Weekly incident summary

Week ending 21 July 2023

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	38
Summarised incident total	5

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0045070 Open cut coal Roads or other vehicle operating areas 	A dozer was pushing off the dump and directing trucks on where to unload. A breakdown in communication occurred, resulting in a truck reversing in behind the dozer as it was reversing across the dump. The ripper box on the dozer hit the tyre on the truck. 	Vehicle collisions continue to be a source of concern. The Resources Regulator recently carried out a targeted awareness campaign focused on the risk of collisions involving heavy mining equipment. A Campaign video is available. Plant operators are reminded that they must establish positive communications before entering the work area of other mobile plant. Workers must check the area behind their machine before reversing. Workers should use all aids such as mirrors, cameras and awareness systems that are fitted.
Dangerous incident IncNot0045072 Open cut coal Roads or other vehicle operating areas	A dump truck was approaching the reject bin to be loaded. As it passed under the bin, the tip of the tray above the operator cabin contacted the left side exit support leg, deforming the tray. This has occurred previously at this mine.	Haul trucks contacting the support legs of reject bins is a recognised hazard. The hierarchy of controls must be followed when determining controls. When a notifiable incident occurs, Work Health and Safety (Mines

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		and Petroleum Sites) Regulation 2022 section 15 requires that mine operators review and revise control measures. Structures must be protected from impact with mobile plant. The extension of headboards and trays, and the accumulation of material under the bin, should be considered during the design of barriers and guides.
Dangerous incident IncNot0045077 Open cut coal Roads or other vehicle operating areas 	A dump truck collided with a dozer while reversing to the tip head. The dozer was performing clean up along the face. The dozer operator was unaware of the truck on the dump. 	When reviewing control measures, Work Health and Safety Regulation 2017 clause 36 requires the hierarchy of controls must be followed. For dumps, controls such as segregation and engineered systems must be considered before resorting to administrative controls. Mine operators should routinely review available proximity detection and collision avoidance systems to determine if they are suitable for their operation.
Dangerous incident IncNot0045083 Open cut coal Roads or other vehicle operating areas 	A service truck was travelling along a haul road. After rounding a bend, the truck slid on a wet section of haul road onto a dry section which resulted in the truck rolling onto the driver's side. The operator was able to exit the truck and was uninjured. 	When developing control measures to deal with the risks associated with service trucks, plant characteristics, including stopping distances, manoeuvrability, operating speeds and fluid movement must be considered. Operators of trucks need to remain situationally aware and drive to the conditions and manage their speed when negotiating turns.
Dangerous incident IncNot0045084 Open cut coal	A haul truck was at the dump and had started to lift the tray. A nearby dozer operator noticed flames and called the truck operator instructing him to lower the tray. The dozer operator called emergency over the radio and told the truck	Workers must be regularly trained in how to respond in an emergency such as a fire on plant. Training should reflect the systems and lay out that workers

Incident type	Summary	Comments to industry
Fire or explosion 	operator to hit the fire suppression and exit the truck. The truck operator noticed flames outside the drivers' side door. The operator pulled the plastic tie on the fire suppression and attempted to activate it but was unsuccessful. The operator exited the cab through the passenger door, descended the primary egress, and waited with the dozer operator. The haul truck was engulfed in flames following the failure of the fire suppression system to operate. The operator was uninjured. 	will be operating in, including activation of e-stop and fire suppression systems. The cause of the fire is being investigated. Further information may be published later.

Other Resources Regulator publications

Have Your Say – Discussion paper - Vehicle interaction controls in NSW mines

The NSW Resources Regulator has released its Discussion paper -Vehicle interaction controls in NSW mines and invites public consultation on the proposed recommendations. The discussion paper is seeking feedback on the potential pathways the Regulator can take to address adverse vehicle interactions in the NSW mining industry.

Industry stakeholders are invited to provide their valuable insights and feedback on the discussion paper. Public consultation is an essential part of the process, as it allows for diverse perspectives to be considered when shaping policies and regulations. The consultation period will be open from Thursday 27 July until 5pm, Friday 8 September 2023.

To provide your feedback visit resourcesregulator.nsw.gov.au.

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)

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Publication	Issue/topic
Resources Safety & Health Queensland	While driving an underground grader, the operator stopped the grader to let traffic past. The operator applied the park brake, but the grader moved approximately two meters before coming to a halt. The grader service brake remained operational throughout the incident. Both service and park brakes had been replaced as part of normal maintenance two weeks prior to the incident. The grader passed the weekly scheduled brake test a day prior to the incident. On the day of the incident, the operator reported having used the park break a couple of times without any problems before he pulled over to let traffic past. Details
Resources Safety & Health Queensland	A Coal Mine Worker (CMW) was checking the emulsion tank. The CMW was making their way back down the ladder (Fixed plant access system) with three points of contact when the second step from the top failed on one side. No CMWs sustained any injuries. The investigation identified multiple fatigue fractures to all the weld joints for the step rung to the ladder side rails. Details
Resources Safety & Health Queensland	The bucket of an excavator working a double bench operation collided with the dovetail of a rear dump truck when swinging towards the truck tray. The excavator was on the lower 3.5m high bench at the time of the incident. The impact caused a significant amount of movement to the truck and injury to the operator. The injured operator received a fracture to the C5 vertebrae, resulting in hospitalisation for a number of days. Details
Resources Safety & Health Queensland	Recent high potential incidents and serious accidents reported to the mines inspectorate have raised concerns about lifting and rigging activities, especially where chain blocks and lever hoists were used and / or loads were being drifted (refer Figure 1). Drifting loads refers to moving loads horizontally while being suspended. The high potential incidents reported have involved coal mine workers (CMWs) being struck, or nearly struck by loads that were being lifted, lowered, or suspended. 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	RDOC23/211019
Mine safety reference	ISR23-28
Date published	28 July 2022
Authorised by	Director Regulatory Operations Mine Safety Office of the Chief Inspector