NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 1 May 2020

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	38
Summarised incident total	6

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous Incident IncNot0037230 Open cut coal mine  Roads or other vehicle operating areas	Two dozers collided when preparing coal. One dozer was ripping when it hit the side of the other dozer, that was pushing. The operator of the dozer that was ripping was looking backwards, away from the other dozer, at the time the incident occurred. The blade of the ripping dozer was raised, damaging the access platform and ladder assembly of the other dozer.	Mines must conduct risk assessments on dozer operations and identify, document and implement effective controls for all risks, including risks associated with dozers operating perpendicular to one another. Supervisors must be able to determine that controls are in place and that dozer operators are using them effectively. Dozer operators should always maintain situational awareness and pay attention to the movement and proximity of other

machinery. Ground implements (blades and rippers) should be kept as low to the ground as possible during operation.

Refer to:

- SB19-10 Dozer incidents increase despite warnings
- SB19-01 Rise in dozer incidents putting operators at risk

Dangerous incident

IncNot0037233

Underground metals mine

Fire or explosion

The operator of an underground dump truck saw flames coming from an engine bay. He tried to activate the fire suppression system, but was unsuccessful. He immediately exited the cabin and retreated to the crib to report the incident. Two other workers in the area tried to extinguish the fire with hand-held fire extinguishers but were unsuccessful.

The mine initiated its emergency response procedures, and all workers retreated to fresh air bases. All workers were subsequently withdrawn to the surface.

The mine's fire and rescue team members re-entered the mine and successfully extinguished the fire.

Vehicles used in underground mines must be rigorously assessed regarding the risk of fire.

An assessment program undertaken by the Regulator in 2019 focused on the contribution of maintenance practices to plant fires. The program identified significant deficiencies regarding fire risk assessments.

Refer to:

- SA19-02 Non-metallic materials add fuel to underground truck fire
- Preventing fires on mobile plant

This incident also highlights the importance of emergency response procedures and their timely activation.

Mine and petroleum site operators are reminded that effective implementation of Work Health and Safety (Mines and Petroleum Sites) Regulation 2014 emergency management (division 6) and information, training and

		instruction (division 7) requirements will have a significant impact on keeping workers safe in an emergency. For further information refer to our dedicated web page Fires on mobile plant.
Dangerous incident IncNot0037234 Open cut coal mine  Roads or other vehicle operating areas	The operator of a scraper was trying to get a load of gravel off a stockpile when the vehicle rolled onto its side over a narrow windrow. The driver was not injured. 	Equipment operators must maintain situational awareness and remain vigilant to manage the risk of machine rollovers. The circumstances of this incident underpin the importance of wearing seatbelts as a mitigating control. When planning tasks and travel paths, supervisors must consider rollover hazards.
Dangerous incident IncNot0037239 Quarry	An operator was working on a bucket wheel when the wheel moved unexpectedly, trapping the operator in the machine. The operator sustained an injury to his leg that required stitches. 	When isolating any equipment to work on gravitational energy must be considered. All equipment should be assessed to determine the best way to isolate against gravitational energy. Mine operators must have systems in place for workers to contact others in the case of an emergency when working alone.
Dangerous incident IncNot0037256 Open cut coal mine	A light vehicle was towing a lighting tower to a workshop when the tower separated from the vehicle and travelled about 60 metres before overturning.	Mine operators and contract companies should review their procedures to determine if their

Roads or other vehicle operating areas

training includes the potential hazards associated with towing.

When connecting a trailer to a vehicle's tow ball ensure that the trailer is securely on the tow ball and locked in position. Safety chains must be attached between the trailer and the towing vehicle.

In the instance where a person other than the vehicle operator attaches a trailer to the vehicle, the vehicle driver should ensure that the trailer has been securely attached before towing the trailer.

Dangerous incident

IncNot0037265

Open cut coal mine

Fire or explosion

An electrician was called to work on an excavator. He parked on the bench about 30 metres away from the excavator. While he was on the excavator, a dozer entered the area and parked about 20 metres in front of the light vehicle. The dozer driver and the excavator operator had a conversation and when the dozer driver re-entered the cab to drive away, he reversed into the light vehicle.

The dozer operator was unaware that he had hit the light vehicle, and left the work area.

Mobile plant interactions in mines, particularly between light vehicles and heavy mobile plant such as dozers, are a well-known risk.

Mine operators must identify, implement and maintain appropriate no-go zones and separation areas between light vehicles and heavy mobile plant.

Mine operators should consider applying engineering controls such as proximity detection, collision avoidance systems and cameras to assist in managing the risks associated with light vehicle and mobile plant interactions.

Refer to:

- Investigation information release IIR20-02 Collision between dozer and light vehicle

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	**Fatality – final report** A 29-year-old equipment operator, with two years of total mining experience, died on 27 February 2020. While working with other miners to set a steel plate vertically against the frame of a feed hopper, the plate fell on him. The incident occurred because mine management did not follow their procedure for securing the steel plate before removing the rigging. Details
	National (other non-fatal)
Queensland Mines (coal) Inspectorate	**Failure of fire suppression system** Upon manual activation of a fire suppression system during routine servicing at an open cut coal mine, the system failed to actuate as designed. On further investigation, it was found that the dimensions of the cylinder discharge valve shuttle assembly were outside of tolerances causing it to not seat or actuate correctly. The department has been made aware that this fault has been identified on several machines. Details
Queensland Mines (coal) Inspectorate	**Miner struck by rock fall off brow – Mines safety alert No 372** Two workers were injured in a rock fall while placing explosives at the brow in preparation for bombing the drawpoint. About 50 kilograms of rocks fell from the backs about five metres from the brow. The ground had been damaged during previous draw point bombing. The mesh was badly damaged, and rocks were bagging in it. Details
Queensland Mines (coal) Inspectorate	**Failure to give way causes collision at T-intersection** Two dump trucks collided at a haul road T-intersection in a mine. Both trucks were travelling at speed when the collision occurred. Significant damage was

caused to the front of one truck and the left-hand side of the other truck. The truck drivers were not injured.

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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