Weekly incident summary

Week ending 20 September 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	42
Summarised incident total	4

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0047652 Underground coal mine	A fitter, who was undertaking a weekly belt service, noticed smoke coming from the walk side of the loop take up (LTU), near the main pulley. The fitter removed a handful of burning coal material from the frame then noticed more embers beneath the carriage. These were doused with water. A build-up of coal material was exposed to heat via the frame of the LTU pulley.	Mine operators should review their arrangements for eliminating or mitigating the risks associated with material accumulating around belt conveyors. Workers conducting conveyor inspections must diligently inspect for fire risks such as accumulation of material and contact between conveyor belts and fixed structures.

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Incident type	Summary	Comments to industry
		
Critical incident IncNot0047669 Underground coal mine	Contractors were using oxyacetylene to cut steel plates that covered a concrete lined shaft about 450 metres deep. While undertaking the task, one of the contractors fell into the shaft and suffered fatal injuries.	This incident is under investigation and further information will be published later.
Dangerous incident IncNot0047680 Open cut coal mine Roads or other vehicle operating areas 	A haul truck reversed from a workshop apron and proceeded to continue reversing to a park-up area. The operator did not identify a parked service vehicle on the offside of the truck. The haul truck collided with the left-hand side of the service vehicle, damaging the main access stairway to the cabin. The operator of the service vehicle exited the cabin of the service vehicle through the passenger side door and exited the machine via the emergency egress with no injuries.	Workers have a duty to take reasonable care of themselves and others while in the workplace. This includes staying alert, being aware of their surroundings, and maintaining control of the plant and machinery they operate. Workers must check the area behind their machine before reversing. Workers should use all aids such as spotters, mirrors, cameras and awareness systems that are fitted.

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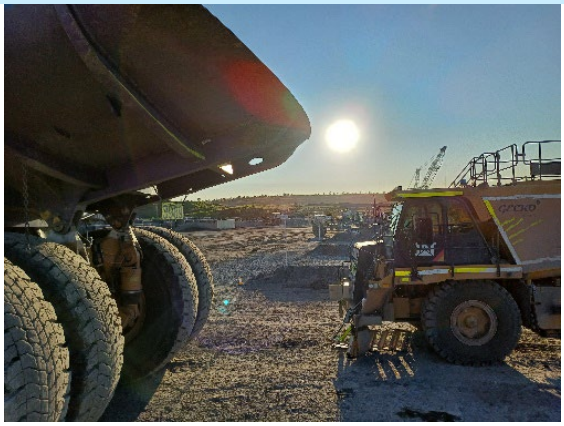
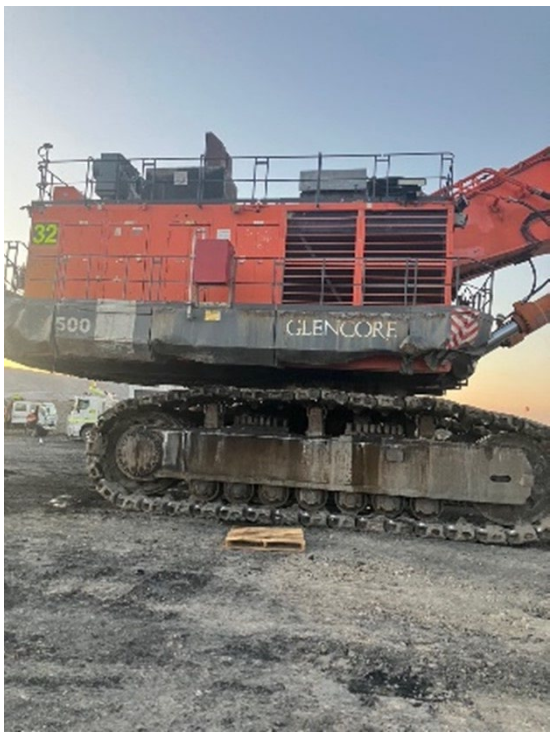
		
Dangerous incident IncNot0047678 Open cut coal mine	A wooden pallet was dropped from the top deck of an excavator, breaking a worker's arm. Following a service on the excavator, a worker on the top deck checked the ground area to see if it was clear then dropped a pallet over the guardrail. The pallet weighed 19.12 kg and fell about 7m from the excavator, hitting the worker below on the forearm and hand. 	Fit-for-purpose equipment should be used to lift service items up and down from excavators. Under no circumstances should items be dropped from such a height. Visual inspection in such circumstances is not an adequate risk control and this incident should be communicated to workers to highlight the risks involved in undertaking such actions.

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	On January 29, 2024, at 4.17am, a 63 year-old haul truck driver with over 13 years of mining experience, died when the haul truck he was operating backed over the end of the feed bank and overturned. The accident occurred because the mine operator did not: • examine the feed bank before miners began working • provide illumination at the feed bank • provide a means to prevent overtravel and overturning at the dumping location • follow their ground control plan • ensure the haul truck driver was wearing the seat belt. 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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