

Weekly incident summary

Week ending 15 December 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	40
Summarised incident total	2

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0046005 Underground coal mine	<p>A driller's offsider had an index finger amputated when their hand was caught between the end of a drill rod and the rib.</p> <p>The injury occurred when the offsider offered the next drill rod up to the gas drainage rig feed frame and positioned their hand between the end of the drill rod and the rib.</p> <p>The driller encountered a band while drilling and pulled the drill motor back about 30 cm in order not to block the drill. The back movement of the drill motor made contact with the drill rod being held by the offsider, crushing their hand between the end of the rod and the rib.</p>	<p>Under no circumstances should any person enter the zone directly behind the drill steel line-of-fire positions while gas drainage rigs are operating.</p> <p>Incidents such as this serve as a reminder of the need to have no-go zones and/or safe standing zones in place when drill rigs are operating.</p>

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Incident type	Summary	Comments to industry
		
<p>Dangerous incident IncNot0046019 Open cut coal mine</p>	<p>The rim of a haul truck tyre ejected from the tyre while the tyre was on the ground being inflated. The tyre was being inflated after having the rim O-ring seals replaced. The rim weighing about 2.5 tonnes was ejected about 300 mm above the tyre.</p> <p>The technician was about 5 m from the tyre when the rim ejected. The technician was having some difficulty trying to get the tyre to seal, possibly due to a leaking O-ring. The pressure was reported to be just above 10 psi at the time.</p> 	<p>The dangers associated with tyre handling are well understood and mine operators should ensure that their procedures have identified the risk of uncontrolled ejection of a rim from a tyre, and that appropriate controls are in place to manage the risk.</p>

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
<p>Resources Safety & Health Queensland</p>	<p>National (other, non-fatal)</p> <p>On the night shift prior to the incident, coal mine workers and their supervisors were dealing with water ingress into the working area. A body of water at the far end of the pit was held back by a solid coal rib. The night shift operators took a first cut of</p>

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Publication	Issue/topic
	<p>approximately 4 metres in depth in front of the coal rib. As water entered the working area, a decision was made to reduce the cut depth to 3 metres and continue to raise it in a sloped manner as the water level increased. At the end of the night shift, a bund was installed to delineate the areas affected by water and the areas still dry and available for mining. Before the day shift started, the edge created by the change in cut height was completely concealed by water. The day shift dozer operator walked the bulldozer through the bund and entered the body of water. As the machine walked further towards the back of the pit it fell off the water covered edge that had been created by the night shift mining activities.</p> <p>Details</p>
Resources Safety & Health Queensland	<p>A number of incidents have occurred recently in underground coal mines where remote-controlled mining equipment continued operating for a short period of time without ceasing operation on command. In one incident, coal mines workers were operating remote-controlled mining equipment and were using the function on the remote. The machine continued to operate for a short period of time resulting in an unplanned movement/failure to stop.</p> <p>Key issues:</p> <ul style="list-style-type: none"> The remote-control actuators were found to be stuck in the operating position due to the ingress of foreign material into the remote-control actuators. <p>Details</p>

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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