

Weekly incident summary

Week ending 8 June 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
Dangerous incident IncNot0047057 Quarries Roads or other vehicle operating areas	An excavator operator began work at 6.15am, clearing clay from a bench he had formed the previous evening. The intent was to begin loading a waiting truck once they had removed the clay from the area. The operator did not conduct a pre-shift inspection of the area and the area did not have supplementary lighting. While tramping backwards, the operator lost situational awareness of the trench and backed into it, rolling on its cab side. The quarry's emergency plan was activated, and emergency services successfully freed the operator from the cab. The operator suffered minor injuries.	Mine operators have a duty to manage risks to health and safety associated with the movement of mobile plant at their mine. The operator must have regard to all relevant matters including the design, layout, construction and maintenance of all roads and other areas at the mine site used by mobile plant. Mine operators must ensure adequate lighting is provided to active work areas to ensure that workers do not lose situational awareness to hazards within their working area. Workers should identify hazards within their workplace before starting work and should implement controls where possible to eliminate or



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		<p>minimise the risk. Where a worker identifies a hazard, the worker should follow the mine's safety management system to control the risk and notify the supervisor where appropriate.</p>
<p data-bbox="124 680 352 943"> Dangerous incident IncNot0047056 Underground coal mine Fire or explosion </p> 	<p data-bbox="392 680 967 1099"> A shuttle car driver noticed smoke when unloading coal onto a belt in a development panel. On investigation, the worker discovered hot embers under a mobile boot end. Water was applied to the area to remove heat. </p> <p data-bbox="392 887 967 1099"> A preliminary investigation identified the design of the mobile boot end allowed for a 200 mm gap from a steel panel to the floor at the loading point and during roadway cleaning on the previous shift fines were pushed under the boot end. </p> <p data-bbox="392 1122 967 1196"> The preliminary investigation recommended the following preventative actions: </p> <ul data-bbox="392 1218 967 1451" style="list-style-type: none"> • Incident learning to be communicated to panel deputies and fitters. • Shift notes to be updated and communicated to deputies to include boot end to be lifted and cleaned following roadway cleaning. 	<p data-bbox="1011 680 1474 1048"> Mine operators must ensure that housekeeping activities in and around plant or structures in underground mines does not create additional risks of fire and explosion. It is suggested that mine operators review their fire and explosion risk assessments and update any hazard management plans or subordinate documents where appropriate. </p>
<p data-bbox="124 1805 320 2018"> Dangerous incident IncNot0047018 Underground metals mine </p>	<p data-bbox="392 1805 967 2018"> An underground load haul dump was bogging waste from an incline in an underground metalliferous mine. The operator was tramping in first gear, at a low speed uphill, when he thought a rock hit the heel of the bucket. He stopped and reversed a metre to </p>	<p data-bbox="995 1805 1474 2018"> Mine operators must ensure that equipment is maintained as per the original equipment manufacturer's instructions, fit for purpose and that workers are trained and competent to undertake required tasks. </p>

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	<p>assess. The position 2 wheel came off the loader. The operator immediately stopped the machine and notified the shift boss. The wheel was lodged between the wall and the position 2 guard.</p> <p>Preliminary findings showed all but 2 wheel studs were undamaged, which would suggest the wheel nuts vibrated loose. The preliminary cause for the loss of wheel nuts was incorrect torque setting on workshop rattle guns. It was worth noting that loss of wheel integrity was not flagged by any operators in previous prestart inspections.</p>  	<p>Mine workers must follow any reasonable requirement set by the mine operator to ensure the health and safety of themselves and their colleagues. This may include undertaking a diligent pre-start inspection of any plant that they will be operating.</p>

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Other Resources Regulator publications

Two workers sustained burn injuries when cleaning fluid they were using ignited after a cordless battery-powered hand-held blower was operated.

Read the full [Investigation information release](#) on our website.

