Weekly incident summary

Week ending 5 July 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

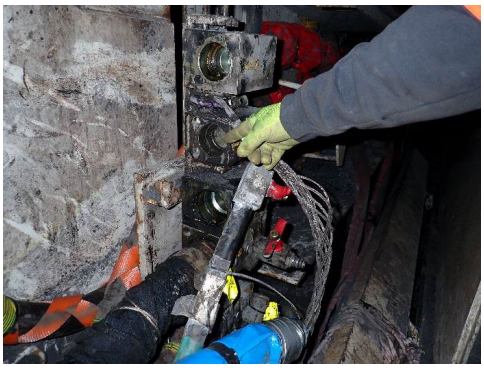
High level summary of emerging trends and our recommendations to operators.

Type	Number
Reportable incident total	51
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
Serious injury IncNot0047205 Coal processing plant	While removing a tooth segment from a secondary crusher, a worker struck the segment with a hammer and felt an injury to his chest. The injured worker was assessed by paramedics and flown to hospital. While waiting for further assessment, the worker's condition deteriorated, and he described increasing pain and shortness of breath. X-rays identified a small metal fragment in his lung. An initial investigation indicated the use of incorrect tooling for removing the teeth.	All mine workers should be reminded of the dangers associated with the use of hard metal tools, including contact with other hard metal surfaces. Fit-for-purpose tools and equipment, work procedures and training should be provided to workers to prevent injury from metal fragments becoming projectiles. Soft faced hammers should be considered where force is being manually applied to hardened steel.

Weekly incident summary week ending 05 July 2024

Incident type	Summary	Comments to industry
		
Dangerous incident IncNot0047192 Underground coal mine	While rolling out air and water hoses across an AFC installation, a fitter was asked to connect a 50 mm air hose to a manifold before the hose was rolled out. The fitter removed a retaining staple to connect into a 50 mm airline supply. The end cap ejected, hitting the fitter in the leg just below the kneecap. The fitter was unaware that the line was pressurised. 	Mine operators should have procedures in place to prevent exposing workers to the hazards of stored energy. Mine operators should ensure workers are trained on these procedures, and that all workers are aware of the status of stored energy sources.
Serious injury IncNot0047169 Open cut coal mine	A worker suffered a fractured tibia and fibula when joining the flanges (pipe ends) of 2 polyethylene pumping pipes of ~Ø355 mm in a pit.	Mine operators should ensure that pulling and/or joining poly pipe is being carried out in accordance with a safe work procedure (SWP) and that all workers conducting the activity have been trained

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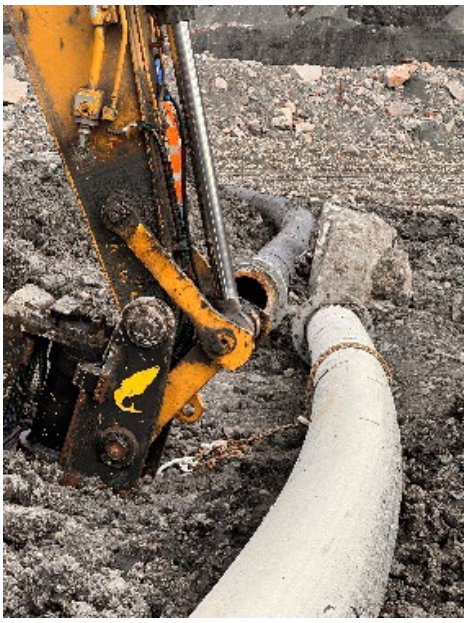
	One of those poly pipes was resting on the ground, being supported by a large rock. The other pipe was secured via a single wrap chain attached to an excavator hitch. There was a slight overlap and misalignment of the 2 pipe flanges. As the 2 poly pipe flanges were being joined, it appears the poly pipe attached to the excavator hitch moved (slipped) within its restraining chain allowing the poly pipe to hit the left leg of the worker. The internal stored energy within the poly pipe released when the chain slipped along the pipe. 	and assessed as being competent in that SWP. The SWP should: • be developed from a risk assessment that sets out and assesses all foreseeable risks to workers during in-pit pulling and/or joining activities. This should include risks associated with mobile plant, potential stored energy within the poly pipe and possible in-pit environmental conditions. • set out fit-for-purpose equipment to be used and how it is to be used. • provide a fit-for-purpose means to secure the poly pipe to the pulling equipment. • provide safe standing zones for workers so they are, so far as is reasonably practicable outside possible recoil zones. • provide processes to pull in-pit poly pipes together • provide processes to join 2 poly pipe flanges together. Refer to Safety bulletin: SB09-03 Broken pull chain results in fatality

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** On August 24, 2023, at 7.48 am, Chad Minenko, a 45-year-old lead with over 17 years of mining experience, died when a wash plant feed box struck and pinned him between a feed box and a handrail. The accident occurred because the mine operator did not: 1. block the feed box against hazardous motion, and

Publication	Issue/topic
	2. correct the hazards of the low oil level in the feed box hydraulic lift system. 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.

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