Weekly incident summary

Week ending 10 May 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	38
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0046876 Open cut coal mine Fire or explosion 	An excavator operator noticed excess oil on top of the stairs and the engine compartment of the excavator. Fitters attended to degrease the oil spill, which occurred from a failed hose. The fitters put degreaser on the roof of the engine compartment to clean up the excess oil. When they went into the engine room, they saw degreaser dripping through the roof. The degreaser fell onto a hot exhaust manifold and started a fire. The fitters exited the engine room, passed the fire and activated the fire suppression system.	Where products such as cleaners and degreasers are used near hot engine components, the ignition point should be assessed and compared with surface temperatures to manage the risk of fires. When selecting products, higher ignition point products should be used. AS 5062:2022 Fire prevention and protection for mobile and transportable equipment was published in November 2022. Mine operators should review this document and update their systems and site procedures.

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Incident type	Summary	Comments to industry
	 	
Dangerous incident IncNot0046873 Underground coal mine Ground or strata failure 	A breakaway was being cut in an intersection with a continuous miner. The miner commenced cutting the breakaway and in doing so, a rib mesh sheet was caught on the miner apron. The mesh was damaged in between the rib bolts. The miner was flited outbye to continue cutting the turn and a vent tube was required to be recovered. As the vent tube was being recovered, the rib slumped between the 2 sets of rib bolts and damaged the mesh, hitting a worker on the left foot and lacerating his toes.	Mine operators should have a procedure in place to assess the risk of slumping, following damage to rib mesh, particularly when the mesh has been torn and exposes the rib. Workers must remain aware of strata conditions.

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Incident type	Summary	Comments to industry
	 	
Dangerous incident IncNot0046869 Underground metals mine Roads or other vehicle operating areas	A haul truck collided head-on with the wall of a decline when the steering function failed because of fluid loss from a damaged hydraulic hose. The operator was uninjured.	Safety critical systems such as braking and steering systems should be inspected, maintained and tested in accordance with the manufacturer's recommendations. Mine operators must develop and adhere to strict inspection and maintenance standards and practices to prevent loss of fluid due to loose fittings or damaged hoses. Operators should review their maintenance procedures to ensure commissioning checks are carried out by competent people before plant is returned to service as fit-for-purpose.

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Incident type	Summary	Comments to industry
		

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
	International (fatal)
MSHA	On December 14, 2023, at 2:40pm, Jay Swaffar, a 56-year-old BEST Electric shop assistant with no mining experience, died when an all-terrain telehandler, being used to pull electrical cable, tipped over and hit him. The accident occurred because BEST Electric did not: • ensure proper task training was provided to the miner operating the telehandler, • ensure the telehandler operator-maintained control of the equipment, and • ensure the telehandler was not being used beyond the design capacity intended by the manufacturer where such use may create a hazard to persons. Details
MSHA	On February 6, 2023, at 3:45pm, Javier Regalado-Cano, a 61-year-old haul truck driver with over a year of mining experience, was fatally injured when he suffered an electric shock. While Regalado-Cano was operating a haul truck, he raised the bed of the haul truck into the energised overhead 13,800-volt phase-to-phase power lines. Regalado exited the haul truck and extinguished a fire on the haul truck's left rear dual tires. Regalado suffered an electric shock when he made contact with the energised haul truck while re-entering it. The accident occurred because the mine operator did not: • install warning devices for the power lines, and

Publication	Issue/topic
	• de-energise or take other precautionary measures when mobile equipment was operating near energised power lines. Details
	National (other, non-fatal)
WorkSafe Victoria	An employee was working as an underground drill operator. He was injured when he used a hardened steel hammer to strike a hardened steel drill shank. The employee was trying to separate jammed drill consumables by striking the shank. He was hurt when the hammer shattered on impact. Steel fragments hit one of the employee's legs, penetrating 4 cm. He required surgery to remove the fragments. Using hardened steel tools on hardened steel can cause the steel to shatter or splinter. Steel fragments can fly off at high speed and cause injuries or death. To control risks: • identify and assess hazards • use alternative non-hardened steel tools if possible • regularly inspect tools for damage and fatigue • ensure employees wear appropriate PPE. 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.

Document control	
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