Weekly incident summary

Week ending 16 December 2022

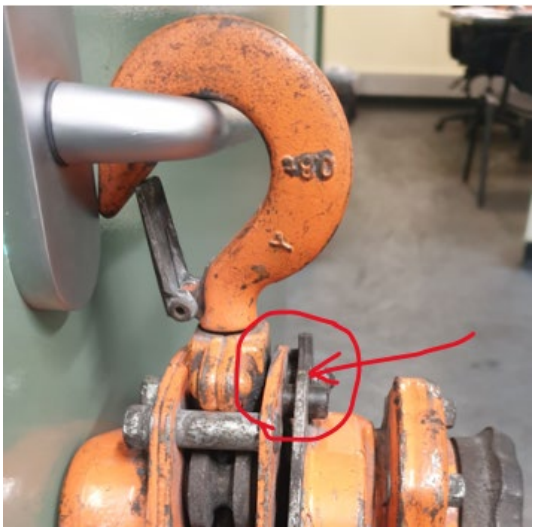
This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the NSW Resources Regulator: phone 1300 814 609 24 hours a day, 7 days a week.

At a glance

High level summary of emerging trends and our recommendations to operators.

Type	Number
Reportable incident total	49
Summarised incident total	4

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0043705 Underground coal mine	Two workers were changing rollers on a drift conveyor. The conveyor belt was lifted using 2 lever hoists and chain shorteners. While changing out the roller, the lifting gear failed, dropping the belt. One worker was hit on the shoulder and neck. The worker was cleared of injury after being assessed at hospital. The investigation identified that the lever block was not fully engaged. 	Workers must be trained to use lifting equipment before carrying out lifting activities. Workers must inspect lifting equipment for damage, defects and debris that may affect the safe use of lifting equipment before starting a lifting task. Workers must be reminded of the risk associated with working under suspended loads and controls put in place to remove the risk.

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Incident type	Summary	Comments to industry
Dangerous incident IncNot0043703 Construction materials Roads or other vehicle operating areas 	A truck was parked in the wash bay with the tailgate propped open. The driver was reaching into the body of the truck hosing out material. A second truck approached the wash bay to clean the truck body. The second truck reversed towards the first truck and hit the tailgate. As the tailgate dropped, it hit the first driver's arm. The driver was able to free their arm. The driver was taken to hospital and cleared of injury.	This incident serves as a stark reminder of the potential for fatal outcomes when working around tailgates on trucks. Please refer to Investigation report: Report into the death of Mr Stephen Norman at the Rix's Creek Coal Mine, Singleton Mines must provide safe areas for truck drivers to load, clean and park up their trucks.
High potential incident IncNot0043683 Open cut coal mine	A dozer was operating when a loud noise was heard and the dozer was suddenly engulfed in a plume of white powder. The operator stopped and inspected the dozer. The 9 kg dry chemical powder fire extinguisher was missing from the mounting bracket on the roll over protection structure. The strap was on the hydraulic oil tank. The extinguisher was found ruptured, with a vertical split, 18 metres away. From initial inspections of the failed extinguisher, the heads of the bolts on the mounting bracket rubbed on the body of the fire extinguisher. 	Mine operators should revise routine fire extinguisher inspections to confirm clearance between extinguishers and any mounting hardware. Workers tasked with inspecting fire extinguishers must thoroughly inspect extinguishers for any sign of damage.

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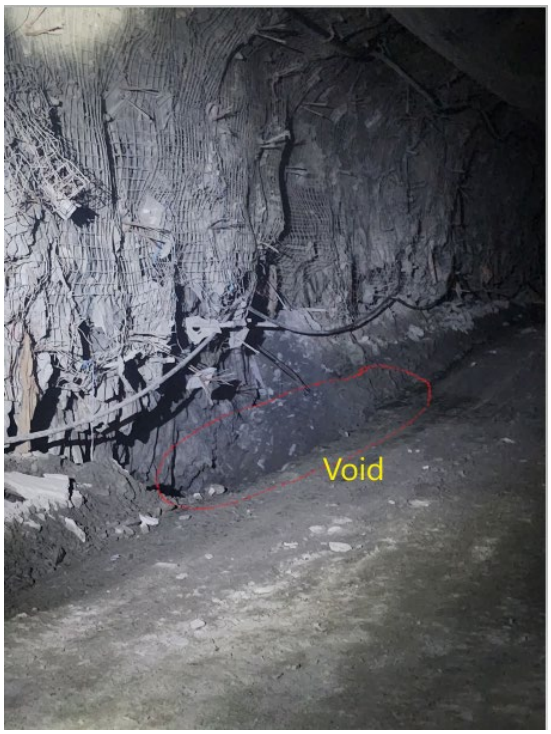
Dangerous incident IncNot0043673 Underground metals mine Ground or strata failure 	A loader operator went into the wrong draw point and proceeded to start bogging out in an underground metalliferous mine. While attending a production drill on the level above, a fitter has observed a void in the floor of the drive. The fitter and the production driller retreated from the drive and informed the shift supervisor. The area was then barricaded, and geotechnical assessment planned. 	Mine operators should use higher order controls to prevent inadvertent bogging of rills such as physical barriers.

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
- use our searchable safety database

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
	National (other, non-fatal)
Resources Safety & Health Queensland	This recent health surveillance report provides a snapshot of mine dust lung disease cases reported to RSHQ. The report includes information on the demographics of those workers with disease, such as work location, role, and length of time in the industry. The report brings into focus the importance of dust control and monitoring across a range of operational areas, not only those historically viewed as being at-risk roles or locations. Details
Resources Safety & Health Queensland	A bulldozer working on a coal stockpile dropped into a void above a conveyor feed valve point. During preparation of the stockpile for train loading, the location of the feed valve was miscalculated. The feed valve location was not available on the GPS system in the bulldozer. External reference points used by bulldozer operators to locate the feed valves were inaccurate. Coal taken through the feed valve to the load out bin created a rathole, because the void did not reach the stockpile surface. The coal bridge above the void failed beneath the weight of the bulldozer. Details
Resources Safety & Health Queensland	There have been 10 rollover incidents on Queensland sites since December 2021, including the recent stockpile dozer entrapment incident (Safety Alert 420). Three other incidents occurred at surface mines in July, October and November this year. Six similar incidents occurred between December 2021 and June 2022. These incidents occurred at nine different surface mines. Incidents have included dozers working on rehabilitation, in bulk push, during floor clean-up and during bench preparation. 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.

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