

WEEKLY INCIDENT SUMMARY

Week ending Friday 26 February 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	36
Summarised incident total	3

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0039277 Open cut coal mine  <p>Roads or other vehicle operating areas</p>	An operator was sitting in his light vehicle with the door open, after clearing a fault on a stacker. An unplanned movement of the stacker caused the front buffer of the stacker to hit the open door of the vehicle causing the door frame to buckle and the glass to shatter. The operator was uninjured. 	Operators need to remain situationally aware around moving plant particularly when there is no clearly identified delineation zone. Drivers should ensure that no part of their vehicle encroaches into the danger zone. Where there is moving components on fixed infrastructure, exclusion zones need to be determined and appropriate delineation installed.



Dangerous incident
IncNot0039280
Quarry



Ground or strata

Following heavy rain, approximately 60 tonnes of loose material slipped onto a ramp. The ramp was not in use and had been bunded off at the top. Nobody was injured.



Mine operators are reminded that when developing the control measures to manage the risks of ground or strata failure consideration must be given to:

- the means by which water may enter the mine
- the procedures for removing water from the mine and how those procedures influence rock stability over time
- the geotechnical characteristics of the rocks and soil, including the effects of water on rock support and stability.

Dangerous incident
IncNot0039325
Underground
metals mine

An electrician tasked with removing redundant cable cut a low voltage cable that was in service. The electrician identified a cable that he believed was redundant. The cable was tested and found to have no voltage, so the electrician proceeded to pull the cable out of its conduit. He reached a point where he could not pull any more cable through, so he cut the cable at a location

Electrical circuits should be identified and labelled so that isolation of circuits can be undertaken with confidence. Test-for-dead verification should be performed prior to cutting cable using a non-contact tester.

further back towards the switch room. There were four conduits running together, but they crossed over where they ran behind a feeder structure, which resulted in the electrician cutting a conduit that was not the one he was removing.

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	<p>Mine fatality– On 8 February 2021, a miner was fatally injured when he became entangled in a fluted tail pulley while attempting to shovel under an adjacent fluted tail pulley.</p> <p>Details</p>
	National (other non-fatal)
Mineral Mines & Quarries Inspectorate Resources Safety Qld	<p>High Potential Incidents – December periodical</p> <p>Details</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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