NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 21 January 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.

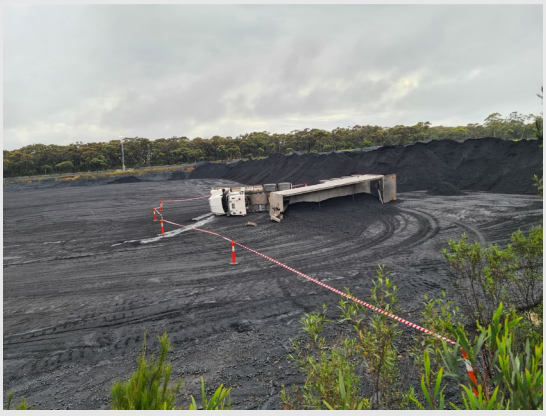
TYPE	NUMBER
Reportable incident total	44
Summarised incident total	3

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0041461 Open cut coal Roads or other vehicle operating areas 	A dozer working around an excavator went over a bank and slowly rolled onto its right-hand side. The driver was able to escape and was not injured. 	Mine operators should consider recommendations in safety bulletins SB19-01 and SB19-10. Refer to Safety Bulletins SB19-01 Rise in dozer incident putting operators at risk and SB19-10 Dozer incidents increase despite warnings

Dangerous incident
IncNot0041424
Open cut coal
Roads or other vehicle operating areas

The operator of single-trailer road truck was trying to dump a load at a stockpile while being spotted by the loader operator (in the cabin of the loader). The truck operator noticed that the truck had become unstable at the first stage of the lift so repositioned and reattempted dumping the load. On the second attempt, the trailer and cabin of the road truck overturned. The truck operator was helped out of the cabin by first responders and an ambulance was called to the site. The truck operator was cleared of significant injury.



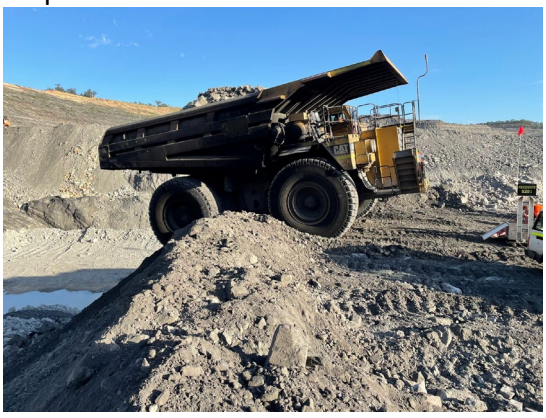
Mine operators should identify all work activities on the mine site where trucks are used and review control measures for truck rollovers. This review should consider:

- risk controls to prevent a truck roll
- risk controls to mitigate the risk of injury following a truck rollover.

Refer to Safety Bulletin SB17-01 Industry reports more truck rollover incidents

Dangerous incident
IncNot0041431
Open cut coal
Roads or other vehicle operating areas

A haul truck was trying to dump material on a working dump face when it went through a windrow and came to rest with the rear wheels through the windrow. The dump dozer saw the incident as it occurred and attempted to stop the truck over the radio.



When designing a dump, ground stability should be a primary consideration. Material consistency, wet conditions and dipping ground stability should also be considered. Inspections should verify the dump integrity. Areas that do not meet the standard should be demarcated, communicated and remediated to meet the standard.

Refer to Safety Bulletin SB18-11 Windrow management and demarcation

Resources Regulator publications

- Safety Bulletin SB22-01
- Safety Bulletin SB22-02 Strata failure

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 4 December 2021, a miner was performing maintenance duties on a continuous mining machine (CMM). When the raised CMM tail boom was lowered it resulted in fatal crushing injuries to the miner. Details
MSHA	**Mine fatality** - On 6 December 2021, a miner was fatally injured while he was working in a pan feeder under a chute. While attempting to remove angle iron that blocked the chute's gate from closing, he was engulfed in material that fell from a surge pile above the chute. The worker died from his injuries on 10 December 2021. Details
	International (other, non-fatal)
MinEX NZ	**Fall from height while working on a power screen** Over the past year, there have been several fall from heights incidents at quarries. This safety alert highlights the serious health and safety risks involved when working at height and the need to carry out risks assessments before undertaking routine work carried out at a height. Details
	National (other, non-fatal)

Safe Work Australia	**Risks of solar ultraviolet radiation (UVR) exposure at work – Fact sheet** This fact sheet contains information on identifying when UVR exposure may be a hazard, and ways to assess and manage the risks associated with exposure. Details
Resources Safety and Health Queensland	**Pick and carry cranes – Safety Bulletin #199** Pick and carry cranes (commonly referred to as Franna cranes) are widely used in coal mines, however, they have been involved in several concerning incidents involving rollovers, loads falling, mechanical failures as well as uncontrolled movements and collisions. The Crane Industry Council of Australia estimates articulated pick and carry cranes currently account for somewhere between 64% - 68% of all crane incidents. In the year to date more than 10 high potential incidents including five rollovers involving pick and carry cranes have been reported to the Coal Mines Inspectorate. Details
Resources Safety and Health Queensland (Coal)	**October 2021 Incident periodical** – Learnings and recommendations from recent high potential incidents. Details
Resources Safety and Health Queensland (Coal)	**Unplanned movement of conveyor belt – Safety Alert #404** A crew was undertaking a belt retraction in an underground coal mine. The belt slipped through the belt clamp, and once released it travelled approximately 300 metres before folding up within the confines of the belt structure. This high potential incident could have resulted in serious injury to coal mine workers. Fortunately, there were no workers in travel path of the belt. There were no injuries resulting from the incident but significant learnings for industry. Details
Resources Safety and Health Queensland (Mineral Mines and Quarries)	**Safety and Health Periodical (December 2021)** Learnings and statistics for the mineral mines and quarries sector. 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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