NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 28 June 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.

TYPE	NUMBER
Reportable incident total	16
Summarised incident total	1

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot 0034938	When carrying out repairs to a broken conveyor chain on a continuous miner, a flight bar became jammed in the foot sprocket. This occurred while pulling the chain on with a winch rope. This resulted in the flight bar snapping and being ejected. Part of the flight bar hit a worker on the left shoulder. The worker was positioned to observe the chain run around the foot sprocket, while standing on the bolting platform.	Mines must have procedures in place when any lifting/ pulling configuration is set up. The procedure must include where the low energy break point of the system is located. Safe standing zones must be established with consideration of all potential system failures.

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 (fatal)
Energy safety Canada	**Worker fatality during snubbing incident** A worker was running diagnostics on equipment, but the equipment was not locked out. The worker was struck and killed when the equipment fell from a suspended position. Snubbing units are used for fishing, milling, drilling, side tracking or any task needed to remove bridge plugs, cement or deepen wells while the well remains live. Details
	International (other non-fatal)
MSHA	**Surface – crushed marble: front-end loader incident** On 17 June 2019, a front-end loader backed over a highwall and the fall projected material from the loader bucket through its windshield. The operator was able to climb out of the cab and only suffered minor injuries. The operator was wearing a seat belt. Details

MinEX NZ	**Stockpile tip hazard** On inspection of a stockpile area, a supervisor observed a ramp and stockpile tip area that had inadequate side berms and no stop bund at the top of the stockpile tipping edge. On further inspection, it appeared from the tyre marks that edge tipping had occurred. A contractor used the loader the day before to clear the stockpile ramp to create more room for when they next needed to cart material to this area. In doing so, he pushed the berms over the tipping edge. He was called away to do other work and left the stockpile edge with no berm in place. 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.

DOCUMENT CONTROL	
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