

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 12 July 2019

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 significant incidents and our recommendations to operators.

ТҮРЕ	NUMBER
Reportable incident total	17
Summarised incident total	3

Summarised incidents

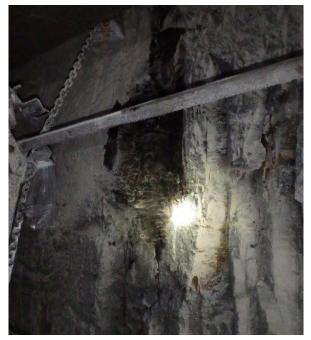
INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0035040	A worker in an underground coal mine was installing 1.8 metre roof bolts (as infill secondary support) using a hand-held bolter on the narrow walkside of a conveyor belt. In the process of relocating the bolter to the next bolt location, it hit the rib side, causing a block of material to dislodge, which hit the worker across the shoulders, back and right leg. The block was about 1.8 metres long and 600 millimetres wide, starting from near roof level (about 1.2 metres above the worker).	The risk of strata failure should always be considered, with appropriate controls identified and implemented before work is undertaken in such locations.
	The worker was knocked to the ground and winded. After co-workers checked him for	

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injuries, he was transported to the surface for treatment, where he was cleared of any significant injury.



Dangerous incident IncNot0035043

A boilermaker was plugging in a lead to a site shed intending to supply power to lights. As he turned the powerpoint with his right hand, he felt an electric shock in his left arm and across his chest. His left hand was touching an I-beam. A supervisor was called and the power was isolated. The worker was assessed by ambulance officers and taken to hospital. The worker was cleared to return to work.



Workers should check that all equipment is fit-for-purpose before using it.

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Dangerous incident IncNot0035054

A boilermaker was trying to remove a seized pin from a rear axle link in a dump haul truck. The pin was heated using a lance, then cooled using water. This process was repeated. As the worker applied water to cool the pin, an explosion occurred, ejecting the pin horizontally from the pin bore where it hit the left pelvis of the boilermaker and pushed him back onto a scaffolding frame. The pin weighed about 50 kilograms.

The scene was secured and the boilermaker was transferred to hospital. He suffered minor injuries.

Lancing and cooling is a regularly practice used to remove seized pins. However, the explosion that occurred was unprecedented and at the time of writing, not understood. The Regulator has commenced a causal investigation into the incident so that the circumstances can be better understood and lessons shared with industry.



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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)
MSHA	Surface – iron ore close call On 29 April 2019, a worker suffered minor injuries when his haul truck travelled over the edge of a stock pile dump point causing the truck to roll onto its top. The driver was wearing a seat belt. Details
MinEx NZ	Flyrock endangers workers While blasting in a limestone operation, a rock was projected beyond the blast exclusion zone of 100 metres striking the roof of a ute, which was parked 120 metres from the blast site. There was minor damage to the ute. Workers were standing in the vicinity of the ute about 20 metres away. Details
	National (fatal)
DNRME (QLD)	Fatal incident when excavator engulfed after pit wall failure: MSA no. 364 On 26 June 2019 at 12.20pm, a 55-year-old coal mine worker was fatally injured while he was operating an excavator at an open cut coal mine in Queensland's Bowen Basin. The coal mine worker was operating an excavator when an adjacent pit wall, about 40 metres high, suddenly failed. This resulted in fallen material engulfing the excavator and partially crushing the excavator's cabin. <u>Details</u>

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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	
CM9 reference	DOC19/610473
Mine safety reference	ISR19-27
Date published	19 July 2019
Approved by	Chief Inspector
	Office of the Chief Inspector