NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 06 August 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.

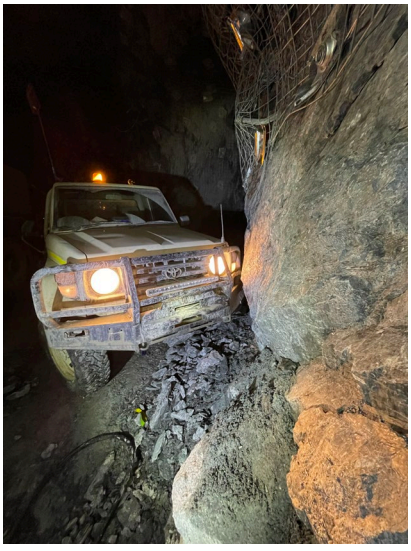
At a glance

High level summary of emerging trends and our recommendations to operators.

TYPE	NUMBER
Reportable incident total	43
Summarised incident total	3

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0040417 Open cut coal mine  Roads or other vehicle operating areas	A dump truck collided with a dozer at the tip head, when it rolled backwards at speed, as the dozer was reversing out of its path. The truck operator had made positive communication advising the dozer operator that he was entering the dump. The truck operator was positioning the truck to reverse to the tip head when the truck shutdown. The truck began rolling backwards and the operator was unable to stop the truck. Initial reports suggest a loss of brakes or mechanical failure with the truck. No one was injured.	The cause of this incident is still being investigated. Further information may be published later.

Dangerous incident IncNot0040438 Underground coal mine	A mechanical tradesperson was performing maintenance on a continuous miner. The worker attached a handheld grease gun to a grease line and after three to four pumps, the grease gun began to stall. The fitter attempted to remove the grease gun coupler from the nipple. When the coupler disconnected, a pressurised spray of grease was released from the nipple, striking the fitter's forearm and bicep. The fitter was treated, and later cleared, for a suspected fluid injection injury. Initial investigation found that the grease line had been capped off.	Mine operators must include the risks associated with grease systems when developing control measures for the unintended release of pressurised fluids. Refer to the following publications: SB13-01 Fluid injections result in surgery, MDG-41-Fluid-power-systems
Dangerous incident IncNot0040419 Underground metals mine  Roads or other vehicle operating areas	A light vehicle was parked behind a jumbo in a decline. After the worker left the vehicle, it rolled 13 metres before hitting a wall. The vehicle had not been parked to site standards. 	Vehicle operators must comply with correct park-up arrangements, particularly when parking on a grade. Mine operators should consider installing interlocks or warning systems for park brakes on light vehicles and other mobile equipment. Refer to Safety Bulletin: SB13-02 Unplanned movements of vehicles - too many near misses.

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)
MSHA	**Mine fatality**– On 28 July 2021, a mine worker was standing on a rock ledge to extract dimensional stone, when a triangular section of the rock broke off, causing the miner to fall approximately 35 feet. Details
MSHA	**Mine fatality** – On 26 July 2021, a contract employee, who was not wearing fall protection, was performing maintenance on a cement cooler when a wooden board broke, causing him to fall 23 feet onto a concrete floor. Details
	National (other, non-fatal)
Queensland Resources Safety and Health (Coal)	**Learnings from conducting level two emergency exercises in Queensland coal mines - safety bulletin #196** This safety bulletin summarises a review of the reports compiled by coal mines following the level two exercise in 2020. It highlights the requirements to conduct the annual exercise and the learnings for industry identified during the exercise. Details
Queensland Resources Safety and Health	**Video animation – Pressurised refuelling systems 1: Lessons learned** An instructional video created to assist workers understand common causes of refuelling incidents, and how they can be rectified. Details
Queensland Resources Safety and Health	**Video animation – Pressurised refuelling systems 2: Process overview** An instructional video created to assist workers understand common causes of refuelling incidents, and how they can be rectified. 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	
CM9 reference	DOC21/687318
Mine safety reference	ISR21-31
Date published	13 August 2021
Approved by	Deputy Chief Inspector Office of the Chief Inspector