

Weekly incident summary

Week ending 10 March 2023

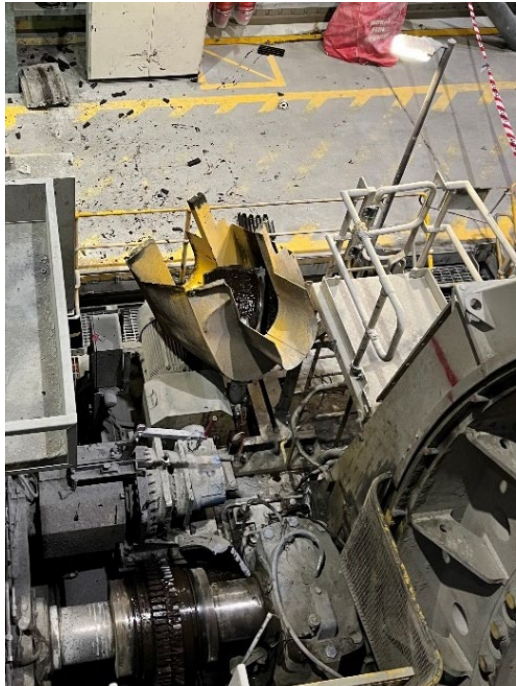
This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the NSW Resources Regulator: phone 1300 814 609 24 hours a day, 7 days a week.

At a glance




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

Type	Number
Reportable incident total	50
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0044271 Underground metal mine		<p>Condition monitoring plans should be reviewed for the rotation plant. Triggers for additional monitoring or further action should be reviewed.</p> <p>Where guarding is a control measure, it should be assessed if the guard is to prevent entanglement or if the guard is to prevent the ejection of components. Where guarding is to protect from component ejection, the energies involved should be considered as part of the guard design.</p>

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Incident type	Summary	Comments to industry
<p>Dangerous incident IncNot0044226 Underground coal mine Roads or other vehicle operating areas</p> 	<p>A shuttle car was side loading at a feeder breaker while another car was queued on the opposite side. A third car approached the feeder to end load. As the car approached the feeder the worker's foot slipped, hit the accelerator and the car lurched forward. The boom struck the boom of the first car that was still unloading. The worker driving the first shuttle car was thrown around in the cab. The worker was in some pain and was taken to hospital by ambulance. The worker suffered an injury to their knee.</p>	<p>Operational pre-use checks should include the cleanliness of operator controls. Maintenance inspections should test the function and cleanliness of controls and operator compartments.</p>
<p>Dangerous incident IncNot0044279 Open cut coal mine Roads or other vehicle operating areas</p> 	<p>A dozer was cutting down a dump at a coal mine. As there was a water body below the dump, the trigger action response plan (TARP) required a double windrow and stand-off from the edge. The operator started dump edge cutting (slot push). The operator cut down to a point where the dozer was unable to reverse back up the slope.</p> <p>The operator decided to continue down the slope towards the water body. The dozer stopped when the blade made contact with the ground in the water. The water was about one metre deep. The worker was uninjured. The Emergency Response Team assisted the worker back up the slope.</p> 	<p>When stand-off distances are specified in procedures, workers must abide by them and protect themselves from further hazards.</p> <p>Supervisors must continually monitor worker compliance with procedures and the controls specified such as windrows and stand-off distances.</p>

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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Other Resources Regulator publications

Review of human and organisational factors

Fact sheet – Structural collapse metalliferous mines

Structural collapse is a hazard which can occur within various mining environments and has the potential to cause serious and/or fatal injuries to workers if not controlled effectively. This factsheet is primarily based on the critical controls for the risk of structural collapse within the metalliferous and quarry sectors and should be considered by mine operators when assessing the risk at their operation.

Guide: Managing risk of subsidence - Updated

This guide provides practical guidance to assist the mine operator of an underground coal mine in:

- 1) complying with their obligations under the WHS laws¹ in relation to subsidence, and
- 2) identifying and controlling hazards that may cause harm to people from subsidence through the development and implementation of a principal hazard management plan (PHMP) or risk management in accordance with a high-risk activity (HRA) notification.

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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