Weekly incident summary

Week ending 24 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 IncNot0046921 Underground coal Ground or strata failure 	A multi-bolter was being used to install rib mesh on the face following a plunge cut. Two workers held a sheet of mesh for the temporary roof support (TRS) to take to the roof. The workers stood back and shortly thereafter a piece of stone (1.8 m x 1.2 m x 150 mm) fell from the roof, slid on the mesh and landed on the timber jacks. There was one worker in the vicinity.	Workers must always be alert to the hazard of unsupported roof strata and must remain vigilant of their position relative to the risk of unsupported strata failure, which may occur without warning. Underground mine operators should review the adequacy of their strata monitoring arrangements and associated trigger action response plans (TARPs) to ensure that workers are not exposed to unacceptable risks associated with strata failure.

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Incident type	Summary	Comments to industry
		
Dangerous incident IncNot0046975 Open cut coal	A haul truck was reversing to the tip head when the pos 1 tyre failed. The release of pressure caused damage to the truck and dislodged the access ladder. The emergency ladder was projected approximately 20 m in front of the truck and a fire extinguisher was projected approximately 95 m in front of the truck. 	Mine operators are reminded of the importance of undertaking a daily inspection routine for tyres to ensure they are fit-for-purpose.

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Incident type	Summary	Comments to industry
Serious injury IncNot0046833 Construction materials	Two workers were in the crusher lube container when there was an explosion that caused a fire. The workers sustained burns to their upper chest and face. 	This incident is under investigation by the Resources Regulator and further information will be published at a later date.

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	**Fatality - Final Report (Machinery)** On July 17, 2023, at approximately 1:06 p.m., Christopher G. Perry, a 37-year-old miner with one year and six months of mining experience, died when he was helping to replace an arm guard on a gyratory crusher. A steel lifting lug that had been welded onto the crusher's narrow arm guard detached and struck Perry while the narrow arm guard was being lifted by a crane. The accident occurred because the mine operator did not ensure the miner was clear of a suspended load. Details
	National (other, non-fatal)
Business Queensland	**Report: Incident periodical for May 2024 - Coal Inspectorate** Risk Control Effectiveness This month's periodical looks at four reported HPIs: 1. Pick & carry cranes roll over whilst unloading pipework. 2. Jack locking system failure. 3. Rotating dragline contacts coal mine worker.

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Publication	Issue/topic
	4. Equipment fires. 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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