0.4-0.6m of stone.	When cutting stone, controls to manage airborne dust must be maintained to the site's documented standards. This includes keeping ventilation tubes advanced to the face, tube

Airborne dust and other contaminants

length within design limits, maintaining picks and sprays, having dust curtains in place and workers positioned in safe locations.

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
	National (other, non-fatal)
Resources Safety & Health Queensland	On Tuesday 17 May, a worker suffered serious cryogenic burns after immersing their hands in a container of liquid nitrogen while trying to shrink a brass bush for inserting into an excavator boom arm. While this incident did not occur on a mine site, this type of work may be conducted on mine sites, and in many cases may be done by contractors. Regardless of who conducts the work, the Mine Safety and Health Management System must manage the risks associated with the safe use and handling of liquid nitrogen or similar substances, if it is used at the mine. Details
WorkSafe QLD	This alert has been distributed to raise awareness of incidents that have been reported to TMR by principal contractors. The information may be used to initiate a review of local risk management arrangements and to ensure that control measures are in place and effective. A worker undertaking a geotechnical inspection of a boring hole for a noise wall footing slipped and fell approximately 4m into the excavation. The coverings normally in place to prevent a fall were required to be removed to perform the inspection, which was when the incident occurred. Initial attempts to rescue the worker using the equipment available on site were unsuccessful. Queensland Fire and Emergency Services were required to attend site to perform the retrieval.

Fall control measures must consider all of the work activities planned to occur on site, including incidental or infrequent activities (e.g., inspections). Arrangements for emergency response must be planned and tested as appropriate.

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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