Weekly incident summary

Week ending 1 March 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	51
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0046451 Underground coal mine	While standing on a longwall maingate, a deputy noticed a burning smell and identified 4 ppm carbon monoxide on a Drager X-am gas detector. The deputy travelled outbye to investigate and found a small ball of material about 20 cm diameter burning on top of the return belt. This was then extinguished with a fire extinguisher. The cause of the fire was a troughing idler failure.	Mine operators must have systems to identify and change-out defective conveyor rollers. Workers conducting conveyor inspections must be aware of the increased risk of roller failure at high tension areas of conveyors. They must also diligently inspect for fire risks such as accumulation of material, failing or collapsed idlers and contact between conveyor belts and fixed structures.

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Incident type	Summary	Comments to industry
		
Serious injury IncNot0046449 Construction materials	A forklift operator was lifting a cab off a truck when the headboard and fork came off the forklift and fell on an offsider, pinning him to ground. The offsider suffered a broken leg and 3 fractured vertebrae. 	This incident is under investigation and further information may be published later.
Dangerous incident IncNot0046452 Metals mine	An operator lost control of a haul truck when leaning down to pick up a water bottle. The 2 front wheels ended up over a bund where there was a 1.5 m drop into bush land.	Inattention and distraction while driving can have fatal consequences. Drivers should remain focused on the task at hand and not be distracted while driving. Drivers should find a safe place to stop and address any issues, rather than continuing to drive.

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		Principal hazard management plans for roads or other vehicle operating areas should consider all factors that may affect operator concentration. Collision detection and avoidance systems, visual aids and segregation should be implemented before relying on procedural controls.

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 (fatal)
Business Queensland	Resources Safety and Health Queensland has published an investigation report into the death of a Queensland mine worker who suffered fatal injuries when he fell from the roof of a workshop at Red October Mine in 2022. At 9:15am on Saturday 26 November 2022, Ronald Selig suffered fatal injuries when he fell 5.8 m from the roof of a workshop to the ground. Mr Selig had been undertaking repairs to the roof of a workshop that was damaged during severe weather. While Mr Selig was walking along the damaged roof line, the ridge purlin gave way, causing Mr Selig to fall through the roof sheeting to the ground. 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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Document control	
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