

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 IncNot0039605 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 IncNot0039601 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.



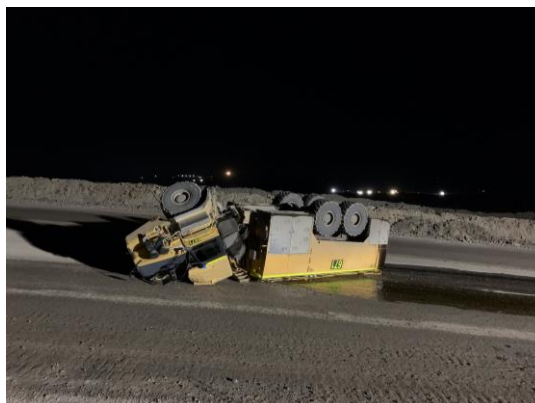
of the bit entering an unidentified blast hole remnant.

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
International (other, non-fatal)	
MinEx NZ	<p>Worker walks behind operating loader</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>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.

© State of New South Wales through Regional NSW 2021 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 (April 2021) 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	DOC21/281504
Mine safety reference	ISR21-14
Date published	16 April 2021
Approved by	Deputy Chief Inspector, Office of the Chief Inspector