

# Weekly incident summary

## Week ending Friday 21 October 2022

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	4


### Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0043240 Underground coal mine Fire or explosion	A small fire occurred at the outbye end of a longwall bootend. Workers on the face smelled smoke and found a flame about 100 mm in height. The fire was on a fist-size lump of coal.	When defects exist on equipment, additional controls should be put in place to manage any increase in risk until repairs can be completed.  Mines should review the adequacy of conveyor and strata inspections conducted of the off-walk side of conveyors.

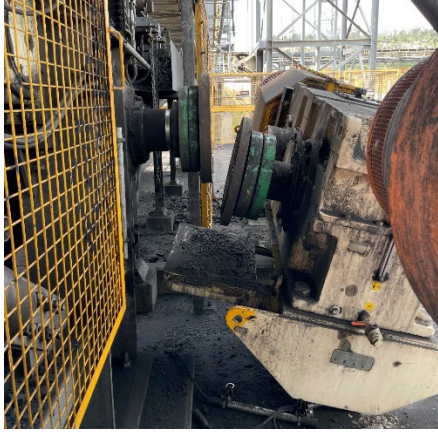





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Incident type	Summary	Comments to industry
<p>Dangerous incident IncNot0043253 Underground coal mine</p>	<p>A mechanical tradesman was directed to separate the tailgate drive from 4 roof supports. A lever hoist chain was wrapped around the relay bar clevis pin to remove it.</p> <p>Load was applied to the lever hoist and then the tailgate drive moved with a heavy lift machine. The worker then applied additional load to the lever hoist.</p> <p>The chain released from the pin and hit the worker in the face.</p> 	<p>Refer to Safety Alert <a href="#">SA22-04 Dangers of lifting and pulling activities revealed</a></p>
<p>Dangerous incident IncNot0043262 Open cut coal mine</p>	<p>Several workers were preparing to remove a conveyor drive assembly (motor, gearbox and torque arm).</p> <p>An electrician was disconnecting the motor and another worker was removing the coupling covers.</p> <p>The worker proceeded to unbolt the coupling before the assembly was slung or supported. The unit rotated forward narrowly missing the workers.</p>	<p>Before removing components, procedures must include hold points when lifting or chocking must be in place to secure loads.</p> <p>Supervisors must confirm workers understand the tasks and steps required to safely complete tasks.</p> <p>Where multiple work groups are working in the same area, risk assessments must include the interaction between the work groups.</p>

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Incident type	Summary	Comments to industry
		
<p>Dangerous incident IncNot0043272 Underground coal mine</p>	<p>A continuous miner was being prepared to be trammed out of the panel for repairs to the shovel lift cylinder and clevis.</p> <p>Due to the damage, the shovel had to be supported from the cutter boom. The cutter boom was lowered and a 10 mm chain connected to RUD lugs on either side of the shovel.</p> <p>The miner driver powered up the miner and started the hydraulic pumps and moved to what he thought was a safe place, clear of the chain on that side of the miner.</p> <p>As the cutter boom was raised, the chain failed on the opposite side of the cutter boom and flung in an arc.</p> <p>The chain hit the worker on the face and shoulder. The worker required stitches to their cheek and neck.</p> 	<p>Refer to Safety Alert <a href="#">SA2-04 Dangers of lifting and pulling activities revealed</a></p>

**Note:** Please ensure all relevant people in your organisation receive a copy of this safety alert and are informed of its content and recommendations. This safety alert should be processed in a systematic manner through the mine's information and communication process. It should also be placed on the mine's common area, such as your notice board where appropriate.

Visit our [website](#) to:

- find more safety alerts and bulletins

## Weekly incident summary week ending Friday 21 October 2022

- use our searchable safety database

If you are required to insert an image, make sure you include a caption. Position the image where it is required, right-click the image and click Insert Caption. Type your caption following the figure number, for position select below image and click OK. See example below.

### 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>National (other, non-fatal)</b>
<b>Resources Safety &amp; Health Queensland</b>	The Queensland Coal Mines Inspectorate at Resources Safety & Health Queensland has released the Incident Periodical for August 2022, which covers recent high potential incidents that have occurred. Incidents include a collision at an open cut coal mine, a CMW crush injury, fly rock incident, burns to hand, hydraulic tooling failure and dust exceedances. This report also contains information on how to report sexual assaults or harassment.  <a href="#">Details</a>
<b>Resources Safety &amp; Health Queensland</b>	Two recent high potential incidents have involved tracked heavy mobile equipment (HME) reversing into stationery light vehicles. Both incidents are still under investigation however key learnings from preliminary investigations show that the LVs had been parked within the HME operating zone and the HME operator was aware of their presence and the HME operators did not ensure that the path of travel was clear before reversing.  <a href="#">Details</a>

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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