NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 14 May 2021

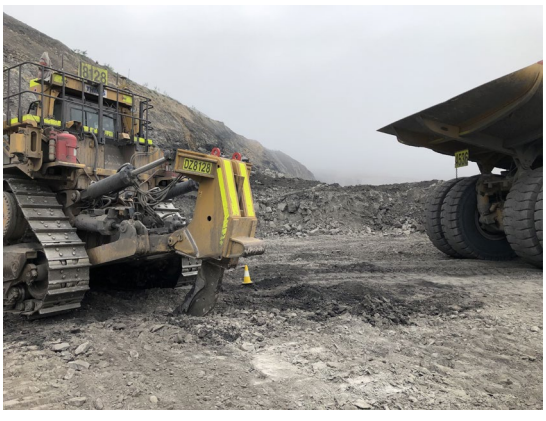
This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the NSW Resources Regulator: phone 1300 814 609 24 hours a day, 7 days a week.

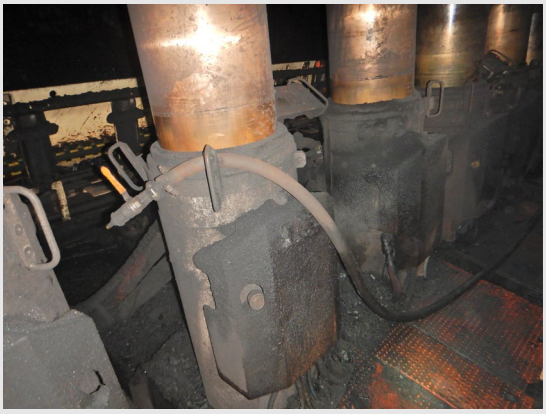
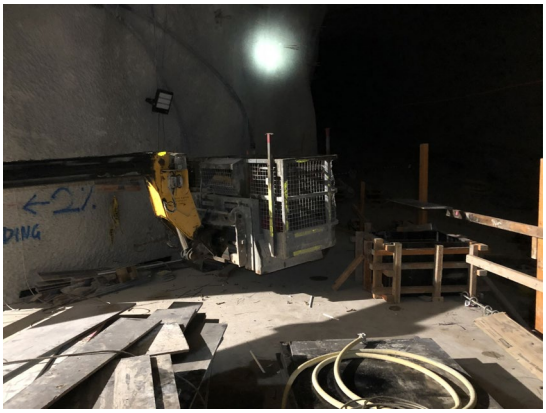
At a glance

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

TYPE	NUMBER
Reportable incident total	34
Summarised incident total	3

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0039848 Open cut coal mine  Roads or other vehicle operating areas	 A dozer operator communicated with a haul truck that he was about to clean up across the face behind the truck. The dozer operator completed one push and reversed back to commence a second push. The truck operator saw the dozer	Operators of mobile plant must establish positive communications with other plant operators before moving into impact zones. There is no room for assumption when the consequences could be fatal. Mine operators should consider periodic refreshers in positive communications protocols for operators using mobile equipment. Refer to: Safety Bulletin 18-06 Lack of positive communications

	reversing out of the area and assumed it had finished cleaning up. The truck operator then reversed towards the face, narrowly missing the dozer cab with the dovetail of the truck. The truck operator assumed the dozer was clear without waiting for positive communication from the dozer operator.	
Dangerous incident IncNot0039838 Underground coal mine	 While retrieving a wash down hose on the longwall face an operator was sprayed on the side of the head with 1200 kilopascals of water pressure when the ball valve inadvertently opened.	Mine operators should consider using gate valves in place of ball valves to prevent inadvertent operation of water hoses.
Dangerous incident IncNot0039872 Underground metals mine	 Two electricians were in a man basket attached to the extended boom of a telehandler when the basket dropped to the ground. When the boom was extended, the telehandler overbalanced causing the basket to drop to the ground and the rear of the telehandler to lift. The basket dropped approximately 3.5	Before completing a task, a risk assessment tool must be used, and control measures put in place for identified risks. If identified controls such as outriggers are installed and cannot be used, Additional control measures must be identified and implemented through a risk management process. Operators must be trained in identifying when a risk is present and how to control the risk. OEM recommendations must be taken into account when developing procedures for tasks.

metres at a slow rate. The outriggers of the telehandler had not been extended due to the tight working location.

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 22 April 2021, a miner was fatally injured when leaving the mine site in his personal pickup truck. The manual swing barrier gate was partially closed. A gate pole entered the truck's windshield as the pickup truck approached, striking the victim and causing fatal injuries. 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	DOC21/399225
Mine safety reference	ISR21-19
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