NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 17 June 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.

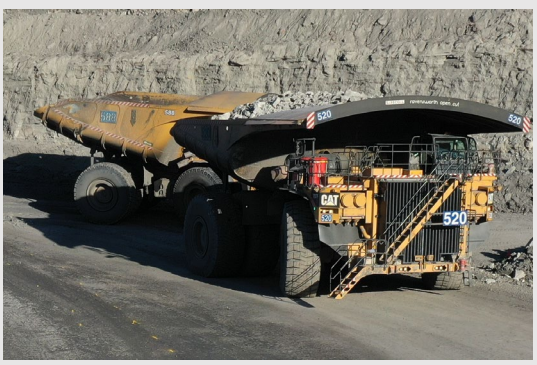
TYPE	NUMBER
Reportable incident total	46
Summarised incident total	5

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0042358 Open cut coal mine Roads or other vehicle operating areas 	A loaded haul truck operator accidentally reversed and breached a windrow while being loaded by an excavator on the same level. The truck stopped on the coal floor below. The seam was 2.5 metres high. A digger operator stopped the truck from moving further by putting the digger bucket onto the body.	While being loaded, haul trucks should have appropriate braking system applied. Dig areas should be designed and maintained to allow ease of maneuvering, without requiring excessive acceleration or braking to position for loading. Windrows should be designed and constructed to suit the mobile plant operating in the area. Workers report and rectify non-compliant work areas.

Dangerous incident
IncNot0042381
Open cut coal mine
Roads or other vehicle operating areas

A loaded haul truck was travelling down a ramp towards a bend. An empty haul truck was travelling towards the bend to continue up the ramp. The empty haul truck entered the corner at an excessive speed, lost traction and started to slide. The rear of the truck slid, the dovetail struck the side of the loaded truck and spun 180 degrees. The empty truck came to a stop behind the loaded truck. Both workers were uninjured.

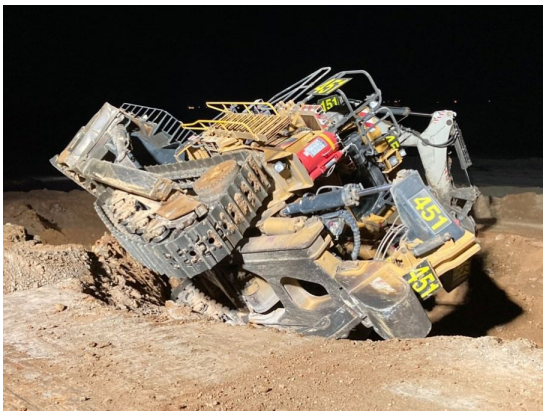


Workers must operate vehicles and equipment at a speed that is appropriate to the prevailing conditions. Workers must remain vigilant in monitoring changes in conditions in operating environments.
Engineering controls that minimise the risk of loss of control should be considered, including the use of centre bunding, speed monitoring systems and alarms.

Refer to:
Safety Alert SA20-09 Operating mobile plant - Incidents and near misses

Dangerous incident
IncNot0042391
Open cut coal mine
Roads or other vehicle operating areas

A dozer was operating on a bench approximately 1.5m high. While reversing, the dozer slid off the side of the bench. Dirt was pushed up against the dozer to prevent it from rolling further.



Situational awareness is a key control when operating mobile equipment. Operators should minimise reversing and consider this when planning tasks. Lighting plants should be strategically placed to provide adequate lighting for tasks and reduce glare.

Refer to:
Safety Bulletin SB19-01 Rise in dozer incidents putting operators at risk
Safety Bulletin: SB19-10 Dozer incidents increase despite warnings

Severe incident
IncNot0042418
Underground metals mine

A worker was hit in the face by a barring steel that ejected from a jaw crusher. The worker was standing on a platform above the operating jaw at the time. The barring steel entered the crusher in production feed. The worker lost four teeth in the incident.

Crushers and rotating equipment involve large energies that are capable of ejecting material with large amounts of force and speed. Mine operators should review access over and around crushers, feeder breakers and other processing equipment to ensure workers are not exposed to the risk of ejecting material.

Dangerous incident
IncNot0042409
Underground metals mine
Roads or other vehicle operating areas

Two workers were travelling down a main decline in a light vehicle. The vehicle hit a slippery part of the decline that resulted in the vehicle sliding into a drain. The vehicle rolled 360 degrees, coming to rest on its wheels and facing back up the decline. Neither occupant was injured.

Equipment operators must maintain situational awareness and remain vigilant regarding the risk of machine rollovers. This incident underpins the importance of wearing seatbelts as a mitigating control and demonstrates roll overs can occur in unexpected situations.
Mine operators should ensure that light vehicles rollover is considered in the risk assessment for roads and other vehicle operating areas, including at underground mines.

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 Safety & Health QLD	Since 2011, there have been 129 reported incidents involving the failure of structures in the mineral mines and quarries sector, with 19 of those occurring in the past 12 months. These structural failures have resulted in uncontrolled movements, and falls of objects, persons and, in some circumstances, whole structures. All of these incidents had the potential to cause serious harm to people. 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	
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