WEEKLY INCIDENT SUMMARY

Week ending Friday 8 April 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	33
Summarised incident total	3

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0041965 Open cut coal mine	A conveyor belt moved approximately 300 mm when a splice clamp was released. The movement caused the conveyor lifters to topple over, near where a roller change was being carried out. The belt was isolated at the time of the incident and the counterweight was on the deck. There were no injuries.	Safe systems of work for people dealing with plant or structures must include the isolation, dissipation of energy and control of all mechanical energy sources from plant or structures.

Dangerous incident IncNot0041952 Open cut coal mine	A mechanical technician removed a plug from the right-hand rear strut of a dump truck believing it was a grease port. The plug was tapped into the chamber of the strut and the technician was using a hand ratchet and socket. The plug was forced out under pressure (approximately 170-200 psi). The technician was just outside the direct line of fire of the plug and was covered in fluid from the strut. The plug was found on the ground a couple of metres away from the technician.	Workers who are unfamiliar with a task(s) must be provided with adequate information, instructions, and supervision. Pre-task hazard assessments should include the assessment of pressurized systems and identification of controls.

Dangerous incident IncNot0041947 Open cut coal mine	A rear-dump truck entered an overburden dump, stopped and prepared to reverse. A nearby dozer established radio contact and advised the truck operator that it needed to sweep the area behind the truck and proceeded to do so. As the dozer went to	This incident and other similar incidents have been caused by a lack of positive communication between operators. Dig and dump areas must operate under robust procedures and

Roads or other vehicle operating areas

take a second sweep, the operator of the truck, thinking the dozer had already completed the clean-up, started to reverse. The dozer operator saw the truck reversing and blew the dozer's horn. The truck heard the horn and braked, however the truck tray still made contact with the dozer ROPS, causing some denting. No one was injured.

controls. Operators must be trained when to establish positive communication as part of digging and dumping operations.

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)
US Mine Safety and Health Administration (MSHA)	On 2 March 2022, a miner was fatally injured when an overhang along the mine rib fell, striking the miner and pushing him against the canopy of a twin boom roof bolting machine. The miner freed himself from the fall, but later died. This is the ninth fatality reported in 2022, and the first classified as "Fall of Face, Rib, Side, or Highwall". Details

US Mine Safety and Health Administration (MSHA)	On 28 February 2022 a contract miner died when he was crushed between the rib and a single boom face drill. The victim was alongside the drill using the onboard tram lever controls. The accident occurred because the remote control was inoperable. This is the eighth fatality reported in 2022, and the third classified as "Machinery". Details
US Mine Safety and Health Administration (MSHA)	On 13 December 2021, a customer truck driver (victim) stopped at a designated tarping area and was assisting another driver with a rear trailer indicator light. The victim's truck moved forward and pinned him against the back of the other driver's truck. This was the 37th fatality reported in 2021, and the 17th classified as "Powered Haulage". 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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