Resources Regulator
Department of Regional NSW

Weekly incident summary

Week ending 2 December 2022

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	48
Summarised incident total	4

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0043615 Underground coal mine Ground or strata failure	A roof fall occurred on a longwall at the maingate corner, the face was 7 m inbye of a cut through. When advancing roof support number 2, a strata failure occurred and extended 5 m from the roof support tip to the blockside rib. The roof fall extended to the installed 6 m tendon bolts. The height was estimated to exceed 2.5 m.	This is a reminder of the importance of support being installed correctly and in a timely manner which potentially reduces the exposure of people to the roof fall. The monitoring and verification of roof support installation is a crucial part of any strata failure management plan.
Dangerous incident IncNot0043613 Open cut coal mine Roads or other vehicle operating areas	A dump truck was reverse parking when it hit the front of a parked truck. The operator misjudged the reverse angle and made a low-speed contact. The incident was not immediately reported by the supervisor to the open cut examiner. At the point of impact, a worker was on an access ladder and was unable to alert the operator to the pending collision.	Workers must report incidents to supervisors immediately. Contract supervisors must be informed of escalation and reporting requirements. When designing park-up areas, scenarios where vehicles can collide should be considered and controls such as drive-through park-up bays included in designs.

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Incident type	Summary	Comments to industry
Dangerous incident IncNot0043578 Underground coal mine Ground or strata failure 	A gas outburst occurred in a development heading while remote mining. The miner tripped and the methanometer exceeded 5%. The return airway peaked at 2.2%. The area was within the influence of a dyke previously intersected and the strata was highly jointed. The roof failed to a height of 2 m. A significant gas drainage program had been undertaken in this area. 	The mine used remote mining methods to remove workers from the risk of outburst during cutting. The importance of elimination of the risk through gas drainage should never be replaced by remote mining, but used in conjunction with each other. Further information will be released in future relating to this incident.
Dangerous incident IncNot0043568 Underground metalliferous mine Ground or strata failure 	In an underground metalliferous mine, a load haul dump (LHD) was bogging out a development face. The front right wheels dropped into a hole in the floor. The operator left the vehicle and contacted their supervisor. The area was barricaded. The next morning, an inspection of the area found a void had formed and the LHD had dropped to the level below. 	Mine operators must continually assess and monitor known voids to ensure they are adequately mapped and separation distances are maintained. This incident is under further investigation.

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Incident type	Summary	Comments to industry

Note: Please ensure all relevant people in your organisation receive a copy of this safety alert and are informed of its content and recommendations. This safety alert should be processed in a systematic manner through the mine's information and communication process. It should also be placed on the mine's common area, such as your notice board where appropriate.

Visit our website to:

- find more safety alerts and bulletins
- use our searchable safety database

If you are required to insert an image, make sure you include a caption. Position the image where it is required, right-click the image and click Insert Caption. Type your caption following the figure number, for position select below image and click OK. See example below.

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
	National (fatal)
Safework SA	A quartzite quarry operator and a labour hire company were fined a total of $479,000 following the death of a worker in April 2020. Kara Resources, trading as Hallett Resources Truro, and Taurus Recruitment both pleaded guilty in the South Australian Employment Tribunal (SAET) for breaches of the *Work Health and Safety Act 2012*. A 29-year-old man suffered fatal head injuries when he entered a cavity of a rock crushing machine and attempted to remove a metal blockage at the quarry near Truro, about 100 km north-east of Adelaide. When the blockage was released, stored energy from within the machine caused its components to move under considerable force, striking the worker in the head. No risk assessment or safe work method was created for this hazardous task. No training was provided to the worker in the removal of metal blockages. SafeWork SA's investigation identified that the risk of injury was foreseeable, and the incident could have been avoided had the company had adequate training and safe work procedures in place. Details
	National (other, non-fatal)
WA Department of Mines, Industry	WorkSafe Mines Safety has noted an increase in incident notifications involving heavy mining equipment and other vehicles rolling over. These incidents can result in serious

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Publication	Issue/topic
Regulation and Safety	or potentially fatal injuries to workers. Mines Safety intends to conduct a targeted awareness campaign that will focus on collisions, near misses and rollovers of mine vehicles. Incident data from 1 January 2017 to 30 May 2022 identified 4 areas of causation factors: human and organisational factors, traffic management, maintenance of equipment and vehicle centre of gravity. 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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