Weekly incident summary

Week ending 21 July 2024

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	39
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
High potential incident IncNot0047286 Coal handling and preparation	A piece of alsynite cladding fell and landed near a worker while undertaking work within a construction project area at a CHPP. The cladding fell from the north-western side of the plant at the height of 12 metres. The sheeting was alsynite material, 800 mm x 1200 mm and 4.05 kg and it fell approximately 12 m. It is important to note the variable effect of an object like cladding in a fall from height scenario and energy from falling mass should not be considered in isolation only. Cladding can be accelerated by wind. The weather was windy on the day with recorded gusts around 30 kph or 8.3metres per second. The cladding landed in an accessible area and could have cut or lacerated a person potentially causing soft tissue damage or knocking workers to the ground.	This high potential incident is a reminder to mine operators that we are heading into the windiest time of year for the east coast of Australia. The Resources Regulator usually sees an increase in incident reports of this nature when the wind is strong. Mine operators are reminded to take a risk-managed approach to building maintenance that considers age of infrastructure, predicted weathering and maintenance/inspection frequency.

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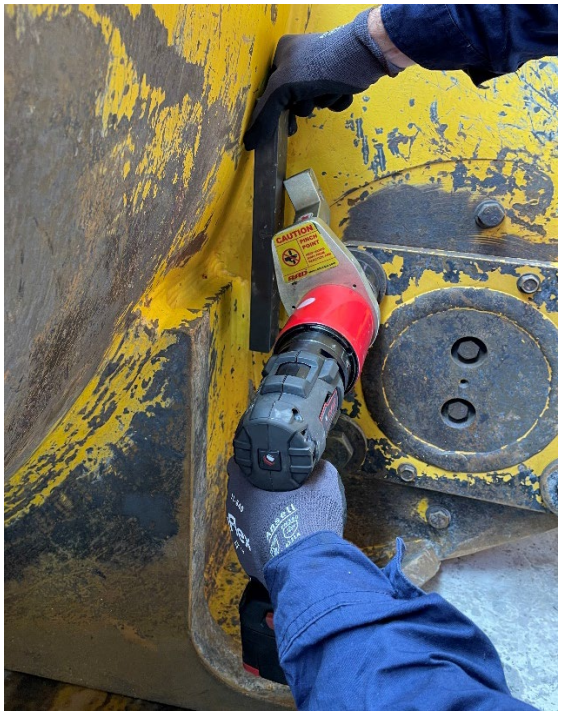
Incident type	Summary	Comments to industry
		
High potential incident IncNot 0047289 Open cut coal mine Roads or other vehicle operating areas 	An empty CAT789 truck was descending a ramp. Rain had started to fall about 30 minutes earlier. As the operator rounded a left-hand bend towards the bottom of the ramp the truck lost traction at slow speed, resulting in the truck sliding about 50 m down the ramp, crossing the centre line, and ending up rotating 90 degrees. 	Situational awareness is a key control when operating mobile equipment. Adequate supervision, training, job planning and risk assessments should be considered and completed before undertaking tasks. Procedures to assess the adverse effects caused by changes in weather and road conditions should be communicated to workers and implemented to prevent incidents. Following a recent awareness campaign on vehicle interactions the Regulator published a video that can be used for training purposes and toolbox talks. Mine operators are encouraged to use this resource. You can watch the video on YouTube.
High potential incident IncNot 0047281 Open cut coal mine	A mechanical tradesperson was removing the bucket pins from a front-end loader during a bucket change out. He attempted to remove one of the pin cap retaining bolts with an impact wrench but could not loosen the bolt. He obtained a battery powered torque wrench to complete the task. When setting up the torque wrench on the bolt he was attempting to remove he determined that the torque reaction arm required packing for it to engage against the back of the bucket. He obtained a piece of steel for this purpose.	There were 2 incidents this week involving inadvertent operation of battery powered torque wrenches. Both incidents were very similar in cause and circumstance. Workers are reminded that they should only use mechanical equipment if they are trained and competent. Equipment should only be used in the manner intended by the original equipment

Incident type	Summary	Comments to industry
	While positioning the steel packer with his right hand between the torque arm and the bucket he inadvertently operated the torque wrench trigger with his left hand causing the reaction arm to rotate against the steel packing. His thumb was between the steel packing and the bucket, resulting in a crush injury. 	manufacturer (OEM) and described in the mine operator's procedure. Mine operators must ensure that their mechanical trades are trained and competent to operate the equipment available to them. Mine operators must also ensue that appropriately risk assessed procedures are available to tradespeople during planned maintenance activities.

Other publications of interest

The incidents are included for your review. The 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
	International (fatal)
MSHA	**Fatality, 20 April 2023 - Machinery, final report** On April 20, 2023, at 12.58pm, Philip Heymann, a 59-year-old contract laborer with over 32 years of mining experience, died when a side plate being removed from a shaker screen fell on him. The accident occurred because the mine operator and the contractor did not: 1) ensure the side plate being removed was blocked against motion 2) provide task training for the disassembly of the shaker screen, and 3) ensure the contractor crew followed the Surface Safety Handbook Details

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Publication	Issue/topic
MSHA	**Fatality, 2 January 2024 - Powered haulage, final report** On January 2, 2024, at 4.46am, a 46-year-old customer truck driver with 19 years of over-the-road truck driving experience, died when his truck's trailer tipped over onto the cab of the truck. The truck driver was in the process of unloading excess material from the trailer when the accident occurred. The accident occurred because the truck did not properly align the truck and trailer prior to raising the trailer to unload the excess material. Details
	National (other, non-fatal)
Business Queensland	**QLD - Report: Incident periodical for June 2024 - coal inspectorate** This month RSHQ have more examples of the inability of mine investigation outcomes to prevent repeating incidents: 1. Vehicle rollovers 2. Lifting and slinging failure 3. Working over stockpile valves 4. Collisions. 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.

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