NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 27 May 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.

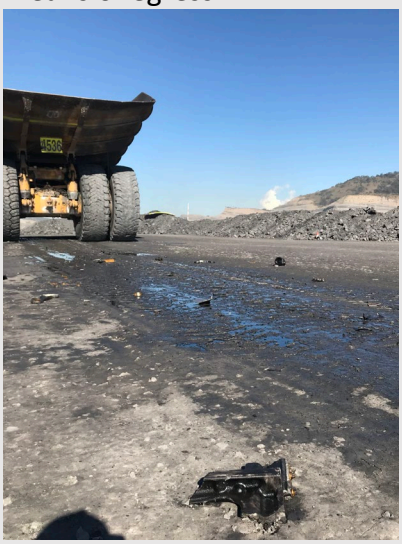
TYPE	NUMBER
Reportable incident total	34
Summarised incident total	3

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0042247 Open cut coal Roads or other vehicle operating areas 	A dozer reversed into a haul truck when it was cleaning up on a loading bench. There were no injuries reported, however the truck received minor damage. 	Where administrative controls such as Positive Communication can not be reliably implemented, mines must consider alternative controls such as segregation.

Dangerous incident
IncNot0042256
Open cut coal mine
Fire or explosion

A haul truck had dumped a second load for a shift and was leaving the dump. The operator smelled something burning then saw flames around the back of the cabin. The operator shut down the truck and unsuccessfully attempted to deploy the fire suppression system. The operator then escaped safely.
The fire was extinguished with the aid of a water cart and on-board fire suppression.
Upon inspection, it was discovered that a significant mechanical failure resulted in a large hole in the bottom of the engine which initiated the fire. The truck was recently down for maintenance.
A further examination of the truck found that the emergency ladder access gate was extremely stiff and not easily opened. The operator did not use this means of egress.



Following the maintenance and repair of mobile plant, the plant should be inspected, tested and verified as fit-for-purpose before being returned to service.
Mine operators should also confirm that emergency access systems are included in routine maintenance inspections on all plant.
Fire suppression activation buttons should be easy to activate in an emergency situation. Devices such as R clips or tamper ties must be easily removed.

Dangerous incident
IncNot0042235
Open cut coal

As a haul truck was leaving a dump and travelling down a ramp, the operator applied the retarder, but it had no effect. The operator then tried the service brake, which also had no effect. The operator noticed there was no air pressure indicated. The operator then used the emergency brakes, which slowed the truck and safely negotiated a bend. The air pressure returned, and the

Under no circumstances should a truck continue to be operated following the failure of a safety critical system such as braking.
Vehicles should be safely parked-up following an incident and not operated until the cause is identified and problem rectified.
Mine operators should ensure that vehicle operators are trained

brakes subsequently worked. The operator then continued to a digger but noticed the brakes were inoperable again, so proceeded to park up and report the incident.
An investigation found an air conditioner compressor belt drive guard was rubbing on the discharge fitting of the compressor. The fitting failed, resulting in loss of system air pressure and loss of the service brakes.

and competent to respond appropriately to safety critical system failures.

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)
NZ MinEx	A dozer was stripping topsoil and ceased operations so that the radiators and intercooler could be cleared out from accumulated dust. The operator was dismounting from the machine and opened the engine bay door. As the door was opened, he fell backwards and caught his leg on a foot plate before landing on his back on the ground. He sustained a serious laceration to the left calf muscle requiring admission to hospital and corrective surgery. Injuries were also sustained to a shoulder and ribs. MinEx data on incidents with the potential to cause harm over the four years to December 2021 shows 16% (728) of all incidents involve falls, with 307 incidents resulting from fall of a person. Details
	National (other, non-fatal)
WorkSafe Victoria	Recently, in separate incidents, two people fell from ladders and were seriously injured when the ladders they were on failed without warning. Both of the ladders had plastic/polymer structural components that appeared to have UV (sun) damage/deterioration. Portable ladders are one of the least stable but most often used tools when working at heights. A ladder failure can result in a fall. Serious and fatal falls continue to happen where risk control measures are not in place or do not adequately control the risk of falls. While ladders are often the first choice when working at heights, they should only be used if safer options have been assessed first and are not reasonably practicable for the task. Safer

	options include long-handled tools, scaffolding or elevated work platforms (EWPs). Details
Resources Safety & Health Queensland	Several mines and quarries have recently reported incidents associated with slope instability and failures in ground integrity to the MMQ inspectorate. Groundwater has a detrimental effect on slope stability. An industry-wide awareness of the likelihood of slope instability due to current groundwater conditions is critical. Saturated conditions leading to standing water within the pit can result in unsafe working conditions. Given the current conditions, pit inspections should be conducted with diligence on a more frequent than usual basis. 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	DOC22/91042
Mine safety reference	ISR22-21
Date published	3 June 2022
Approved by	Deputy Chief Inspector Office of the Chief Inspector