

Weekly incident summary

Week ending 12 July 2024


This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the 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	48
Summarised incident total	3


Summarised incidents

Incident type	Summary	Comments to industry
Serious injury IncNot0047223 Underground coal mine Ground or strata failure	 <p>A fall of ground occurred affecting an entire intersection at a heading where mining had been occurring inbye of the area during night shift. The crew had withdrawn equipment for planned maintenance on day shift before the fall occurred.</p> <p>The area design was a run out on the left-hand side of the bord and pillar panel with herringbone and floor stripping. There was an unbolted section and a bolted section through the run out. At 11am, it was observed there was a roof and skin failure in the open lift (unbolted area). At 3pm, it was reported that the fall of ground had progressed through the entire intersection (bolted and unbolted).</p>	<p>This incident is under investigation and further information may be published later.</p> <p>Mine operators are reminded of the need for workers who are required to install and maintain tell-tale strata monitoring devices to be trained on the correct installation and defect management requirements for the lifecycle of the devices.</p>

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Incident type	Summary	Comments to industry
<p data-bbox="113 194 411 577">  </p>		
<p data-bbox="113 584 411 882"> Dangerous incident IncNot0047225 Construction materials Roads or other vehicle operating areas </p> 	<p data-bbox="416 584 938 1128"> A loader reversed into one of 2 light vehicles that had stopped about 10 metres behind it. The first vehicle failed to make positive communications with the loader because of a flat radio battery. When the loader began to reverse, the first vehicle moved out of the way and the loader continued until it hit the second vehicle. The second vehicle operator assumed the first vehicle operator made positive communications but didn't hear anything. He had his flashing light on and sounded the horn to stop the loader. </p> 	<p data-bbox="943 584 1481 707"> When stopping light vehicles, workers must not place themselves at risk of interactions with heavy vehicles. </p> <p data-bbox="943 719 1481 987"> Following a recent awareness campaign on vehicle interactions the Regulator published a video that can be used for training purposes and toolbox talks. Mine operators are encouraged to use this resource. You can watch the video on YouTube. </p> <p data-bbox="943 999 1481 1783"> To achieve positive communication, a clear direct message must be given. Additionally, the person receiving the message must actively reply with a clear understanding of the message. Supervisors should be continually monitoring positive communications compliance during every radio call on their shift. Work Health and Safety Regulation 2017 clauses 35 & 36 requires higher order risk controls be implemented and administrative controls such as positive communication, only be used when no higher order controls can be implemented. Controls such as equipment segregation and proximity awareness systems should be implemented before positive communication only systems are considered. </p>
<p data-bbox="113 1807 411 1980"> Serious injury IncNot0047226 Underground metalliferous mine </p>	<p data-bbox="416 1807 938 1980"> A worker on foot in a decline was hit by a loader that travelled into the area. The worker suffered serious leg and foot injuries. </p>	<p data-bbox="943 1807 1481 1930"> This incident is under investigation and further information may be published later. </p>

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	<p>A light vehicle stopped in front of vent doors towards the bottom of a decline. The passenger got out and went to the rear of the light vehicle to get equipment. The vehicle driver advised that a loader was coming down the decline and proceeded to go through the vent doors. The loader operator was unaware of the worker on foot and discovered the incident only after parking up.</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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Document control	
ISSN	2982-1010 (Online)
CM9 reference	DOC24/169800
Mine safety reference	ISR24-28
Date published	19 July 2024
Authorised by	Director Technical Operations Mine Safety Office of the Chief Inspector

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