

WEEKLY INCIDENT SUMMARY

Week ending Friday 5 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	40
Summarised incident total	3

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0035013	A forklift operator was unloading a truck, when one of the tines made contact with a crate. This pushed the crate forward, causing a domino effect that resulted in a hydraulic cylinder being pushed from the truck. A worker saw what was happening and tried to stop the cylinder from falling off the truck but failed. The worker was treated on site for bruising to his knuckles.	Procedures for unloading trucks should include safe standing zones for all workers in the vicinity of the activity. When developing safe standing zones, consideration of falling loads and well as vehicle and pedestrian interaction must be considered.
Dangerous incident IncNot0035016	A middle rod that supports the roof purloins fell 15-20 metres to a concrete floor below. No-one was injured. There were workers in the vicinity of the incident, on an adjoining floor between the roof and the concrete	Mine operators should review the adequacy of their structural integrity audits and ensure that remedial actions that have been identified as being required during such audits, are carried out in a timely manner.



	floor. The rod fell past the workers on the middle floor to the concrete floor below. The scene was preserved, and plant	
	stopped work. An investigation has begun.	
Dangerous incident IncNot0035023	A mechanical tradesperson was operating an isolation valve on a spray circuit on a longwall. Fluid released from underneath the isolation valve area and the tradesperson was sprayed with fluid on the knuckles of his right hand. The tradesperson did not sustain a high-pressure fluid injection injury.	One of the causal factors contributing to this incident was the presence of corrosion. The intervals between scheduled component replacement of high-pressure equipment should consider the anticipated duty cycle and the presence of any corrosive influences.

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	Mine fatality On 10 June 2019, a 22-year-old contractor with three years of experience, was fatally injured when he was pinned between a front-end loader and a concrete block. The contractor was working in a conduit trench, preparing to install a junction box. The plant manager was using a front-end loader to backfill the trench. The front-end loader travelled over the edge and toppled into the trench. Details

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MSHA Mine fatality

On 24 June 2019, a 34-year-old contractor with 10 years of experience, suffered fatal injuries when he fell beneath the wheels of a tractor-trailer. Miners were using a bulldozer to pull the tractor-trailer, which had become stuck in sand. As the tractor-trailer began to be pulled, the contractor was seen walking towards the side of the truck. The contractor died at the scene from crush injuries after being run over by the truck.

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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