

# Weekly incident summary

## Week ending 9 June 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.

Туре	Number
Reportable incident total	31
Summarised incident total	5

### Summarised incidents

## Incident type

Dangerous Incident IncNot0044848

Open cut coal mine

Roads or other vehicle operating areas



#### Summary

A haul truck was parked in a queue. A second haul truck approached and came to a stop. The truck then started moving forward and collided with the first truck (nose-to-tail collision). The worker in the second truck was uninjured but could not exit the truck due to damage to the ladder.



#### Comments to industry

Workers have a duty to take reasonable care for themselves and others while in the workplace. This includes staying alert, being aware of their surroundings, and maintaining control of the plant and machinery they operate.

Workers are also reminded that as part of their duty, they must comply with reasonable instructions and procedures of the workplace. Following parking procedures and fatigue management policies is considered reasonable. Fatigue policies require workers to arrive at work rested and ready for a full shift and reporting fatigue events as they occur.

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#### Incident type

Dangerous Incident IncNot0044847

Underground metalliferous mine

Roads or other vehicle operating areas



#### Summary

A shotfirer was returning some leftover packaged explosives to an underground magazine. The vehicle had 27 plugs of 700 mm packaged explosives onboard. The worker parked outside the underground magazine and left the vehicle to open the gate. The vehicle started to roll backwards. The worker tried to get back in the vehicle but tripped and fell. The vehicle ended up travelling about 80 metres before hitting a wall and becoming wedged across the drive. The explosives were recovered and stored in the magazine and the scene was preserved.



#### Comments to industry

When implementing controls for safe parking, mine operators should follow the hierarchy of controls. Engineering controls such as fail-safe brakes and door interlocks should be considered before resorting to procedural controls. Regardless of the engineering controls fitted, workers should always park fundamentally stable. This may include parking on level ground or parked with the wheels turned into the mine wall.

Mine operators and supervisors should routinely verify controls contained within their principal hazard management plans for road or other vehicle operating areas. Checks should confirm that controls are fit-for-purpose, suitable for the nature and duration of the work, and installed, set up, and used correctly.

Under no circumstances should a worker ever attempt to reenter a runaway vehicle.

Dangerous Incident IncNot0044839 Open cut coal mine Ground or strata failure



After being loaded, a haul truck moved off from a dig face. The area being mined was directly over underground workings. As the truck drove over an underground intersection, the ground slumped underneath the rear left-hand side wheels. The truck came to rest with its front 2 wheels off the ground. The operator remained on the truck and was helped down with an elevated work platform.



When procedural checks are the only method used to verify a control, this should be documented and recorded. These records should be accessible to supervisors across shifts.

Mine operators are reminded the NSW Emergency Management Plan, via the Mine Sub Plan, are required to notify NSW Police as soon as they become aware a rescue is required.

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#### Incident type

#### Summary

#### Comments to industry

Dangerous Incident IncNot0044814 Open cut coal mine Workers were changing out a front wheel hub assembly on a haul truck in a workshop. While removing the hub from the taper, the assembly unexpectantly moved. The assembly was fixed to a frame that was sitting on the tynes of a telehandler. The tynes dropped when the load moved. A worker in close proximity was hit in the face. The worker suffered minor grazing.

Photog



When removing components that may release instantaneously (such as those on a taper), controls must be in place to protect workers from the sudden release of energy. This may include using a boss and retaining bolts, timber packing, restraining slings or strops. If forklifts and telehandlers are used, the impact of pneumatic tyres and boom extension should be considered when assessing movement of the load.

Dangerous Incident IncNot0044813

Open cut metalliferous mine

Ground or strata failure



A dozer was working on a main ramp directly above a drill working below. The dozer dislodged some material that fell about 55 metres to the working level below. It is estimated that 100 kg of material fell. The material broke up and 2 of the rocks hit a blast hole drill rig working below. One rock landed on top of a car body of the machine and the other hit the rear window of the operator's cabin, smashing the glass. The worker was off the drill at the time of the impact and was standing about 30 metres away from the drill. Nobody was injured.

Catch bunds should be in place wherever possible.

When work is being carried out above other work areas, no-go zones should be established considering the type of work, height between work areas and suitable stand-off distances.

When working against high walls and faces, no work should occur directly above.

Autonomous drill rigs remove the workers from the risk of falling objects when working near highwalls and faces.

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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.

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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