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 alert - Powered haulage On May 9, 2024, a miner died when he was pinned between the personnel lift that he was operating, and the roof of a structure. The miner was tramming the personnel lift from the basket to conduct a roller repair on an elevated belt conveyor. Best practices: <ul style="list-style-type: none">• Ensure miners maintain control of personnel lifts while in operation.• Use a spotter when moving mobile equipment in congested areas and around structures.• Monitor miners routinely to ensure miners follow safe work procedures while operating personnel lifts.• Ensure miners are aware of their location in relation to nearby structures.• Conduct workplace examinations to identify and eliminate hazards before beginning work in an area.• Train miners in the safe performance of their tasks in accordance with the manufacturer's manual. Details
MSHA	Fatality alert - Machinery On May 16, 2024, a miner died when the excavator he was operating travelled over a highwall. Best practices: <ul style="list-style-type: none">• Reduce fall hazard exposure by limiting the distance equipment can safely operate near the edge of highwalls.• Examine benches to identify hazards related to insufficient bench width, locations of other equipment, loose material, etc.• Discuss highwall hazards with miners and train miners to recognize these hazards.• Address hazards in the mine's surface mobile equipment safety program. Include safe work practices for weather conditions (fog, heavy rain, or snow) that could reduce visibility.

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Publication	Issue/topic
	Details
MSHA	<p>Fatality – Final report (powered haulage)</p> <p>On September 8, 2023, at 10.25 am, Eric Komlosky, a 39-year-old plant labourer with less than 2 years of mining experience, died while he was working inside a recirculation hopper after a front-end loader dumped limestone material into the hopper. The accident occurred because the mine operator did not:</p> <ol style="list-style-type: none"> 1) provide adequate task training for performing maintenance work inside the recirculation hopper, and 2) stop and lock out the supply and discharge equipment, ensure the plant labourer wore a safety belt or harness equipped with a lifeline, and ensure a second miner was stationed nearby. <p>The mine operator did not provide task training to any miner, including Mr Komlosky, to safely enter bins and hoppers or how to safely clear blockages from the recirculation hopper. The mine operator recklessly disregarded several mandatory safety standards and instead implemented a noncompliant procedure. Investigators determined that this contributed to the accident.</p> <p>Details</p>
	National (other, non-fatal)
Resources Safety & Health Queensland	<p>Operator injured after fall from dump truck ladder</p> <p>After climbing part-way down a dump truck's access ladder, an operator fell to the ground resulting in a broken arm. The incident is under investigation; however, the preliminary findings are:</p> <ul style="list-style-type: none"> • A fire extinguisher had been installed adjacent to the handrail of the dump truck's access ladder. • The position of the fire extinguisher prevented the handrail from being held while ascending or descending the lower part of the ladder. • The operator was unable to maintain three-points of contact when descending the ladder and fell to the ground. <p>Key issues:</p> <ul style="list-style-type: none"> • Plant selection, design and installation practices and processes at the quarry did not ensure that the installation of the fire extinguisher did not affect safe access and egress. • After the fire extinguisher was installed, risk management practices did not identify that 3 points of contact was not always possible when ascending or descending the truck's access ladder. <p>Details</p>
Resources Safety & Health Queensland	<p>Loader falls into stope void over vertical edge</p> <p>On Wednesday 18 May 2024, an incident occurred at an underground metalliferous mine when a loader and its operator fell into a stope void from a tipping point. The operator was rescued from the stope unharmed. The operator was trying to place a fabricated steel stop log near to the stope open edge in preparation for backfilling operations. Inspectors are investigating this incident to identify its nature and cause,</p>

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	<p>however, it was understood the loader operator drove beyond a safe operating area into an open stope, lost control and became stuck.</p> <p>Key issues:</p> <p>Stope voids without adequate edge protection can lead to serious harm or death.</p> <p>While this particular incident is still under investigation, factors that may contribute to incidents of this nature could include:</p> <ul style="list-style-type: none">• the manoeuvrability of machinery and operator's visibility.• inadequate training or hazard awareness for people involved.• the appropriateness of machinery for the activity.• signs/markup. <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 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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