NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 15 October 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 IncNot0040901 Coal processing plant	 A team of fitters were replacing a hydraulic cylinder above a conveyor. A hired elevated work platform (EWP) was required to access the cylinder. The EWP basket was moved into position to allow	Mechanical engineering control plans must set out the control measures for the unintended operation of plant. This must include function testing as part of the introduction of plant to site process and pre-use inspections by operators. Refer to: SB15-04 Collisions of mobile elevated work platforms increase

removal of the old cylinder. After releasing the joystick (while the operator's foot was still on the deadman switch), the basket moved up approximately 200 millimetres. The safety bar contacted the cylinder support structure, which activated and stopped the EWP. The fitters were standing beside the cylinder support structure. No personnel were injured during this incident.

The investigation found the boom control joystick locking collar was not functioning correctly. The locking collar requires the operator to lift the collar before selecting a function to prevent accidental activation. The grub screw that secures the top of the joystick was missing, allowing the mechanism to partly unscrew. As a result, the function could be activated without lifting the locking collar, resulting in an unplanned movement.

Dangerous incident
IncNot0040868
Underground coal mine

A high voltage cable supplying a conveyor starter in an underground coal mine was found to have impact damage. The PVC outer sheath was damaged and the armouring distorted, exposing the internal lead sheath. It was discovered hanging from the roof about one metre from the rib. A duckbill carrying an air track was sitting underneath the cable.

When developing control measures to manage the risks associated with roads or other vehicle operating areas, the placement of services that may be exposed to risk of damage such as cables and pipelines must be considered. Factors for consideration include:

- roadway height and width
- height and width of loads that are required to be transported in the roadways, including the effect of bumps and dips with overhanging loads
- positioning of cables and other services suspended from the roof
- effect of roadworks that may alter the effective roadway dimensions over time.

Dangerous incident IncNot0040899 Underground coal mine	An operator was installing rib support using the continuous miner. The worker was on the same side as the ventilation tubes. Whilst inserting a rib bolt, the operator's cap-lamp and helmet were sucked into the ventilation duct. Earlier in the day the auxiliary fan speed was increased from 12.5 m^3/sec to 19.5 m^3/sec to assist dust management due to the continuous miner cutting stone.	Mine operators should ensure that appropriate control measures are in place to protect operators working near open-ended ventilation tubes. Guarding should be installed on the most inbye tube to prevent objects being sucked into the tube. Operators should use cap-lamp pouches with retaining straps. Mine operators should review their auxiliary fan operational risk assessments (for each type of auxiliary fan in use at each site) to identify and control the risks to health and safety for people working in close proximity to ventilation ducts. Refer to: SA20-05 Worker sucked into auxiliary fan ventilation tube

Other Resources Regulator publications

- Safety Bulletin - SB21-08 - Incident investigations
- Safety Bulletin - SB21-07 - Polyurethane resin selection

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)
Health and Safety Executive (UK)	**Lubrication of circuit breakers – Safety bulletin (STSU2 – 2021)** The incorrect use and application of lubrication on HV and LV circuit breakers resulting in mal-operation and increased risk of catastrophic failure and downstream fire. **Details**
	National (other, non-fatal)
Resources Safety and Health Queensland (Mineral Mines and Quarries Inspectorate)	**Safe use of quick hitches on excavators – Safety alert #398** A worker was seriously injured while performing maintenance work on the bucket of a 30-tonne excavator. The bucket suddenly detached from its quick hitch, swinging about 1.5 metres before it fell to the ground. The worker was knocked over by the bucket, hitting their head on the concrete floor and sustaining a crush injury to their leg. **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	DOC21/914558
Mine safety reference	ISR21-41
Date published	22 October 2021
Approved by	Deputy Chief Inspector Office of the Chief Inspector