

Weekly incident summary

Week ending 04 October 2024


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


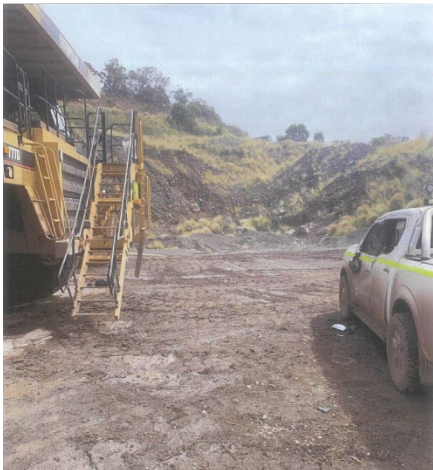
High level summary of emerging trends and our recommendations to operators.

Type	Number
Reportable incident total	47
Summarised incident total	4



Summarised incidents

Incident type	Summary	Comments to industry
Dangerous Incident IncNot0047782 Open cut coal Roads or other vehicle operating areas	<p>A dozer was cleaning up around a dig face when a haul truck reversed into place. The truck contacted the dozer on the drivers offside.</p> <p>The truck driver breached the mine's procedure by positioning the rear of the truck towards the loading unit prior to the bucket being presented.</p> 	<p>Workers have a duty to take reasonable care for themselves and others while in the workplace. This includes staying alert, being aware of their surroundings, and maintaining control of the plant and machinery they operate.</p> <p>Workers are also reminded that as part of their duty, they must comply with reasonable instructions and procedures of the workplace. Following procedures for loading trucks is considered reasonable.</p>

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Incident type	Summary	Comments to industry
<p>Dangerous Incident IncNot0047779 Underground coal Leave blank</p>	<p>A continuous miner operator was struck on the head by a monorail trolley when it fell from the end of the rail in a development production area.</p> <p>There was no mechanical stop on the end of the monorail to prevent the trolley from falling.</p> 	<p>The omission of a simple but necessary control can have serious consequences for workers.</p> <p>When extending monorails, it is essential that the monorail brake is secured at the end of the line to prevent the trolley from falling off.</p> <p>Operators should do a visual check to ensure the brake is in place before proceeding forward and engaging the trolley.</p>
<p>Dangerous Incident IncNot0047769 Construction materials Roads or other vehicle operating areas</p>	<p>A supervisor pulled up near a stationary haul truck to pick up the operator. The operator, unaware of the nearby light vehicle, moved the truck forward several metres to realign it, contacting the light vehicle with the ladder, which was in the lowered position.</p> <p>The supervisor assumed the truck was parked up when he stopped in front of it.</p> 	<p>Parking near a haul truck without establishing positive communications can have fatal consequences and should not occur under any circumstances.</p> <p>It is never safe to assume you know what another plant operator is going to do. Assumptions are not controls.</p>
<p>Dangerous Incident IncNot0047767 Underground metals Leave blank</p>	<p>While scaling loose material from a batter a large volume of hung-up material was brought down resulting in a rock deflecting off another rock on the rilled material and shattering the</p>	<p>Work methods for scaling must consider the risk of falling material and locations of people and equipment operators.</p> <p>Consideration should be given to the height of the excavator operating</p>

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	<p>side window of an excavator. Some rock also flowed onto the excavator tracks.</p> <p>The catch-bund had previously caught scaled material, leading to overflow when a large volume of scaled material came in at once.</p>  	<p>platform so that scaled rock will fall down and away from the excavator.</p> <p>Ensure that the catch-bund is large enough to safely hold the quantity of scaled rock.</p>

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
	<p>International (non-fatal)</p> <p>Energy Safety Canada</p> <p>A light vehicle (LV) entered an active work area where a dozer was back blading in a narrow corridor. The LV operator called the dozer operator via radio but received no response, however continued to approach. The dozer reversed, causing major damage to the LV.</p> <p>Learnings:</p> <ul style="list-style-type: none"> - Regularly assess the strength of safeguards to ensure they are properly implemented and capable of helping to fail safely in the event of human error. - Work areas and access evolve throughout a project, ensure ongoing assessment of workplace set-up, hazards and associated safeguards. - Use hard barriers where possible to separate LVs from heavy equipment in active work areas. - Regular practice and field verification of Safe Approach standards are necessary to ensure understanding and compliance. <p>Read more</p>

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Publication	Issue/topic
NZ MinEx	<p>A worker was towing a fuel trailer behind a ute in a quarry when a wheel axle snapped. The ute was travelling at a relatively slow speed and was in an isolated work area. There was no loss of load, spillage of fuel or additional damage to the trailer or ute. If this had occurred while towing the trailer at speed or on a public road, this could have been a very significant incident.</p> <p>You need to ensure that:</p> <ol style="list-style-type: none">1. Pre-start checks are conducted on all plant prior to being used.2. All plant is serviced and maintained in accordance with the original equipment manufacturers recommendations.3. Service intervals on plant that is not used regularly are adjusted to ensure plant is serviced regularly. <p>Read more</p>
	National (fatal)
WorkSafe QLD	<p>In a recent incident, a worker suffered fatal crush injuries while operating an elevating work platform (EWP). Initial enquiries indicated the worker became trapped between the top rail of the EWP basket and a panelled bulkhead above.</p> <p>Read more</p>

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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