Weekly incident summary

Week ending 4 August 2024

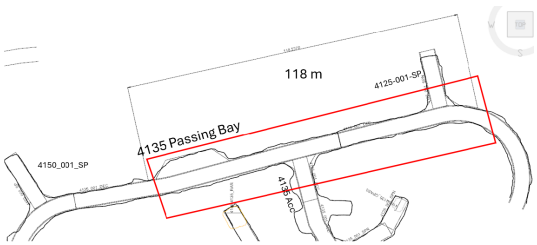
This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the NSW Resources Regulator: phone 1300 814 609 24 hours a day, 7 days a week.

At a glance

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

Type	Number
Reportable incident total	37
Summarised incident total	3

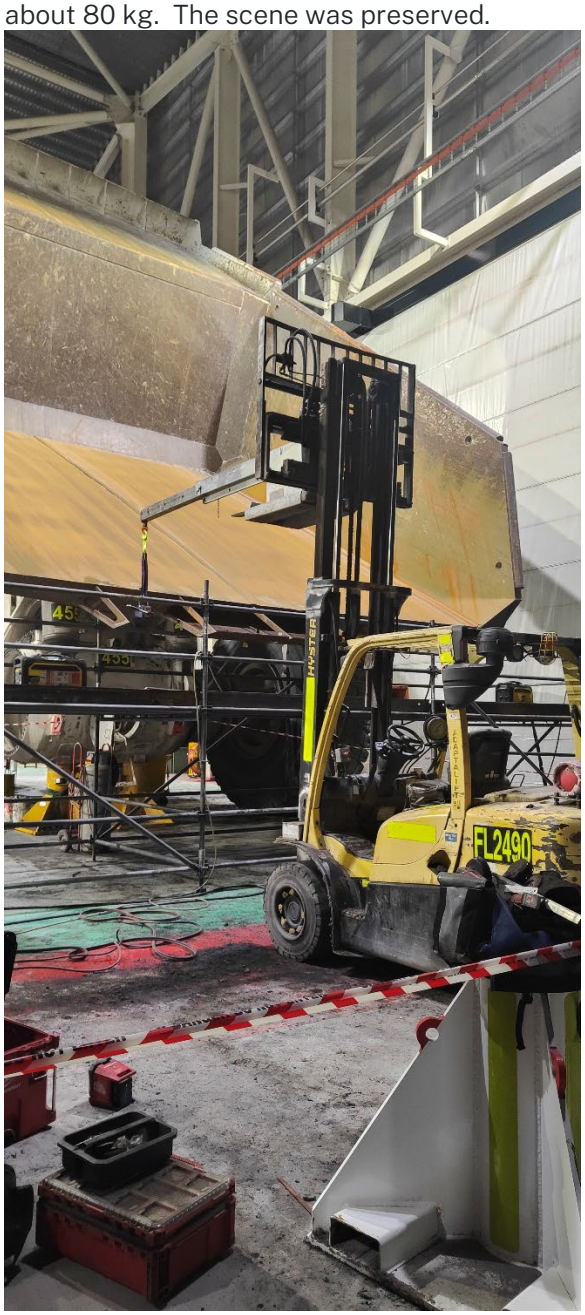
Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0047366 Underground metalliferous mine	A mine worker was driving a light vehicle with 3 other occupants down a decline when the service brake became unresponsive. The driver shifted to first gear and applied the park brake and stopped the vehicle. It took 118 metres to bring the vehicle under control and stop. The wheel nut indicators appear to have melted off due to high heat from the brakes. Low range was not engaged. 	Brake fade (or vehicle braking system fade) is the reduction in stopping power that can occur after repeated or sustained application of the brakes of a vehicle, especially in high load or high-speed conditions. Brake fade is caused by a build-up of heat in the braking surfaces and the changes and reactions in the brake system can be experienced with both drum brakes and disc brakes. Mine workers are remined that before commencing a decent they should choose an appropriate gear with the appropriate speed range to allow the engine braking to maintain speed. Mine operators must ensure that their workforce is trained and

