Weekly incident summary

Week ending 20 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	42
Summarised incident total	7

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0043912 Construction materials Roads or other vehicle operating areas 	A worker reversed a fuel truck up a grade and parked the truck with the wheels turned. The worker applied the park brake, engaged the PTO for the fuel pump and left the engine running. The truck rolled away when the worker started refuelling. The truck rolled 8 metres, hitting an A frame of a mobile stacker. The worker was exposed to a risk of serious injury.	Workers should ensure their vehicles are parked appropriately and are fundamentally stable before exiting them. For areas where mobile plant is regularly required to park, level park-up areas should be provided.

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	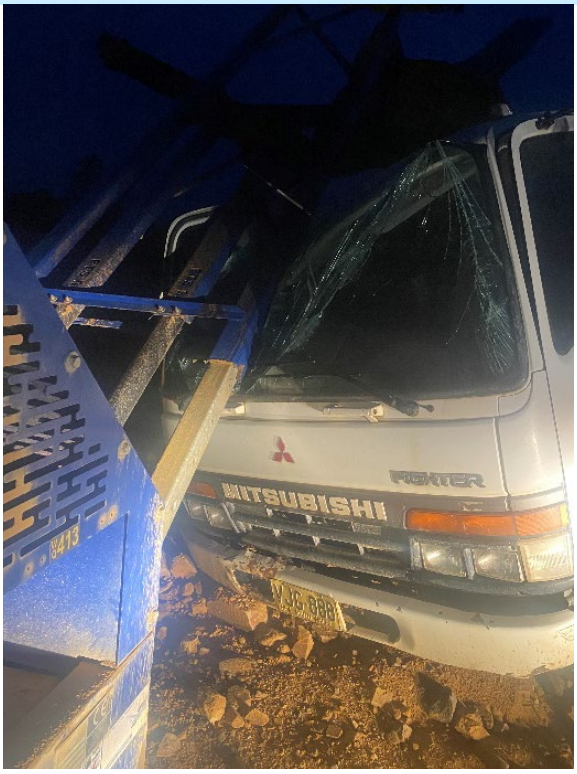	
Dangerous incident IncNot0043911 Underground coal	Two workers were operating an air track drill rig installing 8 metre roof bolts. They had finished drilling a hole when the steels bogged. The hole was over drilled but the drill steels remained stuck. There was insufficient drill steel exposed for the gripper jaws to grab them. A timber jack was lowered about 400 mm. A worker climbed a ladder and tried pulling the steels out of the roof by hand. The steels released and dropped, crushing the worker's fifth finger on the timber jack. The tip of the finger was severed.	Workers should never place their hands between suspended drill steels and bolting rigs. Mine operators must provide sufficient information, training, and instruction for all reasonably foreseeable tasks that a worker may be expected to complete. Where formalised procedures are not provided, workers are expected to be appropriately supervised and take a risk-managed approach when undertaking these tasks.
High potential incident IncNot0043888 Underground coal Fire or explosion 	A crew was setting up to install roof and rib support from a mobile bolter in an underground coal mine. A battery impact driver was found, which was immediately removed from the mine.	Battery-operated tools should only be used when alternative, lower risk tools, are not reasonably practicable. The hierarchy of control measures must be applied when determining what type of tools should be used for a task. When battery-powered tools have been risk assessed as the lowest reasonably practicable risk option, mine operators must have systems of work, such as a portable electrical apparatus scheme, in place to manage introduction to site, inspection,

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		maintenance, and use of battery-operated tools.
Dangerous incident IncNot0043877 Open cut coal Roads or other vehicle operating areas 	A haul truck was stopped at a give way sign at an intersection. Another haul truck was approaching with a light vehicle in convoy. After the haul truck passed the intersection, the stationary truck began to move forward, turning right into the path of the light vehicle. The light vehicle operator was distracted while looking for the two-way approaching the intersection and when looking up had to take evasive action to avoid a collision. The proximity detection system alarmed. 	Workers must ensure that intersections are clear before proceeding. Mine operators should take a risk-managed approach considering the hierarchy of controls when reviewing their principal hazard management plans to ensure that all workers show appropriate situational awareness of their surroundings and other vehicles on the road. Mine operators should have regard for human and organisational factors when reviewing the number of systems devices that may alarm in haul trucks. Mine operators should assess the risk of white noise and desensitising workers to alarms.
High potential incident IncNot0043872 Underground coal Fire or explosion 	A battery-operated drill was being used in an underground coal mine while building a ventilation stopping. A spark was observed inside the vents at the rear of a battery rattle gun.	When battery-operated tools are used in hazardous zones of an underground coal mine, procedures must include the requirements of section 82 of the Work Health and Safety (Mines and Petroleum Sites) Regulations, additionally, only brushless motors should be used to avoid the possibility of sparking. A safety bulletin was recently released about batteries and charging, please refer to SB22-17 Fires on battery powered tools increase
High potential incident IncNot0043870 Open cut coal Roads or other vehicle operating areas	A Caterpillar D10 dozer was inoperable and required towing to an inpit maintenance area, which was several hundred metres down a ramp. A JHA was completed and required a D11 dozer and a large wheel loader to carry out the task. The D10 dozer would be unmanned for the task. The wheel loader was not available so a 36-tonne excavator was used instead. The JHA was not reviewed. The task commenced and, in the process, the sling attached to the excavator broke. The inoperable dozer rolled 19 metres until the slack	When changes are required to procedures, workers must stop, assess the risk of the changes and raise the matter with their supervisor. When towing mobile plant, the attachment method must be suitably rated and slings securely attached to both vehicles involved. Slings must not be pulled over sharp edges.

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	was taken up by the D11 dozer. While the D11 dozer was repositioning, the sling slipped off the ripper. The D10 dozer then rolled approximate 230 metres down a ramp. The dozer stopped when it struck a windrow. 	
High potential incident IncNot0043869 Underground coal Roads or other vehicle operating areas 	A shuttle car became bogged in an intersection. A load haul dump (LHD) was brought into the intersection to assist recovery. A safety chain fitted to the LHD was attached to the shuttle car. While attempting to free the shuttle car, a RUD lug broke the weld and flung towards the shuttle car. Two operators were hit in the legs. One worker suffered a laceration that required stitches. The other worker had no injuries. 	Safe standing zones must be identified and communicated before towing and snigging activities commence. Attachment points on mobile equipment must only be used for the purpose intended by the equipment designer. Attachment points must be maintained and should undergo regular non-destructive testing.

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

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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)
Worksafe Victoria	WorkSafe is urging employers to ensure all machinery is properly guarded and operated safely to avoid the risk of life-changing amputation injuries. In 2022 WorkSafe accepted 137 claims for workplace amputation injuries, with more than 150 body parts amputated, including at least 127 fingers or thumbs. Digits caught or crushed in machinery or severed while using a saw accounted for about one third of all amputation claims. WorkSafe Executive Director of Health and Safety Narelle Beer said, "Employers need to make sure safety guards are fixed to machines at all times, and that staff are appropriately trained and supervised to undertake all tasks safely". 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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