WEEKLY INCIDENT SUMMARY

Week ending Friday 13 March 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	53
Summarised incident total	3

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous Incident IncNot0036900 Open cut coal mine  Roads or other vehicle operating areas	Two haul trucks collided nose to tail at an open cut coal mine. There is no evidence that the rear truck attempted to brake before the collision. The operator of the rear truck was found to have a mobile phone in the truck. Neither operator was injured.	Whilst the cause of this incident is not yet known, mines are reminded of the need to monitor and enforce their policies regarding mobile phone usage. Strong consideration should be given to implementing technologies that continuously monitor and identify operator distraction, warning the operator via a tiered alarm system.

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY

Dangerous Incident

IncNot0036906

Underground metals mine

A fitter was in the process of re-gassing an accumulator on a drilling jumbo with nitrogen, when the nut connecting the regulator and gauge on the nitrogen bottle failed. This caused the regulator and gauge to be ejected into the air.

There were no injuries.

When developing control measures for the unintended release of mechanical energy, mines must consider:

- the identification, assessment, management and rectification of defects that affect the safety of plant
- the risks associated with pressurised fluids
- the inspection and testing of plant, including the testing of safety critical components.

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous Incident IncNot0036951 Underground coal mine  Roads or other vehicle operating areas	A flatbed service vehicle was parked on a slight gradient behind a continuous miner. Two workers at the rear of the parked vehicle were unloading roof bolt materials, when the vehicle rolled forward about three metres and came to a stop without intervention. The vehicle was in the off position and the operator stated that the park brake had been applied.	Vehicle operators need to comply with correct park-up arrangements, particularly when parking on a grade. Workers should receive communication regarding: ▪ compliance with correct parking procedures ▪ being situationally aware of hazards. Mine operators should consider: ▪ audible warning systems and/or visual alarms to warn of the lack of park brake application ▪ interlocking that automatically applies the park brake when the operator leaves the operator's position (i.e. door interlock) ▪ functional testing of park brake application warning systems. Refer to Safety Bulletin: ▪ SB13-02 Unplanned movements of vehicles - too many near misses.

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	**Metal/non-metal mine fatality** On 29 February 2020, a plant foreman was priming the main suction pump on a dredge when a two-inch coupling on the waterjet pipe failed, knocking the worker into the water. Divers retrieved his body several hours later. The worker was not wearing a life preserver and lost his life. Details
MSHA	**Mine fatality** On 27 February 2020, a trucking company employee suffered fatal injuries while helping to position a low-boy trailer. The worker was standing in front of the trailer wheels to assist the driver. The truck driver moved the truck forward causing the wheels of the trailer to strike the worker. Details
International (other, non-fatal)	
Worksafe NZ	**Worker suffers serious crush injuries** A trainee worker was seriously injured at a mechanical workshop when he was crushed while working under a six-tonne truck. He was working without supervision at the time of the incident. Details
National (fatal)	
DNRME Qld	**Serious accidents involving retractable hydraulic access ladders on mobile mining equipment – Mine safety bulletin no.185** A serious incident, causing the death of a coal mine worker in 2019, has been investigated and the findings will be made available to industry. The findings from the incident investigation and related incidents in Queensland and other states, suggest that significant similarities exist across the industry, requiring mine operators to audit their equipment and operating practices to ensure the lessons learnt are not forgotten. Details

PUBLICATION	ISSUE/TOPIC
National (other, non-fatal)	
DNRME	**Coal mine worker struck by load haul dump (LHD) – Mine safety alert no.370** A coal mine worker was seriously injured when he was struck by an Eimco Load Haul Dump (LHD) bucket. As the Eimco articulated, it momentarily pinned him between the side of the bucket and the rib. This resulted in crush injuries due to the impact from the Eimco bucket. Details
DNRME	**Boosters eroded by stemming material – Explosives safety alert no.100** Multiple incidents have occurred where primers (detonators and boosters) have been impacted by the aggregate material during stemming processes, causing significant erosion to the explosive's composition. 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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