Weekly incident summary

Week ending 15 November 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	33
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0047993 Underground coal mine Roads or other vehicle operating areas 	A worker was driving inbye in an underground mine vehicle when he had a micro sleep. He woke up just before there was a collision, but when he went to brake, his foot missed the brake pedal. The vehicle collided with the corner of an intersection he was approaching. It was the worker's second night shift in 3 months.	Workers should ensure that they turn up fit to work long hours and for several days and or nights in a row. Other reasonable controls are: • roster patterns that allow for adequate sleep and life activities (eating, washing and family) • shift durations that consider workers' commuting times to allow for adequate sleep and life activities • allowing a 48-hour break after a block of night shifts and an adequate break between blocks of shifts for recovery • allowing an adequate break between shifts to enable 7 – 8 hours' sleep

Weekly incident summary week ending 9 November 2024

Incident type	Summary	Comments to industry
		• increasing supervision during periods of low alertness (e.g. 3am to 5am) • providing training and information on the risks of shift work and ensure supervisors and management can recognise problems • ensuring breaks are taken within shifts to mitigate fatigue. Further information can be found at our health control plan resources guide.
Critical incident IncNot0047989 Small mine - quarry	A worker died from natural causes while undertaking work at a mining operation. Workers tried unsuccessfully to revive the worker.	The NSW code of practice into managing psychosocial risks has identified exposure to traumatic events such as experiencing, witnessing, a serious near miss, injury or workplace fatality as a psychosocial hazard. Mine operators should ensure that psychosocial risk assessments that are undertaken to comply with clauses 55A-D of the Work Health and Safety Regulation 2017. Consider this hazard and ensure appropriate controls are implemented. The code of practice should be used to assist practitioners with assessing and controlling psychosocial risk within the workplace. The code can be found at www.safework.nsw.gov.au/resource-library/list-of-all-codes-of-practice/codes-of-practice/managing-psychosocial-hazards-at-work
High potential incident IncNot0048016 Surface coal mine	An empty rear dump truck slid 90 degrees clockwise while descending a ramp following wet weather.	Mine operators must undertake appropriate examinations of haul roads following wet weather periods. Where appropriate you must stop

Weekly incident summary week ending 9 November 2024

Incident type	Summary	Comments to industry
Roads or other vehicle operating areas 	Rainfall on the previous night had resulted in a wet haul road surface. The wet weather trigger action response plan (TARP) was implemented limiting speed to a maximum of 30kph. After hauling laden onto the dump, the operator commenced the return run. On descent of a short section on the access road, the truck lost traction. It slid at low speed for about 50 metres before rotating clockwise and stopping in the middle of the road. The truck crossed the centre line of the road at this point. 	production until a dry line can be graded in or there is appropriate traction available to trucks even at low speeds.

Other publications of interest

The incidents are included for your review. The 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	**Machinery accident, final report** On March 1, 2024, at 9.45am, Johnny Daniels, a 61-year-old truck driver with over 16 years of mining experience, died after being struck with a steel slurry pipe. Records indicated that Mr Daniels received all training in accordance with MSHA Part 46 training regulations. Mr Daniels was tasked with trained on the SOP for moving the slurry line. However, Mr Daniels' direction to another worker to lift the slurry line away from the flange to a height was not in accordance with the SOP. The accident occurred because the mine operator did not ensure the slurry pipe was blocked against hazardous motion. Details

Weekly incident summary week ending 9 November 2024

Publication	Issue/topic
MSHA	Fatal electrical accident, final report On May 8, 2024, at 11.20am, Sean Marek, a 44-year-old crew member of Belt Tech Industrial Inc with over 2 years of mining experience, suffered a fatal electric shock as a result of a crane contacting high-voltage powerlines. The accident occurred because US Aggregates Inc did not: • conduct an adequate workplace examination of the belt conveyor take-up area • provide adequate site-specific hazard awareness training, and • conspicuously mark and install warning devices for restricted clearances. Additionally, US Aggregates Inc, Belt Tech, and Muck's Crane & Contracting LLC did not ensure work was conducted at least ten feet away from high-voltage powerlines. 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	
CM10 reference	RDOC24/212674
Mine safety reference	ISR24-45
Date published	22 November 2024
Authorised by	Deputy Chief Inspector Office of the Chief Inspector