Weekly incident summary week ending 4 August 2024

Incident type	Summary	Comments to industry
		competent to operate vehicles in underground conditions.
Dangerous incident IncNot 0047351 Underground coal mine Roads or other vehicle operating areas	A mine was undertaking work on its main travel roads as part of recommencing mining operations. The mine was scheduled to transport some heavy mining equipment underground. Due to wet conditions, the mine operator decided to do a trial run with the mine dozer and attachments on wet concrete on a 1 in 5 drift. During the trial the dozer lost traction and the jib attachment hit a disused 8 inch poly pipe on the right-hand rib line, damaging the pipe. Before the incident, it was ensured no personnel or vehicles were in the drift except for the dozer and operator. 	Mine operators must identify, and risk assess hazards associated with the principal mining hazard, roads and other vehicle operating areas. Mine workers must be trained and competent in the principal hazard management plan and vehicle use. Mine operators must ensure that the estimated coefficient of friction between mobile plant tracks and the ground is sufficient to ensure grip and stability. Appropriate machinery must be chosen for the mine's conditions.

Weekly incident summary week ending 4 August 2024

Incident type	Summary	Comments to industry
Dangerous incident IncNot0047350 Open cut coal mine	Two workers were standing on a 1.5 metre scaffold to position an extension plate on top of the dovetail on a haul truck. The plate was secured with a lift jib and magnet. During the lifting process, the plate dislodged and hit one worker on his left knee. The worker suffered a soft tissue injury and was later released back to the site following an assessment. The plate dimensions were 8 mm thick 132 cm 98 cm and about 80 kg. The scene was preserved. 	Workers must ensure that they do not work under suspended loads and that they choose the appropriate lifting apparatus for the job. In this instance, the worker suggested that they should have welded lifting points onto the plate, which would have had a higher factor of safety.

Other Resources Regulator publications

Investigation information release IIR24-06
Serious injury arising from vehicle/pedestrian interaction in an underground coal mine
A service crew worker was seriously injured while walking in a decline when the bucket of a moving loader hit him. The Regulator has commenced an investigation and will issue a report when the investigation is finished. Download the full report.

Safety Bulletin SB24-05
Wheel assemblies detaching from mobile plant
In the past 4 months, there have been 4 significant incidents involving failed wheel assemblies where the assembly has detached from the mobile plant. In one incident, a wheel came to rest beside an articulated dump truck. Download the full report and recommendations.

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 - Powered haulage, final report** On July 26, 2023, at 2.45 pm, a 24-year-old miner with over 4 years of mining experience, was seriously injured when he lost control of a pick-up truck while driving up a slope. The worker passed away on March 19, 2024, due to complications from injuries sustained during the accident. The accident occurred because the mine operator did not correct the defective service brake in a timely manner before it created a hazard to the worker. Details
MSHA	**Fatality - Machinery, final report** On December 14, 2023, at 7.00 am, a 36-year-old maintenance leadman with over 11 years of mining experience, died when they were pinned between the feed chute and a handrail of the screen platform on a wash plant after disconnecting a brace supporting the feed chute. The accident occurred because the mine operator did not: 1) block the feed chute against hazardous motion, and 2) have a tag or other effective method of marking the defects on the feed chute hydraulic system. Details
	National (other, non-fatal)
Department of Energy, Mines, Industry	**Drilling company fined $385k after worker suffers serious injuries** Drilling and exploration company Boart Longyear has been fined $385,000 and ordered to pay $5,105.20 in costs after a driller's assistant received serious crush

Weekly incident summary week ending 4 August 2024

Publication	Issue/topic
Regulation and Safety	injuries while working at Oz Mineral's West Musgrave project. The company pleaded guilty in the Kalgoorlie Magistrates Court to failing to provide and maintain a safe working environment under the *Mines Safety and Inspection Act 1994*. In February 2021, the driller's assistant was part of a crew at a remote exploration camp who were carrying out maintenance to a reverse circulation drill rig. During the task, the driller's assistant was standing between the rod handler arm and the breakout assembly when the rod handler arm unexpectedly swung down pinning his head against the rig. The worker suffered significant injuries including facial lacerations and a broken jaw. Details

Note: While most 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	
ISSN	2982-1010 (Online)
CM9 reference	RDOC24/117884
Mine safety reference	ISR24-31
Date published	9 August 2024
Authorised by	Director Technical Operations Mine Safety Office of the Chief Inspector