Weekly incident summary

Week ending 13 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	30
Summarised incident total	4

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0043849 Underground coal Roads or other vehicle operating areas 	While positioning a large air conditioner unit on top of a transformer, a worker suffered a serious finger laceration that required surgery.	When large components are being moved or positioned by workers, suitable mechanical aids and task-sequencing should be used to reduce the workers' exposure to pinch points and manual handling injuries.
Dangerous incident IncNot0043846 Underground coal	A worker was struck on the head and shoulder by a falling pallet that was stacked with diesel particulate filters. One pallet had been stacked on another and other workers had been removing filters from the lower pallet.	Mines should review their practices for stacking filters and other consumables. Workers must consider the stability of stacked pallets when removing items so as not to pose a hazard to other workers.

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Incident type	Summary	Comments to industry
		
High potential incident IncNot0043845 Mineral sands Fire or explosion 	A large tractor was working on rehab carting topsoil. Fluid sprayed from the engine bay over the windscreen and shortly after flames appeared around the engine. The operator received minor burns to their wrist and was taken to hospital for assessment. Several nearby workers immediately rendered assistance and attempted to extinguish the fire. The workers were unable to directly raise the emergency and relied on another worker to relay the emergency message. The mine's emergency response team responded with a fire tender, and water carts were used to extinguish the fire. The tractor was destroyed. 	An investigation into this incident has commenced and further information may be released in the future. Mines must ensure all work groups have suitable means to raise emergencies, including when working in isolated or locations remote from mine infrastructure.

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Incident type	Summary	Comments to industry
		
High potential incident IncNot0043811 Open cut coal Roads or other vehicle operating areas 	The operator of a loaded haul truck was using a two-way radio while descending a ramp. The operator failed to control the speed of the truck and could not stop. The operator drove through an intersection and into a flat park-up area beside a crib room. The truck was safely brought to a stop. Another truck was approaching the intersection and was 40 metres away, no other workers or vehicles were in the park-up area. The worker had only recently been deemed competent to operate a haul truck.	When operating machinery, workers' primary focus must remain on the operation and control of the plant or vehicle. Interactions with radios, dispatch systems and vehicle controls should only occur when safe to do so. Mines should review the triggers for competency assessment and the minimum level of competence required before workers are authorised for solo operations.

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

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
	National (other, non-fatal)
Resources Safety & Health Queensland	On 27 July 2020 two coal mine workers (CMWs) received serious injuries from rib spall while working on a continuous miner (CM) in an underground development panel heading. The incident occurred as the CMWs were installing roof support and extending ventilation tubes. The Inspectorate's investigation into the incident identified that the rib protection installed on the fleet of CM did not provide effective protection from rib spall to CMWs and the mine had a fleet of three CM supported by two different original equipment manufacturers. 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.

Document control	
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