

WEEKLY INCIDENT SUMMARY

Week ending Friday 12 November 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	32
Summarised incident total	4

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0041037 Underground metals	<p>A contract worker was operating a winch to pull new belting onto a conveyor. The third section of belting was winched into position and a clamp was applied to the belt. The winch rope then failed. The synthetic fibre rope failed at a snatch block and recoiled 25 metres, passing the winch and worker. The recoiling rope missed the operator by about a metre.</p> 	<p>When winches are being used, controls such as safe standing zones and guarding must be in place to protect workers in the event of a failure.</p> <p>Operators must ensure all ropes used are within their working load limits.</p> <p>While synthetic fibre ropes usually do not recoil when they fail, workers should be reminded that any rope, including synthetic ropes, can recoil and place them at risk of serious injury.</p>

Dangerous incident
IncNot0041043
Open cut coal

A haul truck was travelling fully loaded from an excavator when the position two trailing arm failed and caused the front of the truck to collapse and hit the ground. The truck slid about 20 metres. The operator of the truck did not suffer injuries.

The cause of the component failure is yet to be determined. Further information may be published later.



Dangerous incident
IncNot0041070
Underground
metals
Fire or explosion

A loader was being refuelled underground. A bolt retaining the air filter housing (mounted to the fuel tank) compromised the integrity of the fuel tank, allowing fuel to spray onto the turbo exhaust system and DPF box. A worker used two fire extinguishers to put out the fire.

Mine operators should ensure stringent monitoring and quality control of maintenance and repair activities. Refer to Safety Bulletin: [SB21-01 Fires occur while refuelling plant](#)



Dangerous incident
IncNot0041049
Open cut coal

A haul truck made contact with a reject loading bin twisting a structural support. The worker incorrectly aligned the truck with the approach guides resulting in the rear wheels hitting the tyre barriers. This caused the truck to pivot and the headboard to hit the support column. The barrier was not effective in preventing a collision.



Structures must be protected from impact with mobile plant. The extension of headboards and trays should be considered during the design of barriers and guides. Equipment operators must maintain situational awareness and remain vigilant to manage the risk of collisions while operating mobile plant.

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 1 November, 2021, an electrician with 25 years of mining experience was fatally injured while traveling down a mine slope. He lost control of a four-passenger, rubber-tyred personnel carrier, and the vehicle crashed at the bottom of the slope, pinning the worker underneath.

[Details](#)

National (non-fatal)

Resources Safety and Health, Queensland (coal)

Electric motor terminal cover catastrophic failure – Safety alert #400

A 400kW electric pump motor suffered a rapid pressurisation in the motor body resulting in the motor terminal cover catastrophically failing. It was ejected from the terminal box propelling metal fragments approximately 15 metres.

[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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DOCUMENT CONTROL

CM9 reference	DOC21/1013838
Mine safety reference	ISR21-45
Date published	19 November 2021
Approved by	Deputy Chief Inspector Office of the Chief Inspector