NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 19 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	42
Summarised incident total	3

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0039443 Open cut coal mine  Roads or other vehicle operating areas	A dozer tipped on its side while in the process of levelling a windrow. The operator was able to exit the machine and sustained no injuries. 	Workers have a legislative duty to care for their own health and safety and that of others (*s28 Work Health and Safety Act 2011*). One of the duties is to cooperate with any reasonable policy or procedure. Failure to comply with a duty is an offence for which penalties apply. Site procedures are developed to help protect workers from injury or illness. Where a procedure exists for a particular task, workers should follow the procedure. Any deviation from a procedure should first be discussed with a supervisor and

		appropriate risk control measures put in place. Refer to safety bulletin SB19-01 Rise in dozer incidents putting operators at risk.
Dangerous incident IncNot0039450 Underground metals mine  Ground or strata failure	A fall of ground occurred across a haul road approximately 300 metres above the mine portal. Two operators were unable to drive out of the pit due to the ramp being blocked. There were no injuries. 	The fall of ground is currently being investigated and further information may be published at a later date. The mine's emergency plan must identify triggers for activation of the plan, actions to be taken and appropriate rescue equipment must be available. For recommendations in relation to highwall failures, refer to safety bulletin: SB20-01 Failure of highwalls, low walls and dumps
Dangerous incident IncNot0039477 Underground metals mine	A worker received an electric shock from an air conditioner controller switch that was housed in a weather-proof enclosure. The subsequent investigation found that the IP rating of the switch did not meet the site standards. 	Mine operators are reminded of the need to follow introduction to site procedures to ensure second-hand equipment meets the required standards. The Electrical Engineering Control Plan Code of Practice, (1.6.8 Acquisition of Plant) states that "the EECP should provide systems to ensure the acquisition of plant includes the processes to verify that any plant, new to the mine, is fit for the intended purpose in the intended operating environment and is safe to use (introduction to mine site)."

Other Resources Regulator publications

Safety Bulletin SB21-01 – Refuelling fires

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)
MSHA	**Mine fatality** On 5 March 2021, a miner was fatally injured when the excavator he was operating rolled over into a body of water. **Details**
	International (other, non-fatal)
MinEx NZ	**Rockfall damages excavator** While an excavator was working at the toe of a bench, a rock fell out of the face hitting the excavator. The excavator was damaged, but no injuries were sustained by the operator. **Details**
	National (other, non-fatal)
DMIRS	**Radiator blades seriously injurie mechanics hand**; **Significant Incident Report #284** A service mechanic had just completed a general service of a 300 kVA generator, de-isolated it and bought it back online. He then conducted post service inspection and clean up, including wiping oil and grease marks with a rag. When the mechanic leaned into the generator enclosure, with the rag in his hand, it appears the rag and hand, were drawn into the rotating radiator fan blades, causing serious injuries. **Details**

DMIRS	**Hazards associated with use of e-cigarette devices; Mines Safety Bulletin #181** There was a report of an incident where an electronic cigarette (ape) battery spontaneously ignited in his pocket, while he was travelling in a ute with two other workers. **Details**
DMIRS	**Competency of spotters during mobile load shifting operations; Mines Safety Bulletin #182** Spotters can be an effective control for reducing the risk of inadvertent impact by operators of mobile load shifting equipment. It is important that they have the necessary knowledge, skills and experience to do so competently. **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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