

# WEEKLY INCIDENT SUMMARY

Week ending Friday 27 November 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	41
Summarised incident total	2

## Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0038712 Underground coal mine	<p>An operator was using a heavy lift loader to move a loaded shearer transporter a short distance. When negotiating a slight decline, the shearer transporter jack-knifed and snapped the tow hitch on the heavy lift loader.</p> <p>Preliminary investigation suggests that speed was a factor, as well as lack of knowledge/experience in moving heavy machinery on a decline. The investigation will determine if there was a delay in the shearer transporter brakes engaging, following application of the brakes on the heavy lift loader and if there was a requirement for a tow vehicle to assist braking.</p>	<p>It is imperative that operators have a procedure for towing heavy loads, including the weight of loads and the vehicle/s to be used.</p> <p>These procedures must refer to the OEM specifications of the towing vehicle and include road grades, road surfaces and vehicle to road surface contact.</p> <p>Operators should be trained in the requirements for towing heavy equipment, particularly in the effects of braking when on a decline and when the towed load is turning.</p>



Refer to:

[MDG 1009 - Managing road and vehicle operating areas in underground coal mines.](#)



Dangerous incident  
IncNot0038720  
Underground coal  
mine

A load haul dump vehicle (LHD) and PJB collided in an underground coal mine. Two PJBs were travelling in convoy passing the LHD that was in a cut through. The first PJB passed safely, but the LHD pulled out and collided with the second PJB. The bucket of the LHD contacted the frame of the windscreen of the PJB on the driver's side. Nobody was injured.



Lack of positive communications continues to be an issue throughout the industry.

Mine operators, supervisors and vehicle operators all have a role to play in ensuring effective communications between vehicle operators.

Mine operators must have protocols and procedures documented and implemented, including signalling when entering a roadway, and should consider proximity detection and collision avoidance technologies.

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

Refer to: [Safety Bulletin 18-06 Lack of positive communications](#)

## Resources Regulator publications

- [Safety Bulletin – SB20-05 Increased risk period](#)

## 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
	<b>International (other, non-fatal)</b>
<b>MinEx NZ</b>	<p><b>Worker injured from truck fall</b></p> <p>At the end of a shift, a dump truck operator slipped down steps while exiting his vehicle.</p> <p><a href="#">Details</a></p>
	<b>National (fatal)</b>
<b>SafeWork NSW</b>	<p><b>Tipper truck roll away - Fatality</b></p> <p>On 11 October 2020, a 50-year-old mechanic suffered fatal crush injuries in Tumut, whilst working on the brake line of a tipper truck. The worker was situated underneath the truck when it rolled forward over the worker, before coming to rest, after colliding with another parked tipper truck. <a href="#">Details</a></p>
	<b>National (other, non-fatal)</b>
<b>Qld Mines Inspectorate (Mineral Mines and Quarries)</b>	<p><b>High potential Incidents summary – September</b></p> <p><a href="#">Details</a></p>

**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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