Resources Regulator
Department of Regional NSW

Weekly incident summary

Week ending 8 September 2023

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	30
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
High potential incident IncNot0045366 Open cut coal mine Fire or explosion	A fire occurred on the boom conveyor of a stacker. The control room slewed the stacker away from the stockpile to assist fire-fighting. The fire was extinguished by site personnel using onsite fire hoses. The belt was shut down for about 2 hours before ignition.	The hazard of collapsed conveyor idler bearings must be considered in the fire and explosion risk assessment for surface mines. Defective idler management is not only a concern for underground mines. Every mine operating conveyors should have a defect management system for idlers.

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<table>
<tr><th>Incident type</th><th>Summary</th><th>Comments to industry</th></tr>
<tr><td></td><td> </td><td></td></tr>
<tr><td>High potential incident
IncNot0045342
Underground coal mine</td><td>A concrete wall that formed part of a coal stockpile failed. Initial investigations identified overloading and water management as contributing factors.
 </td><td>Mine operators must ensure the operating parameters specified in the design of structures are adhered to. These can include:
• volumetric and weight restrictions, including product density
• water management
• the method that product is moved
• the physical operating envelope
• the rate material is added/drawn from the structure.</td></tr>
<tr><td>Dangerous incident
IncNot0045337
Underground coal mine
Fire or explosion
 </td><td>A low water shutdown test failed during the daily inspection on a load haul dump (LHD). A tradesman inspected the machine and found a bypass had been placed on the system, preventing the machine from shutting down if the scrubber water was low.</td><td>Shutdown systems are critical safety systems on diesel engines used in underground coal mines. Workers must not place bypasses or overrides on systems without following the relevant procedure at the mine.
Workers are reminded of their obligation in the Work Health and Safety Act section 28 to:
• take reasonable care for their own health and safety and for the health
• take reasonable care for the health and safety of other people in the workplace.
• comply with reasonable instructions
• comply with reasonable policies and procedures.</td></tr>
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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)
US Mine Safety and Health Administration (MSHA)	On August 5, 2023, a customer truck driver fell from a large container mounted on the trailer of his truck. After opening the container lid, the driver slipped while descending the container. The driver died from his injuries on August 7, 2023. Details
US Mine Safety and Health Administration (MSHA)	On January 23, 2023, a utility management miner died, and another miner was seriously injured, while removing an unused waterline pipe suspended from a mine roof. The 2 miners were using hand tools to remove a pipe fitting when the waterline pipe suddenly came apart, striking the miner. Details
US Mine Safety and Health Administration (MSHA)	On August 4, 2022, a mine manager died while performing maintenance on a bulldozer. Details
US Mine Safety and Health Administration (MSHA)	On February 25, 2023, a miner, with 5 days of mining experience drowned when his excavator travelled over a berm into a sediment pond. 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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