NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 28 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.

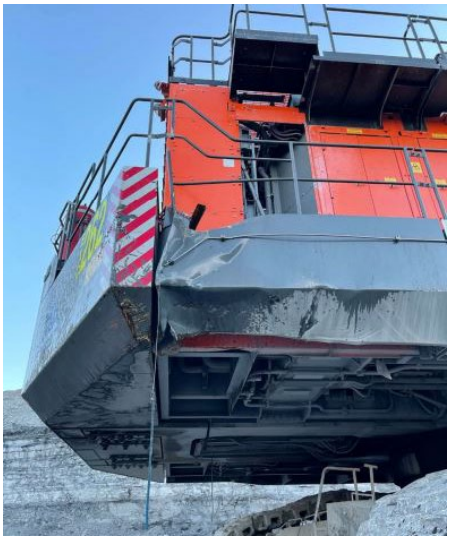
At a glance

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

TYPE	NUMBER
Reportable incident total	41
Summarised incident total	4

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Critical incident IncNot0039928 Open cut construction materials	A contract fitter was fatally injured when run over by a light vehicle.	This incident is under investigation and further information will be published at a later time.
 Roads or other vehicle operating areas		

Dangerous incident IncNot0039957 Open cut coal mine	A drill rig trammed to a demarcated shot hole to re-drill it. The drill operator accessed the loaded shot without authorisation of the nominated shotfirer and without the guidance of a spotter. The operator was unaware that he was drilling inside the demarcated area. A booster and detonator were on the cuttings of the original drill hole about two to three metres from the operating drill. The mine has a procedure in place for re-drilling, but the rig operator failed to follow the procedure. 	Section 28 of the Work Health and Safety Act 2011 prescribes the duties of workers. Workers must: • care for their own health and safety and that of others • cooperate with any reasonable policy or procedure. Where a procedure exists for a particular task, workers should follow the procedure.
Dangerous incident IncNot0039959 Open cut coal mine  Roads or other vehicle operating areas	An excavator collided with a dozer causing significant damage to the cabin. The operators had established positive communications to allow the dozer to enter the excavator's swing radius. However, the excavator operator restarted operation without confirming that the dozer was clear of the swing radius. 	To control the risk of collision excavators should cease operation while dozers are operating within the swing radius. Mines should not rely on procedural controls for managing the risk of collisions. Collision avoidance technology should be integrated into mobile equipment.

Dangerous incident
IncNot0039972
Open cut coal mine

Roads or other vehicle operating areas

An excavator collided with a dozer that was working inside the swing radius of the excavator. The excavator bucket has hit the exhaust stack and blade lift cylinder at the front of the dozer. There were no injuries.

Dozer operators must maintain a safe distance when operating in close proximity to excavators (must remain outside of the excavator swing radius).
Machine operators should not rely on experience or previous movements of other operators as a substitute for positive communications.
Refer to Safety Bulletin 18-06 Lack of positive communications which addressed similar incidents.

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 14 May 2021, a continuous mining machine operator was fatally injured when a piece of rock fell from the roof and struck him. The victim was working under an unsupported roof in the Number One entry. Details
MSHA	**Mine Fatality** – On 18 May 2021, a telehandler was towing a trailer, with a diesel pump onboard, up an inclined underground roadway when the tow hitch suddenly broke. The trailer rolled down the roadway, striking and fatally injuring a contract labourer. Details
	International (other, non-fatal)
MinEx NZ	**Excessive wear leads to mechanical failure under load** A front end loader was being used to conduct lifting operations when the end of the link arm broke off and projected itself nine metres away Details
	National (other, non-fatal)
Resources Safety and Health Queensland (Coal)	**Dragline hoist drum uncontrolled movement – Safety Alert #390** The uncontrolled release of hoist brakes and bucket from a significant height, combined with no controls contributed significantly to this event. The hazards posed by the uncontrolled release of the hoist brakes and dragline bucket were not identified by the personnel in any formal process. Details
Resources Safety and Health Queensland (Mineral Mines & Quarries)	**High Potential Incident Summary – March Periodical** Details

DMIRS (WA)	Near miss following unplanned movement of autonomous haul trucks during recovery operations – Significant incident report No.286 Two operators were exposed to potentially serious injury when the two autonomous haul trucks (AHTs) they were attempting to board unexpectedly drove forward. Details
DMIRS (WA)	**Hazard of lightning strikes on vehicles – Mine Safety Bulletin No.183** Over the past three years, the Department has been notified of several vehicles on mining operations being struck by lightning, with some experiencing tyre pyrolysis following the event. Pyrolysis may result in tyres exploding unexpectedly, and this poses a risk of serious or fatal injury to workers due to the sudden release of energy. This type of catastrophic failure may occur after a delay of several hours. 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	DOC21/448694
Mine safety reference	ISR21-21
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