NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 18 February 2022

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	39
Summarised incident total	4

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0041643 Quarrying Roads and other vehicle operating areas 	A worker parked on the offside of a wheel loader and had a brief conversation with the loader operator. The worker then walked towards a mill. The loader operator then reversed the loader, hitting the driver's side door of the worker's ute. The worker was not near the vehicle when the collision occurred.	Past incidents similar to this have resulted in fatalities. Effective separation of light vehicle parking areas and pedestrians from mobile equipment operations should be a fundamental consideration when risk assessing operations and implementing controls. Workers must be adequately trained in the controls identified and compliance audited.

Dangerous incident
IncNot0041631
Underground coal
Roads or other vehicle operating areas

A 25 tonne Franna crane was tasked to move a 7 tonne belt reeler. When the load was lifted, the crane rolled onto its side. The crane was in an articulated position at the time of the incident. The operator was able to exit the crane uninjured.

When planning for safe lifting activities, factors that must be considered include the:

- cross grade
- travel path
- crane configuration including articulation of Franna cranes
- ground conditions
- load movement
- weather conditions
- interaction with other plant and mobile equipment.

Dangerous incident
IncNot0041605
Open cut coal

A dozer was working on a stockpile during train loading operations when the active valve ceased feeding. Train loading was then completed on an alternate valve.
The dozer operator then attempted to clear the original valve when a void opened underneath the dozer. The dozer did not fall into the void because the blade and ripper were still on solid coal. The dozer driver got out safely.

The hazard of concealed voids exists on stockpiles and must be included in risk assessments, training and procedures for operators.
Operators must be trained to identify when the risk of concealed voids is present and the procedure required to control the hazard.

Dangerous incident IncNot0041628 Underground coal	While driving out of a mine following a load haul dump (LHD), a personnel transport driver lost control and hit the rib on the driver's side. The windscreen and pillar were damaged. There were no injuries. 	Drivers must maintain focus on the task at hand. If a driver's visibility is affected, the driver should slow down, find a safe place to stop and address the issue rather than continuing to drive with obstructed vision.

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	**Fatality alert** On 7 January, 2022, a 49-year-old front end loader operator with 15 years of mining experience died when a large rock fell from the mine roof, crushing the cab of the front-end loader. When the accident occurred, the operator was loading material from a recently blasted shot. Best practices include to scale the back and ribs before performing work in the area and to conduct examinations of the back, face and ribs where miners work and travel. Details
MSHA	**Fatality alert** On 13 December, 2021, a miner was fatally injured when he became entangled in the drill steel of the roof bolting machine he was operating. This was the 36th fatality reported in 2021, and the seventh classified as 'machinery'. Best practices include turning off engine before performing maintenance and repair work on roof bolting machines or other equipment, and to securely block equipment against hazardous motion by following manufacturer's recommendations. Details
	International (other, non-fatal)
NZ MinEx	**Uncontrolled movement of dozer** A mechanic was returning a dozer to a workshop along a sloping haul road. While shifting from reverse to first gear, the first gear would not engage, and the dozer started rolling backwards. As the dozer gathered backward momentum, the mechanic jumped from the cabin to the ground approximately 10 metres from the top of the slope. The dozer continued to travel approximately another 140 metres before stopping on the roadway below. The mechanic sustained no injuries while exiting the cabin and the dozer had minor damage to a window. Details

	National (other, non-fatal)
Resources Health and Safety Queensland	**Safe use of portable generators** Incorrect use of portable generators caused by unsafe installation and operating practices have caused several high potential incidents in Queensland mines and quarries recently. These have included exploding batteries, fires, and electric shocks. High starting currents in batteries have caused explosions. Electrical faults and leaking fuel or engine oil contacting hot exhaust components have caused fires. Damaged and burnt extension leads and fittings have caused electric shocks. Additional safety measures are required to reduce the risk of simultaneous earth faults on isolated winding generators in heavy industrial and mining environments. Damage to electrical equipment and tools is likely to occur in these work environments. Details
NT WorkSafe	**Power tool battery fires** Lithium-ion batteries are sensitive to temperature and flammable. They are a serious safety risk to health and safety if used, transported, or stored incorrectly. Businesses using lithium-ion powered devices are urged to make sure their workers are provided with information, training, and instruction to minimise the risk of flash burns, explosion, and exposure to hazardous chemicals. Businesses and workers who use any equipment fitted with lithium-ion batteries should consider control measures to prevent a similar incident from occurring. 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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