WEEKLY INCIDENT SUMMARY

Week ending Friday 31 May 2019

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	28
Summarised incident total	9

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Serious injury IncNot0034693	A load haul dump operator suffered a fractured left cheek bone when a rib bolt hit his face while he was working in an underground coal mine. The operator was towing a sled and pulled over to the rib at an intersection to let another vehicle pass. A loose rib bolt entered the operator's cabin, hitting the operator's shoulder and face. The operator was taken to hospital and a fracture was identified in his left cheek bone.	Mines must consider roadway design when developing transport rules. Passing of vehicles in underground roadways should only be completed after considering roadway width, machine size and surrounding infrastructure.
Dangerous incident IncNot0034699	An unplanned movement occurred on a mobile elevated work platform (MEWP) at a coal handling plant. The MEWP was being trammed to a park-up area. The MEWP failed	Operators must carry out pre-use inspections of plant where defects must be recorded. When identified,

	to stop and rolled about 20 metres, coming to rest on a flat area.	defects must be assessed, and repair works planned. When defects pose a risk to the safe operation of plant, the item of plant must not be used.
Dangerous incident IncNot0034701	A light vehicle rolled in an open cut coal mine. The vehicle was exiting a crib hut park-up area. As it turned onto the road, the driver was distracted by a noise and the sun affected the driver's vision. The vehicle hit the centre island and rolled onto its side. The driver climbed out of the vehicle uninjured. 	Drivers must maintain focus on the task at hand. When there is a distraction, the driver should find a safe place to stop and address the issue rather than risk causing an incident by trying to fix the problem while driving. Roadway and intersection designs must consider all environmental factors including sunlight, fixed lighting, visibly etc.
Dangerous incident IncNot0034703	An articulated dump truck rolled in a quarry. The truck was reversing up a narrow ramp onto a clay dump. The truck slid off the ramp and overturned.	Operators should review their strategies to ensure they comply with documented traffic management plans. These strategies should incorporate effective supervision and auditing of compliance to documented arrangements.
Dangerous incident IncNot0034712	A collision occurred between a manned excavator and a dozer, which was operating autonomously. The excavator's ladder was damaged and the operator required assistance to exit the machine. The operator was not injured.	A causal investigation has commenced and further information will be provided to the industry.

Dangerous incident IncNot0034754	A fire was detected and extinguished by workers in an underground coal mine. The workers were inbye of the boot end of the drift belt when they smelled burning rubber. On investigation, they identified a return roller running in fines and reported a 'light glow' from the fines. The area was hosed down and cleaned immediately.	Operators should review the adequacy of their arrangements for eliminating or mitigating the risks associated with the accumulation of material beneath belt conveyors.
Dangerous incident IncNot0034752	A light vehicle was damaged and lost control in an open cut coal mine. The vehicle was being driven on a haul road when it hit a pile of wet material that was being cleaned up. The front left-hand wheel hit the material and separated from the vehicle. The vehicle travelled about 60 metres and came to rest on the opposite side of the road. There were no oncoming vehicles and the worker was uninjured.	When works create a potential hazard to other workers, suitable controls such as demarcation must be put in place. When workers are driving through other work areas, they must slow down to an appropriate speed.
Dangerous incident IncNot0034759	A continuous miner was working at a development panel when it unexpectedly rolled backwards. The continuous miner was working on a slope under remote control. The miner rolled backwards about 15 metres. It hit a worker, who fell underneath it. Other workers moved out of the way. No-one was injured.	Investigations are ongoing.
Dangerous incident IncNot0034760	A worker was hit by stone on a longwall face at a coal mine. A large slab of roof fell across the pan line and some pieces broke and fell into a walkway. A small piece hit an operator, bruising his leg.	Operators should review the adequacy of their safe standing zones to consider all hazards including dust, face slabbing and moving equipment.

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	**Quarry death from crane fall** On 13 May 2019, a 59-year-old supervisor, with 40 years of experience, was fatally injured when the crane he was operating fell 25 metres into the quarry. Details
MSHA	**Haul truck fatality** On 13 May 2019, a 57-year-old truck driver, with 12 years of experience, was fatally injured when his haul truck rolled over. As the vehicle was climbing a haul road, it slowed, stopped and rolled backwards. It rolled uphill, which caused it to roll-over. Details
	International (other, non-fatal)
MinEX NZ	**Loader over-balance incident** A loader was delivering a bucket full of sand to an aggregate blending stockpile. As the loader approached the mixing point, the operator began to raise the bucket in preparation to unload the bucket. The centre of gravity shifted too far forward, beyond the limits of the counterweights' effectiveness and the loader slowly came to rest on its bucket and front wheels, with the rear wheels in the air. The body of the loader was slightly off centre to the operator's right when it experienced the overbalancing event. Details
	National (fatal)
DRNME QLD	**Engineering and maintenance of mobile plant braking systems** The safety bulletin provides information on investigations by the Mines Inspectorate where deficiencies in engineering and maintenance of mobile plant braking systems have contributed to several serious and fatal incidents. It is expected that implementation of recommendations will reduce the risk of braking system failures. Details

DRNME QLD	**Hazardous area – assurance of conformity of equipment** An inspection at a drill rig operating plant identified electrical motors installed within a hazardous zone that were not ANZEx or IECEx (International Conformity Assessment Scheme) certified. 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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