

# Weekly incident summary

## Week ending 25 October 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 | 51     |
| Summarised incident total | 3      |

### Summarised incidents

| Incident type  | Summary   | Comments to industry   |
|--|---|--|
| Dangerous incident<br>IncNot0047871<br>Underground coal mine | <p>The driver of an underground coal transport vehicle parked, turned off the vehicle and exited via the driver's door, when the vehicle rolled forward about one metre.</p> <p>The driver re-entered the cab and applied the foot brake to bring the machine to a stop.</p> <p>During the daily inspection it was identified that the park brake was slow to apply. The vehicle was driven nonetheless.</p> <p>Due to the position of the e-stop in the cabin, drivers could rest their hands on it while driving. This put light pressure on the brake valve, causing the brakes to drag and accelerating brake wear.</p> <p>The vehicle effectively had no park brakes and only 50% functional service brakes. Despite this, the vehicle was</p> | <p>Brakes are a safety-critical function and if issues are identified during a daily inspection the vehicle is to be placed out of service until the fault can be rectified.</p> <p>Following any incident where brake failure is the cause, under no circumstances should the vehicle be driven until the issue has been diagnosed and remedied. If the vehicle needs to be moved for repairs, adequate controls are to be implemented to move the vehicle to a safe place.</p> |

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| Incident type  | Summary  | Comments to industry  |
|--|--|---|
|  | driven out of the mine following the incident.   |   |
| Serious injury<br>IncNot0047897<br>Underground coal mine                       | <p>An operator of a hand-held bolter suffered a fractured rib and bruising to the lower back when the drill steel got caught and kicked the bolter, which pushed the worker over the pan line onto the armoured face conveyor.</p> <p>The height from floor to roof meant the bolter was at near full extension with only the tip of the bolt penetrating the roof before getting caught on mesh and causing the bolt to bend and push the handle into the operator's chest.</p> | <p>Operators of hand-held bolters need to understand the hazards associated with such equipment, in particular the amount of torque generated when the power to the drill steel is increased.</p> <p>Operators should apply lower force when the drill steel is fully exposed and slowly increase speed according to the penetrative depth of the drill steel.</p> <p>Operators should also be mindful of the extra risk when bolting around mesh in which the drill steel can be caught.</p> |
| Serious injury<br>IncNot0047878<br>Construction materials<br>Fire or explosion | <p>A worker suffered serious burns when the fuel being used to refill a petrol-powered pump ignited.</p>   | <p>Hot engine exhausts are a well-known ignition source.</p> <p>As a minimum petrol-powered pumps shall be turned off and allowed to cool down prior to any refuelling activities.</p> <p>Mine operators should have documented safe work procedures for refuelling petrol engines and workers trained in those procedures.</p> <p>Consideration should be given to using diesel engines in place of petrol engines.</p>  |



## Other Resources Regulator publications

### Safety Bulletin SB24-08 Recent increase in vehicle interactions

Vehicle interactions have shown an increasing trend throughout the mining industry across the state as evidenced by the 46 incident notifications that have been reported to the Regulator.

Of the notifications made, 45% were from surface coal mines, 26% from surface metalliferous and quarry operations and 32% from both underground coal and metalliferous mines. A review of these incidents has indicated that the predominant causes have been a lack or inadequate communication between people involved in the incidents, as well as a lack of situational awareness on the part of

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operators of equipment involved in the incidents. Instances were also noted where procedures were not followed and equipment had malfunctioned.

[Read the full bulletin and its recommendations.](#)

### 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  |
|-----------------|--|
|                 | <b>International (fatal)</b>   |
| <b>NZ MinEx</b> | <b>New Zealand - Company convicted over conveyor fatality</b><br><p>A company has been convicted after a worker died from being crushed in a conveyor belt accident in Mount Maunganui. The victim lost his footing while trying to step over the running belt and fell. He rolled several times and was dragged underneath the metal frame of a crossing conveyor belt. A colleague held the worker's head and body in an attempt to stop him from being dragged any further until he was rescued by emergency services. The worker died from his injuries.</p> <p>Mine operators need to ensure that:</p> <ul style="list-style-type: none"><li>• emergency stop lanyards are installed along all conveyors where there is a risk of someone falling onto the belt</li><li>• all nip points are guarded, and engineered controls are in place to keep workers away from entanglement hazards</li><li>• emergency stops are appropriately located and regularly checked to ensure they are working</li><li>• no maintenance is conducted on plant while it is running without adequate guarding in place.</li></ul> <p><a href="#"><u>Details</u></a></p> |
|                 | <b>International (other, non-fatal)</b>  |
| <b>MSHA</b>     | <ul style="list-style-type: none"><li>• USA - Safety alert: Highwall failure</li><li>• On September 30, 2024, a miner sustained permanently disabling injuries while operating a Caterpillar 992K front-end loader beneath a highwall. A section of highwall fell onto the loader, crushing the cab and pinning the miner's legs under the dashboard.</li><li>• Best practices:</li><li>• Develop and follow procedures for the safe control of all highwalls where miners work and travel in close proximity to the highwall.</li><li>• Train miners to recognise highwall hazards.</li><li>• Use auxiliary lighting during low light conditions to conduct highwall examinations and illuminate active work areas.</li><li>• Never park equipment, perform maintenance or store materials beneath the highwall.</li></ul>  |

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| Publication | Issue/topic   |
|-------------|---|
|             | <ul style="list-style-type: none"><li>• Conduct highwall examinations and eliminate hazards (loose rocks, overhangs, trees, etc.) prior to working or traveling near the highwall. Examine highwalls from multiple perspectives (bottom, sides and top/crest). Examine highwalls more frequently after rain events and periods of freezing and thawing.</li></ul> <p><u>Details</u></p>   |
| MSHA        | <p><b>USA - Safety alert: Near miss dozer entrapment</b></p> <p>On October 10, 2024, a bulldozer fell into a feeder when a bridged coal pile collapsed, engulfing the bulldozer and trapping the operator inside the cab. Emergency response efforts were swift and organized, resulting in the successful rescue of the operator. The bulldozer was equipped with high-strength glass, oxygen bottles, and a remote shut-off for the feeder, all of which contributed to the successful rescue of the entrapped operator. This near miss event highlights the importance of how proactive safety measures can help prevent fatalities.</p> <p>Best practices:</p> <ul style="list-style-type: none"><li>• Maintain stability. Don't operate equipment directly over feeders and stay away from draw holes.</li><li>• Use remotely operated dozers where available when working on surge piles.</li><li>• Stock equipment cabs with safety equipment. Include emergency oxygen, CO<sub>2</sub> scrubbers, and remote shut offs, and ensure all safety devices are properly maintained.</li><li>• Provide training for miners on recognizing hazards and responding to emergency situations.</li><li>• Install high-strength glass certified for at least 40 psi with a frame and supports designed to withstand the added loading of entrapment conditions.</li><li>• Always wear seatbelts when operating mobile equipment to ensure safety in case of sudden impacts or entrapments.</li><li>• Use spotters to assist operators working in potentially unstable environments.</li><li>• Maintain clear communication during emergency response efforts.</li></ul> <p><u>Details</u></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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