NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 12 March 2021

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	40
Summarised incident total	3

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0039385 Open cut coal mine  Roads or other vehicle operating areas	While working on a haul road, a grader operator performed a u-turn. The position 2 tyre of the grader contacted the position 3 tyre of a haul truck that was overtaking the grader at the time. The grader operator did not look to see if the road was clear before initiating the u-turn. The haul truck operator had followed the correct procedure for overtaking.	Mines should develop, review and update procedures that manage the interaction of all mobile plant operating on site, including requirements for proximity detection and positive communication. Mines should consider including protocols for graders to conduct U-turns in their traffic rules. The installation of passing indicators on graders could facilitate positive communications allowing trucks to safely pass. Refer to Safety Bulletin 18-06 Lack of positive communications

Dangerous incident
IncNot0039419
Open cut coal mine

Roads or other vehicle operating areas

A dozer and a haul truck collided at a tip head. Both vehicles were reversing at the time of the incident. A preliminary investigation suggests that the truck operator did not follow the site requirement for positive communications with the dozer operator.

Machine operators should not rely on experience or previous movements of other operators as a substitute for positive communications. Lack of positive communication has been the root cause of many incidents and mine operators must consider higher-order controls including proximity detection. Mines should consider periodic refreshers in positive communications protocols for operators using mobile equipment.

Refer to Safety Bulletin 18-06 Lack of positive communications

Severe incident IncNot0039423 Open-cut construction materials	A worker sustained a compound fracture to his leg during the removal of a bucket from an excavator. The bucket holding-pin was being pushed from one side of the bucket by a pin pusher attached to a loader. The pin was almost free of its housing when the operator moved to the other side of the bucket, the pin came free, bounced off the bucket and hit the operator on the leg.  	The risk of an unsecured pin falling and hitting a person is an easily identifiable risk for which controls need to be put in place prior to work commencing. Documented risk assessments and/or procedures for such a task should be available and supervisors should ensure that controls, such as no-go zones and safe standing zones, are in place and communicated to all workers involved in the task.

Other publications of interest

These 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 25 February 2021, a 26-year old plant operator died after entering a cyclone discharge box. The local fire department recovered the victim lodged in an 18-inch wide discharge pipe that was full of water. **Details**
	International (other, non-fatal)
MinEx NZ	**Loader collides with light vehicle** A contractor's light vehicle was parked next to an aggregate stockpile, facing away from a loader. The loader got a call to load a truck and trailer from an adjoining stockpile, and as he reversed, the loader collided with the contractor's light vehicle. **Details**
	National (other, non-fatal)
Queensland Resources Safety and Health **Coal Mines Inspectorate**	**Falls from walkways and platforms – Mine Safety Bulletin #193** Coal mine workers (CMWs) have fallen through a mesh walkway and a mesh platform in recent incidents reported to the Coal Mines Inspectorate. In both instances the CMWs required medical treatment, however the potential existed for injuries to have been far more serious. **Details**
Queensland Resources Safety and Health **Minerals Mines and Quarries Inspectorate**	**Fire on RC drill rig from compressed air system – Safety Alert #388** On 3 February 2021, a serious incident occurred while a worker was adjusting the compressed air delivery system on a UDR 1000 RC drill rig. The drill rig was engulfed in fire causing serious burns to the workers face, arm, chest and back. Fortunately, the worker's eyes were protected from the fire by safety glasses. **Details**

Queensland Resources Safety and Health	**High potential Incidents – January Periodical**
Coal Mines Inspectorate	**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	DOC21/195024
Mine safety reference	ISR21-10
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