NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 19 August 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	42
Summarised incident total	4

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0042791 Open cut coal mine Roads or other vehicle operating areas 	A dozer was cleaning up around an excavator when it slid off the coal floor into a body of water and dropped a track. The water level came up to the level of the tracks. The driver was unharmed in the cabin. Material was used to form a bridge so the operator could exit the vehicle safely.	Mine operators must have controls in place to manage the risks posed by planned and unplanned bodies of water near vehicle operating areas. Shift change-over procedures should include communication about the status of sumps/water particularly after rain.

Dangerous incident
IncNot0042803
Open cut coal mine
Ground or strata

When an operator was ready to dump a load of overburden in a haul truck, all 4 rear wheels sunk when the dump slumped. The operator exited the truck safely.

When co-disposing material with different properties, an assessment should be conducted to confirm the suitability of the material for the dump design (e.g. dump height).

A system must be in place to ensure that dump operations are compliant to site standards about material types and design parameters.

Dangerous incident
IncNot0042812
Open cut coal mine

A worker was servicing a pontoon pump when a defect was identified on the primer pump. The faulty primer pump was removed and placed in a boat tethered to the pontoon.

The worker noticed the pontoon tilting and decided to swim to the bank. As the worker swam away, the pontoon sank dragging the boat under the water. The worker was not wearing a life vest.

The pontoon had an IBC filled with water on one side of the pontoon to act as ballast control. When the vacuum pump was removed, the water syphoned out of the IBC. The centre of gravity changed, tipping the pontoon and allowing it to take on water.

When a task changes, workers must stop and reassess the job steps and the risks involved in the task. If appropriate controls can't be put in place, the task must not proceed.

Any worker who is required to work on or access floating plant or involving boats must wear an appropriate life vest.

All floating vessels must be addressed in an emergency plan and workers should routinely practice evacuation drills for a rapidly listing or sinking event.

Floating vessels should have a stability and buoyancy assessment with consideration given to critical scenarios where a vessel could rapidly list or sink.

Dangerous incident IncNot0042819 Open cut coal mine	An operator was boarding a reject truck when a clump of reject fell from the headboard and hit the operator on the back of the neck. The operator suffered spinal bruising. 	Wet material hanging up on headboards is a hazard that poses a risk to operators entering and exiting vehicles. The method and rate of loading reject should be reviewed to minimise material spraying all over vehicles and infrastructure. Controls such as hosing down headboards should be implemented to control the risk to operators of falling material.

NSW Resources Regulator

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)
US Mine Safety and Health Administration (MSHA)	The MSHA has released a fatality alert for an incident on 21 July 2022. A miner suffered fatal injuries when his right arm became entangled in an auger (screw) conveyor. Best practices include securing all conveyors in place during normal operation, and to keep tools, clothing and body parts away from moving conveyors. The mine should de-energise, lock out, tag out and block machinery against hazardous motion before performing repairs and maintenance. Details
	National (other, non-fatal)
Safework SA	SafeWork SA reminds all mine operators to develop, implement and maintain safe systems of work following a serious injury to an underground miner on 3 August 2022. The incident occurred when a Jumbo operator was in the process of installing a dewatering pump using the Jumbo boom. While tramming forward, it is believed that the Jumbo ran over the dewatering pump line hose, causing the hose connection to fail on the pump. The hose connection consequently flung back under pressure and hit a worker standing near the rear of the Jumbo, causing serious facial injuries. Details
Resources Safety & Health Queensland	Resources Safety & Health Queensland have released the June 2022 Incident Periodical detailing recent high potential incidents for the Queensland Coal Mines Inspectorate. Incidents include a strangler valve failing to shut down a diesel engine system, a dozer making contact with a dragline at a surface mine, a gas exceedance at an underground mine and 3 dozer rollovers at surface mines. 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.

WEEKLY INCIDENT SUMMARY

Week ending Friday 19 August 2022

NSW Resources Regulator

© State of New South Wales through Regional NSW 2020 You may copy, distribute, display, download and otherwise freely deal with this publication for any purpose, provided that you attribute Regional NSW as the owner. However, you must obtain permission if you wish to charge others for access to the publication (other than at cost); include the publication in advertising or a product for sale; modify the publication; or republish the publication on a website. You may freely link to the publication on a departmental website.

Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (May 2020) and may not be accurate, current or complete. The State of New South Wales (including Regional NSW), the author and the publisher take no responsibility, and will accept no liability, for the accuracy, currency, reliability or correctness of any information included in the document (including material provided by third parties). Readers should make their own inquiries and rely on their own advice when making decisions related to material contained in this publication.

DOCUMENT CONTROL	
CM9 reference	DOC22/236890
Mine safety reference	ISR22/33
Date published	26 August 2022
Approved by	Deputy Chief Inspector Office of the Chief Inspector