NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 27 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.

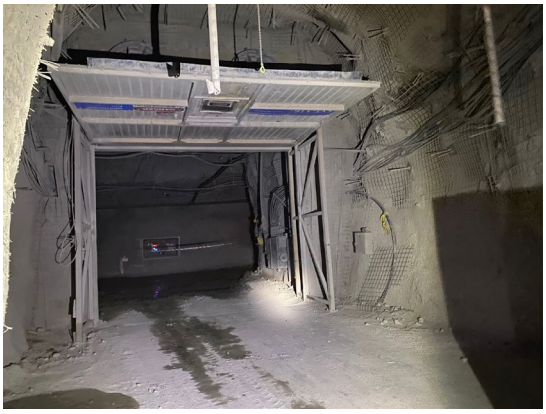
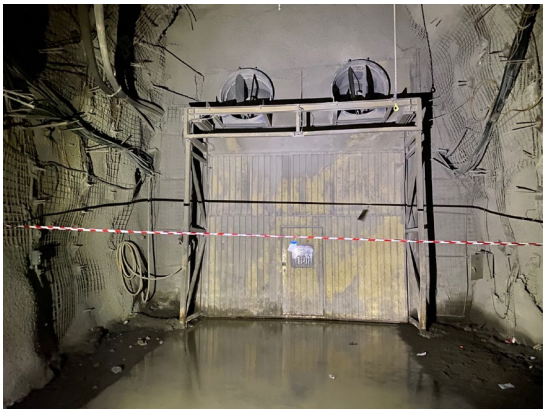
At a glance

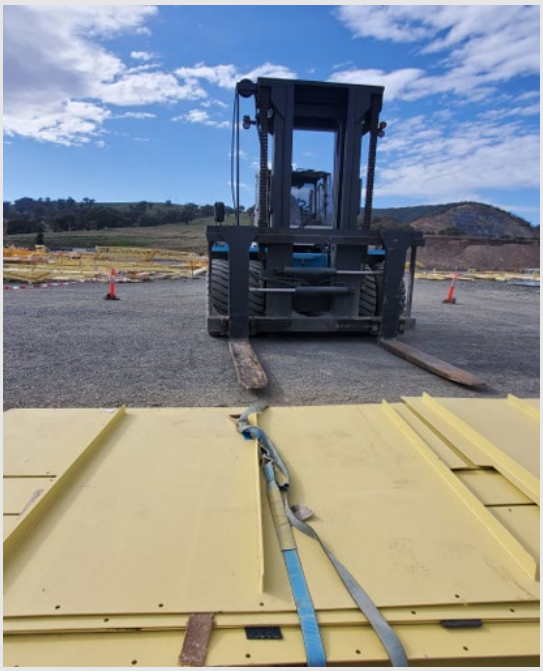
High level summary of emerging trends and our recommendations to operators.

TYPE	NUMBER
Reportable incident total	41
Summarised incident total	2

Summarised incidents

INCIDENT	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0040563 Underground coal mine	A mine worker was found caught by his arm in a fully opened underground ventilation door. The door is hydraulically operated and opens vertically. The ventilation door had been jamming in the frame earlier in the shift. The worker requested the ventilation door be opened, however, it failed to open. The worker then opened a personnel access door fitted to the ventilation door and the ventilation door unexpectedly opened. The personnel access door slammed, jamming two of the worker's fingers. The worker was lifted from the ground as the ventilation door opened and he was left suspended by the two	Engineering systems or controls should be installed such that when a piece of equipment fails to operate as intended it should fault to a safe state. The equipment should then require a reset or other signal before being capable of being energised. Mine operators should review the risk of entrapment associated with ventilation doors which are either hydraulic, automatic or operate in high ventilation pressures

	trapped fingers. A short time later, another worker drove a machine to a nearby fill point. The trapped worker yelled for help. The colleague lowered the door to free the trapped worker and initiated an emergency response.  	
Dangerous incident IncNot0040543 Surface fixed plant	A rigger sustained a broken right tibia and fibula after being struck by a forklift. Two riggers were directing the forklift into position when a misalignment was identified, requiring the forklift operator to reverse and reposition the forklift. During this time, the riggers identified the need to alter the rigging before the forklift lifted the load. The riggers began altering the rigging on the load. At the same time the forklift operator moved forward, striking one of the riggers on the back of the lower leg.	Mine operators and workers must ensure clear communication between forklift operators and spotters. Forklift operators must be aware of worker position before moving. No standing zones should be identified and implemented prior to a task commencing.



Resources Regulator publications

- SB21-05 - Safety Bulletin - Fire risk of battery units for underground battery electric vehicles

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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
	National (fatal)
Queensland Resources Safety and Health (Coal)	**Fatality During Excavator Bucket Wear Plate Removal - Technical Learnings** An article produced by the Queensland Coal Mines Inspectorate on the technical learnings following a fatality at a Queensland Coal Mine. Details
	National (other, non-fatal)
Qld Resources Safety and Health (Coal)	**Underground coal mines: Ventilation control device (VCD) hatch seals – Guideline** Following a death in 2020, of a mine worker, the coroner recommended that the Queensland Department of Resources Safety and Health establish a guideline of what may be considered in relation to preventing further ingress to the goaf during sealing up operations. Details
Qld Resources Safety and Health (Mineral Mines and Quarries)	**High potential incident periodical (MMQ) – June** 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	DOC21/763123
Mine safety reference	ISR21-34
Date published	3 September 2021
Approved by	Deputy Chief Inspector Office of the Chief Inspector