

## NSW Resources Regulator

# WEEKLY INCIDENT SUMMARY

Week ending Friday 04 December 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.

ТҮРЕ	NUMBER
Reportable incident total	55
Summarised incident total	3

# **Summarised incidents**

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0038755 Industrial minerals	A worker was trapped under the cab of a loader when the cab lowered onto him as he was working beneath it. The worker was trapped for about three minutes before he was released. Preliminary investigation found that the cab was unsupported at the time. No locking pin or chock was used to hold the raised cab in place. The worker sustained minor injuries.	This incident is under investigation and a full report will be published at a later date. Under no circumstances should an operator work beneath an unsupported cab. OEM recommended chocks and locking pins should be used to secure the raised cab in place.

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#### Dangerous incident IncNot0038773 Coal processing plant

An operator was checking the oil on a loader while positioned between the counterweight and the rear wheel. Another operator entered the loader and started the vehicle. The worker removed himself from the area and was uninjured.



Prior to undertaking any tasks around heavy machinery it is imperative that the machine is isolated.

Operators should follow procedures and ensure there is nobody in the vicinity of the machine before starting it. Visual checks and sounding the horn before starting the vehicle are basic controls that should be followed.

#### Dangerous incident IncNot0038778 Open cut coal



Roads or other vehicle operating areas

As an overloaded dump truck was travelling across the working area, a dozer doing floor clean-up changed the direction of travel and reversed into the driver side rear tyre (POS-3). No one was injured.



Mine operators must have protocols and procedures to ensure positive communications are established between vehicle operators in collision zones.

Consideration should be given to proximity detection and collision avoidance technologies.

Supervisors must ensure that vehicle operators comply with the protocols and procedures.

Ensure that any equipment mounted inside the cab, such as a fan, does not impede operator vision.

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Refer to:

Safety Bulletin 18-06 Lack of positive communications

# **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 21 August 2020, a truck driver sustained fatal head injuries while he was deploying the automatic tarp on his fifth-wheel side-dump trailer. Details
MSHA	Mine Fatality On 19 October 2020, an excavator's bucket struck a plant operator who was standing on the cross beam of a grizzly hopper screen. <u>Details</u>
MSHA	Mine Fatality On 27 October 2020, a miner was digging a hole to install a wooden post for roof control when a section of the roof fell on him. 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.

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#### **DOCUMENT CONTROL**

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