NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 22 July 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.

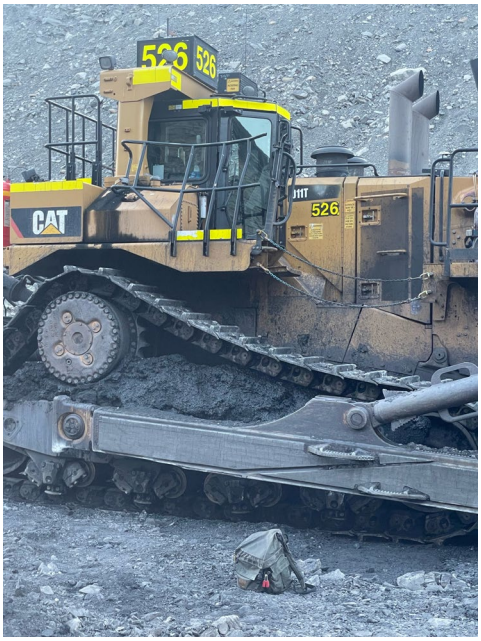
At a glance

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

TYPE	NUMBER
Reportable incident total	41
Summarised incident total	8

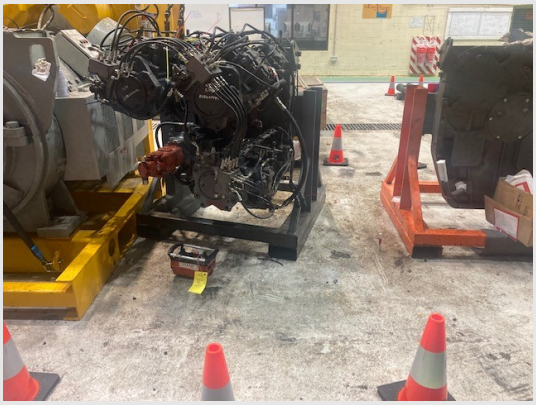
Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0042611 Open cut coal mine	An excavator and dozer collided when the dozer travelled into the swing zone of the excavator. The excavator slewed and the bucket hit the handrail of the dozer adjacent to cabin.	To control the risk of collision, mine operators should have robust controls in-place for when equipment enters the swing radius of excavating equipment, such as ceasing movement and grounding the bucket. Operation should not recommence until positive communication has confirmed the swing radius is clear of equipment. Where possible, collision avoidance technology should be integrated into mobile equipment to help control the risk of collision.



Dangerous incident IncNot0042624 Underground coal mine	Three workers were hand-bolting in the drift of a coal mine when they had to jump out of the way of a dolly car that was driven into the mine. The dolly car caught the bolter hoses and dragged it down the drift. One of the workers was hit by the bolter as it was dragged by the dolly car and suffered a broken leg.	This incident is under investigation by the Resources Regulator and further information will be published later.
Dangerous incident IncNot0042642 Underground metals mine	A vent brattice door (tarp over steel mesh) was blown off its hinges past a light vehicle before coming to rest against an IT loader. An operator in the area got into the light vehicle as a precaution when the air pressure changed. The mine was in shutdown mode and two primary fans were switched off, causing a spike in ventilation, which caused the door to be forced of its mounts.	When changes to ventilation systems are made, vent modelling should be conducted to ensure the changes do not pose a risk to workers in the mine.

Dangerous incident IncNot0042647 Underground coal mine	A 14-tonne excavator was being trammed across a creek at a crossing on a concrete causeway. The creek was flowing with water at the time and the excavator operator trammed off the concrete causeway, resulting in the excavator tipping forward. The operator dropped the bucket to the ground to stabilise the excavator. As water entered the cab, the operator exited the cab and waded through the water to the edge of the creek crossing. 	All bodies of water present unknown hazards and should be avoided where possible. Where water crossings are created, a means of delineating the edge should be included in the design to allow safe passage.
Dangerous incident IncNot0042650 Underground coal mine	A continuous miner was taking a plunge in a cut-through when the operator observed a flash resulting from frictional ignition.	Mine operators must implement controls to ensure designed ventilation quantities for panel work areas are documented, implemented and measured at regular intervals. Further controls must be developed and implemented to ensure roof cavities remain free of methane gas accumulations.

Dangerous incident IncNot0042663 Open cut coal mine	A worker was using a gantry crane to position a pump drive. The crane was holding weight but had not lifted the drive off the ground. While a tradesperson was between the load and another piece of machinery, the pump drive moved, causing the tradesperson to be pinned. The remote for the crane was placed on the ground at the time. A second tradesperson hit the E-Stop and the pinned tradesperson was freed. 	This incident is being investigated by the mine operator and further information may be published later.
Dangerous incident IncNot0042665 Underground metals mine	A three-person crew was working in a shaft installing a communication cable. The crew started at the surface and was 433m below the surface when the cable failed above the winder cage. Between 50 and 100 metres of cable then fell onto the canopy above the inspection cage in which they were working.	Attachment points for infrastructure installed into shafts must be engineered and rated for the life of the installation.
Dangerous incident IncNot0042627 Open cut coal mine Roads or other vehicle operating areas	An excavator was being tracked off the bench at the end of a shift. After two failed attempts of positive communications, the excavator tracked behind an operating dozer regardless. The dozer then reversed, hitting the walkway on the excavator.	Positive communications must be confirmed before moving plant into the operating area of other mobile plant. Plant operators should never rely on the assumption that other operators will see them when moving.

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 (other, non-fatal)
WorkSafe NZ	Two serious incidents occurred within a month of each other when the electrical workers involved relied on a live polarity testing method. The first incident occurred when a live polarity test was used to test the connection of a newly installed mains cable and mains entry box. Because the connection was transposed between the phase and the neutral at the mains entry box, it resulted in the installation being livened in a fault condition. The second incident occurred adjacent to a school property and resulted in a neighbouring iron fence becoming energised because of electrical work being carried out on the mains at the school. This was a serious near-miss incident and created a risk of electrocution for anyone coming into contact with the fence. Details
	National (other, non-fatal)
Resources Safety & Health Queensland	While driving an underground grader, the operator stopped the grader to let traffic past. The operator applied the park brake, but the grader moved approximately 2 m before coming to a halt. The grader service brake remained operational throughout the incident. Both service and park brakes had been replaced as part of normal maintenance two weeks before the incident. The grader passed the weekly scheduled brake test a day before the incident. On the

day of the incident, the operator reported having used the park brake a couple of times without any problems before he pulled over to let traffic past.

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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