NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 4 March 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.

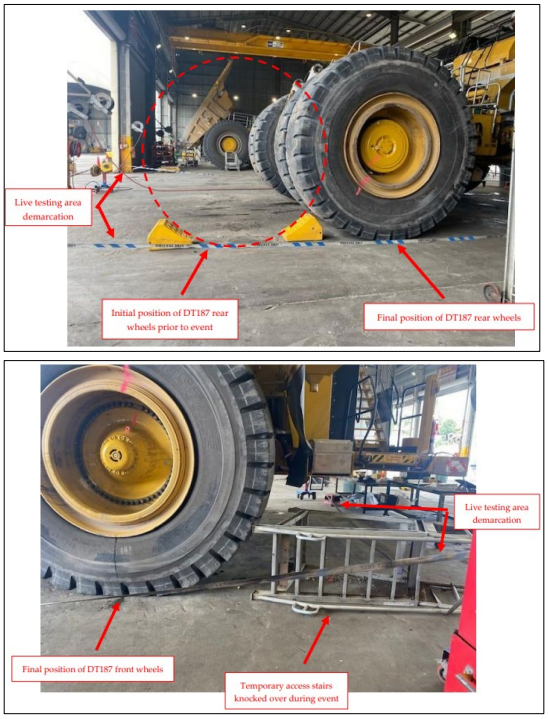
At a glance

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

TYPE	NUMBER
Reportable incident total	47
Summarised incident total	4

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0041698 Surface coal	A Caterpillar 789C was being commissioned after a rebuild. Four workers were investigating a transmission fault when the transmission engaged unintentionally propelling the truck forward about 1.5 metres. The truck stopped when one of the workers applied the service brake. Live testing protocols were in place and all workers on the task were onboard the truck.	This incident demonstrates the need for a safe system of work to be in place when conducting function testing. This system should limit workers to a bare minimum required for the testing. Additionally, no-go zones and barriers must be in place and enforced to prevent other workers from entering the work area.



Dangerous incident IncNot0041718 Underground coal	A worker suffered an electric shock while operating a continuous miner. At the time of the incident, the worker was standing on the left-hand side of the miner with one hand resting on the bolting cassette and other hand touching installed rib mesh. The worker felt the shock when the miner driver started the cutter head. The power supply tripped at the control board outlet for the continuous miner.	This incident is under investigation and further information may be published later.
Dangerous incident IncNot0041734 Construction materials	A worker suffered an electric shock while leaning on a conveyor structure and using a stick welder with voltage reduction device (VRD) protection. The worker's clothing was damp because of humid conditions.	People involved with welding activities should remain insulated from the welding job. Welding gloves are not electrical insulators. Damp gloves and clothing can increase the likelihood of suffering an electric shock. Refer to: Safety Bulletin SB19-03 Welding-related electric shocks increase

		NSW Resources Regulator Information Sheet No 2: Basic welding practices
Dangerous incident IncNot0041738 Underground coal	A worker was cleaning under an operating conveyor belt. As he repositioned himself, he placed his hand on the belt stringer and in doing so, his glove made contact with the belt roller. This caused the worker's hand to be pulled between the roller and the bracket. The worker suffered a laceration requiring medical treatment. The worker was inexperienced and had recently started in the industry.	When working near operating conveyors, workers must remain clear of the conveyor belt, idlers and other entanglement points. Inexperienced workers must be supervised and trained for the tasks allocated. Training related to the hazard associated with common mining equipment such as conveyors must be provided to new workers.

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 11 January 2022, a 32-year-old miner died while driving on a mine road when a tree fell from a highwall onto the cab of his pick-up truck. This was the third fatality reported in 2022 and the first classified as 'falling, rolling or sliding rock or material of any kind'. Best practices include examining highwalls frequently and from as many perspectives as possible, and to train all workers to recognise hazardous highwall conditions. Details
MSHA	**Mine fatality** On 7 January 2022, a 35-year-old continuous mining machine operator was fatally injured when he was pinned between the remote-controlled miner and the coal rib. This was the second fatality reported in 2022, and the first classified as 'machinery'. Best practices include operating equipment from a safe location, maintaining proximity detection systems in the approved operating condition and developing and implementing procedures for tramming, repositioning, cable handling and moving remote controlled miners safely. Details
MSHA	**Mine fatality** On 3 December 2021, a miner was fatally injured when he became entangled in the return idler on the belt conveyor under a portable crusher plant. This was the 33rd fatality reported in 2021, and the 16th classified as 'powered haulage'. Best practices included removing power from the belt drive before performing maintenance and guarding moving machine parts to protect workers from making contact with moving parts. Details
MSHA	**Mine fatality** On 14 January 2022, a 44-year-old contract labourer with 13 years of total experience suffered fatal injuries when he fell to a concrete surface. At the time of the accident, the contractor was on a belt conveyor in a preparation plant and

	was working to replace a belt conveyor roller. This is the fourth fatality reported in 2022, and the first classified as 'slip or fall of person'. Best practice includes establishing and following safety policies and procedures when working at heights. Details
NZ MinEX	**Fatal injury during hydraulic hose repair** The main hydraulic pressure hose failed on a wheeled loader, requiring replacement. Residual hydraulic pressure was released from the loader's lifting system to allow access to the main hose valve. The boom was then raised with assistance of a second machine allowing the grapple to flop to a natural position. It was then lowered and supported by the loader's grapple tine tips. The mechanic was working under the boom when it slumped unexpectedly, fatally pinning the mechanic. Details
	National (other, non-fatal)
WA Department of Mines, Industry, Regulation and Safety	**Companies fined after workers exposed to asbestos** A multinational resources company and a mining services company will both pay after multiple employees came in contact with a carcinogen. Alcoa and Monadelphous Engineering Associates pleaded guilty to failing to provide a safe work environment after two contractors became exposed to asbestos at the Pinjarra Refinery in Oakley, south of Perth. Mandurah Magistrates Court heard the pair were improperly trained in asbestos awareness before entering the work site, where they installed a 33 kilovolt power cable in 2018. The judge ruled Alcoa should pay $30,000 plus $5000 in litigation expenses, and Monadelphous $25,000 plus $6000 in costs, to the Western Australian Department of Mines, Industry Regulation and Safety. Details
Resources Safety and Health Queensland	**Managing the risks of storm season 2022** A mine site's emergency management plan (EMP) for storm events should include adequate resources, facilities and procedures that are available before, during, and after a storm. Ideally, storm-related management should be included in the safety and health management system, safety management system or safety and security management system (system relevant to your site). The EMP must be based on a risk assessment. There are check lists at the end of this bulletin that include items to consider when preparing for or recovering from storms. Details

Resources Safety and Health Queensland	**Incident periodical** Significant safety incidents have occurred recently at coal mines in Queensland. This information should be used to improve safety awareness and outcomes. This report includes an uncontrolled movement at a surface mine, worker being partially engulfed at a coal handling preparation plant, mechanical failure at a surface mine, heat stress at a surface mine, equipment rollover at surface mine, lifting and slinging incident and a microsleep incident at a surface mine. 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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