NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 16 September 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	4

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0042991 Underground metals mine Roads or other vehicle operating areas 	A concrete agitator was travelling down a decline when a fire started behind the position 1 tyre. An emergency was called for all underground workers to retreat to refuge chambers. Emergency response attended the scene and extinguished the fire. After removing the postion 1 tyre, it was found that the position 1 brake pack oil cooling line was capped off. This resulted in excessive heat generating from the brake pack. It was suspected that the brake oil cooling line was capped off during an off-site service and was reconnected before returning to site.	Following the maintenance and repair of mobile plant, plant should be inspected, tested and verified as fit-for-purpose before being returned to service. Safety critical systems such as braking should be inspected, maintained and tested in accordance with the manufacturer's recommendations.

Dangerous incident IncNot0042993 Open cut coal mine Roads or other vehicle operating areas 	As a truck was tipping a load at a tip head, the material beneath the rear of the truck began to fail. The operator exited the truck and the ground continued to slump until the truck was at a 45-degree angle front to rear. The tip head was about 12 m high. 	When designing a dump, ground stability should be a primary consideration. Material consistency, wet conditions and water management should be factored into the design. Inspections should verify dump integrity. Areas identified that do not meet the design standard should be demarcated, communicated to the workforce and remediated to meet the standard.
Dangerous incident IncNot0042995 Underground coal mine	A worker suffered an electric shock while adjusting a conveyor pre-start alarm level. The worker touched a gland and structure and received a tingle across his hand. The mine implemented its electric shock response plan. The worker was assessed by ambulance officers.	Mine operators should seek every opportunity to apply the hierarchy of controls when managing electrical equipment in harsh environments. Using extra low voltage electrical equipment and field devices considerably reduces the risks associated with electric shock.
Dangerous incident IncNot0043023 Open cut coal mine	A loaded dump truck was delivering waste rock to a dump. While turning to reverse to the dump face, the truck drove into an unprotected slot that was dug by a dozer. The slot was about 15 m	Hazards created by earthworks should be suitably bunded to protect mobile plant from accessing unsafe areas.

Roads or other vehicle operating areas

long, 10 m wide and 3 m deep. The slot had no edge protection established on either side.

Supervisors should communicate changes to operating areas and ground surface to all machinery operators entering the area. Mine operators should review the adequacy of their communication arrangements on shift.

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
	National (other, non-fatal)
Resources Health & Safety Queensland	A fuel truck driver received serious injuries which required hospitalisation after being crushed between the rear of a front-end wheel loader and the rear of a stationary fuel truck. The incident is under investigation however the preliminary findings are that the driver parked the fuel truck close to the crushing plant and was fuelling plant in that area, part of the fuelling task required the worker to be at the rear of the fuel truck and while at the rear of the fuel truck, the worker was crushed between the rear of the front-end loader and the rear of the fuel truck.

	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.

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