NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 26 March 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	44
Summarised incident total	2

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0039531 Underground coal mine  Fire or explosion	Two workers suffered nausea and headaches after taking about 30 minutes to extinguish a fire on a compressor. The compressor was on the mine surface, however, the workforce was withdrawn from underground as a precaution. Repairs had recently been completed to the compressor and it was deemed fit to continue in operation.	The cause of the fire is unknown. Further information may be published at a later date, following examination of the compressor.

Dangerous incident
IncNot0039521
Underground coal mine

Roads or other vehicle operating areas

A continuous miner (CM) collided with a loaded shuttle car which damaged the glass on an explosion protected enclosure. The shuttle car had pulled away from the CM towards the boot-end when the operator stopped to correct an issue with the supply cable.
The CM operator then reversed, to line up for bolting, and the tail of the CM has collided with the shuttle car. There was no positive communication between the shuttle car operator and the CM operator when the shuttle car stopped.

The lack of positive communications continues to be an issue on mine sites. Workers are reminded that they have a legislative duty to care for their own health and safety and that of others (*s28 Work Health and Safety Act 2011*).
Establishing positive communication between plant operators is a risk control designed to help prevent collisions. Vehicle operators need to remain situationally aware and ensure that other operators in their vicinity know of their presence.
Operators should visually check their surroundings prior to reversing rather than assuming the way is clear.
Mine operators should consider applying engineering controls such as proximity detection and collision avoidance systems to assist in managing the risks associated with mobile plant interactions.

Refer to:
Safety Bulletin 18-06 Lack of positive communications

Other publications of interest

These 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 12 March 2021, a miner was fatally injured while attempting to insert a steel pin into a spud beam. Details
	National (other, non-fatal)
Queensland Resources Safety and Health **Mineral Mines and Quarries Inspectorate**	**High Potential Incident Summary – January Periodical** Details
DMIRS (WA)	**Near miss during lifting operation – Significant Incident Report #285** A davit crane was being used to lift a mini excavator, when the lift points welded to the excavator failed. The excavator fell approximately 10 metres down a crusher vault, missing two workers in the area. 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	DOC21/237277
Mine safety reference	ISR21-12
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