

Weekly incident summary

Week ending 17 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	40
Summarised incident total	2

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0046914 Underground metals mine Roads or other vehicle operating areas	<p>A 90 tonne excavator was tracking parallel to a bench. While in transit, the embankment under the left track of the excavator gave way. The operator observed material moving in the rear vision mirror, exited the vehicle and reported the incident to the area supervisor.</p> 	<p>Situational awareness is a key control when operating mobile equipment. Adequate supervision, training, risk assessments and job planning are to be completed before undertaking tasks.</p>



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Incident type	Summary	Comments to industry
<p>Dangerous incident</p> <p>IncNot0046906</p> <p>Underground coal mine</p> <p>Ground or strata failure</p> 	<p>While in the bolting cycle at a longwall shield, a slab of coal fell from the face and toppled into the work area and onto the armoured face conveyor (AFC). The coal slab landed about one metre from the hand bolter.</p> <p>An operator was 2 metres from the coal slab's final position, standing under an adjacent shield. The dimensions of the coal slab were one metre by 0.7 m by 0.4 m.</p> <p>The top of the spalled coal released from a height of about 2 m.</p> 	<p>Mine operators must ensure that workers are provided with adequate information, training and instruction in relation to hazards associated with ground and strata failure.</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
	International (fatal)
MSHA	<p>On April 15, 2024, a miner died when the tail section of a collapsible belt conveyor fell and pinned him between the tail section and the middle section. The miner was working as part of a crew to tear down the conveyor in preparation to be moved.</p> <p>Best practices:</p> <ul style="list-style-type: none"> • Block all equipment against hazardous motion before beginning work. • Stay clear of suspended loads. • Never enter or work in pinch points or red zones around equipment. • Identify hazards associated with the task. Review those hazards with all miners involved, and implement measures to protect miners. • Train all miners in the safe performance of tasks. <p>Details</p>

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Publication	Issue/topic
	International (other, non-fatal)
MSHA	<p>On 11 April 2024, a continuous personal dust monitor (CPDM) was placed on top of a continuous mining machine and was hit by a rock that fell about 1.8 m. Immediately after impact, miners reported flames coming from the device, followed by an explosion and larger flames encompassing the unit for a short period of time before extinguishing. Many devices, such as the CPDM, hand-held radios, cell phones, and cap lamps are powered by lithium batteries. When designed, manufactured, used, and maintained properly, lithium and other battery sources for these hand-held devices are a safe power source.</p> <p>Best practices:</p> <ul style="list-style-type: none"> • Ensure miners appropriately use and protect lithium battery-powered devices from unusual and excessive heat, stress, impacts, and other hazards. • Conduct workplace examinations and eliminate hazardous conditions. • Control roof, face, and ribs where persons work or travel. • Train miners in the use and proper care of lithium battery-powered equipment including the proper use of PPE. • Follow manufacturer's instructions for storage, use, charging, and maintenance of lithium batteries. • Keep fire extinguishing equipment readily available. <p>Details</p>
	National (other, non-fatal)
Resources Safety & Health Queensland	<p>Safety bulletin: Worker loses consciousness following the inhalation of nitrogen supplied through an air-line helmet respirator.</p> <p>How did it happen?</p> <ul style="list-style-type: none"> • On 26 April 2024, a contractor boilermaker, was setting up for a hot work task and attached their air-line welding helmet respirator to a nitrogen line. • The worker put on their air-line welding helmet and fell to the ground. • Other workers in proximity saw the worker fall and went to their aid. <p>Key issues</p> <ul style="list-style-type: none"> • The worker inhaled nitrogen through their air-line welding helmet respirator. • Boilermakers are often tasked with connecting air-line welding helmet respirators to compressed air lines. • Nitrogen lines at this site were previously charged with compressed air. • The fittings on the nitrogen lines were the same as the air-line helmet fittings. • Air-line helmet respirators are not authorised for use in this part of the workplace. • The nitrogen supply pipework was clearly labelled as being nitrogen. • Reliance on administrative controls was ineffective. <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

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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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