Weekly incident summary

3 week period from 17 December 2022 to 6 January 2023

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	71 (3 week period)
Summarised incident total	7

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0043823 Open cut coal Roads or other vehicle operating areas	Two haul trucks were approaching a t-intersection. The truck that had right of way observed the other truck not slowing so braked hard, stopping their truck and sounding the horn. The second truck, continued through the intersection. This truck was being driven by a trainee who was being assessed at the time.	Mines should review the triggers for when a trainee operator is assessed. This should be driven by the competence level of the trainee, familiarity with the task, the mine, and their confidence, not driven by an arbitrary number of training shifts completed, or production demands.
High potential incident IncNot0043820 Open cut coal Fire or explosion	A dump truck was being driven into a crib hut parking area when it lost power. The operator called maintenance who instructed the operator to park the truck. A mechanical tradesman was entering the park up area at the same time and saw steam coming from the engine. As they approached the truck, there was the smell of coolant, and coolant could be seen dripping under the truck. After	When lagging is used as a control for hot surfaces, joints and transitions must be managed to minimise gaps and prevent flammable fluids flowing onto hot surfaces. Where products are used near hot engine components such as cleaners and degreasers the ignition point should be

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	opening the covers, a flame was seen between the lagging on the turbo.	assessed and compared with surface temperatures to manage the risk of fires. When selecting products, higher ignition point products should be used. AS 5062:2022 Fire prevention and protection for mobile and transportable equipment was published in November 2022. Mines should review this document and update their systems and site procedures.
High potential incident IncNot0043811 Open cut coal Fire or explosion 	A contractor commenced cleaning a drill rig engine bay with degreaser. The lagging became soaked with degreaser and when some was sprayed on a gap in the lagging it ignited. The contractor yelled out to another worker on the ground who immediately got into the water cart, moved it to the side of the drill rig and extinguished the fire using the watercart's cannon. The water cart was parked at the drill to assist in cleaning.	Where products are used near hot engine components such as cleaners and degreasers the ignition point should be assessed and compared with surface temperatures to manage the risk of fires. When selecting products, higher ignition point products should be used.
Dangerous incident IncNot0043798 Open cut coal	A mechanical tradesperson was undertaking repairs to a large hydraulic excavator. When removing a retaining clamp on the accumulator charge hose, hydraulic oil was	Sites must have an energy isolation system in place to identify and control all energy sources for all equipment on

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Leave blank	released, spraying the worker on the chest and face. The worker was transported to hospital where they were assessed and cleared of injury.	site. This system must be regularly reviewed to verify is it effective. Workers must be regularly trained in the isolation procedures for equipment they are tasked to operate, maintain and repair on site. Supervisors must routinely assess whether isolations have been correctly applied as part of their worksite inspections Workers must be trained in the hydraulic oil injection protocols at the mine.
Dangerous incident IncNot0043767 Underground coal Fire or explosion	An ignition of methane gas occurred on a longwall face. The flames self-extinguished after several seconds. The investigation identified the causal factors being a rib bolt jammed in the bottom race of the armoured face conveyor (AFC) as the ignition source and a floor break emitting methane gas in the immediate area.	This incident is a reminder to mines of the risk of methane emissions from lower seams impacting the work area. Mining supervisors must continually monitor and manage ventilation dead spots and layering of methane. The risk of frictional heating caused by metallic objects and the AFC must be considered in the risk assessment for longwall operations. Sources such as strata support, and poor housekeeping should be addressed.
High potential incident IncNot0043761 Underground coal Fire or explosion	A load haul dump (LHD) was towing a supply trailer into an underground coal mine. The operator of another vehicle saw a flame on one of the off-driver's side wheels, stopped the LHD and used an extinguisher to put out the fire. Inspections identified a delaminated tyre.	An uncontrolled tyre fire in an underground coal mine can have catastrophic consequences. Tyres should be inspected closely as part of pre-use inspections. Operators should receive training to assist them in identifying tyre defects.

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		The suitability of tyres for the duty cycle must be considered. Analysis should be reviewed when changes are made to payload, operating speeds, or cycle distances. Tyre data such as the Tonnes Kilometres Per Hour (TKPH) rating should be included in this review.
Dangerous incident IncNot0043703 Open cut coal Roads or other vehicle operating areas 	A worker was tasked with creating a park up area in a new work area at an open cut coal mine. The operator of a dozer reversed into and crushed the light vehicle they drove to the area. There were no other workers in the vehicle or working in the area at the time. 	Mines should review their park up procedures when workers are accessing parts of the mine without designated park up areas. Operators must always remain vigilant and focused on the area surrounding the machinery they are operating. Please refer to the Investigation report and animation video of the fatal incident that occurred in 2019 involving a dozer and light vehicle.

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:

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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 (fatal)
WorkSafe Victoria	A worker has died while operating a telehandler at Willaura, south of Ararat, last Thursday. It is understood the 55-year-old was using the telehandler to move a large steel door frame when the load fell and struck him about 2pm. WorkSafe is investigating. This brings the workplace fatality toll to 55 for 2022, 20 fewer than at the same time last year. Read more
	National (other, non-fatal)
Resources Safety & Health Queensland	QLD - Tyre explosion on rear dump truck following lightning strike A short but significant storm passed across a mine during day shift operations. Surface trucking operations were halted, and operators were instructed to park machines. Personnel were transported to crib and office facilities until the storm passed. Upon returning to the parking areas to resume operations, workers discovered the tyres (positions 3, 4 and 5) on a rear dump truck had exploded. The explosion caused tyre fragments to project into the general park up area and nearby mine road, and a rock ejector was found approximately 10 metres away from the machine. It is believed a lightning strike during the storm caused internal pyrolysis on the tyres leading to the explosions. Read more

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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