Weekly incident summary

Week ending 12 April 2024

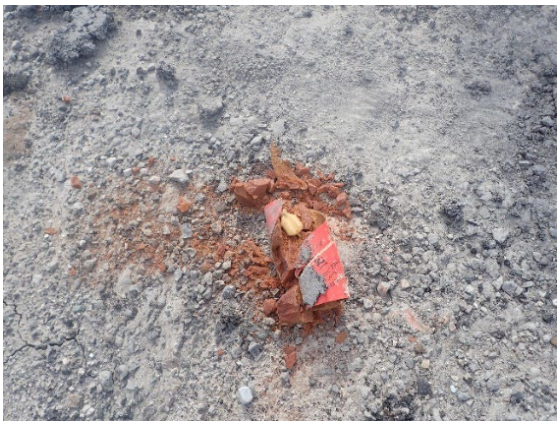
This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the NSW Resources Regulator: phone 1300 814 609 24 hours a day, 7 days a week.

At a glance

High level summary of emerging trends and our recommendations to operators.

Type	Number
Reportable incident total	44
Summarised incident total	5

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0046674 Open cut coal mine	A worker operating a front end loader ran over 3 boosters while cleaning up on a shot. The operator was taken through the task before starting by the blast supervisor, and was given instructions to stay away from explosives on the ground. 	Workers have a legislative duty to care for their own health and safety and that of others (Section 28 of the *Work Health and Safety Act 2011*). One of the duties is to cooperate with any reasonable policy or procedure. Failure to comply with a duty is an offence and penalties apply. The traffic management plan for a shot floor should clearly identify travel routes so that trucks do not inadvertently drive along the incorrect path. Drivers should know the travel routes before entering the shot floor. To help the drivers, demarcation of usable tracks should be clearly identified by using visible cues such as cones or signs.

Weekly incident summary week ending 12 April 2024

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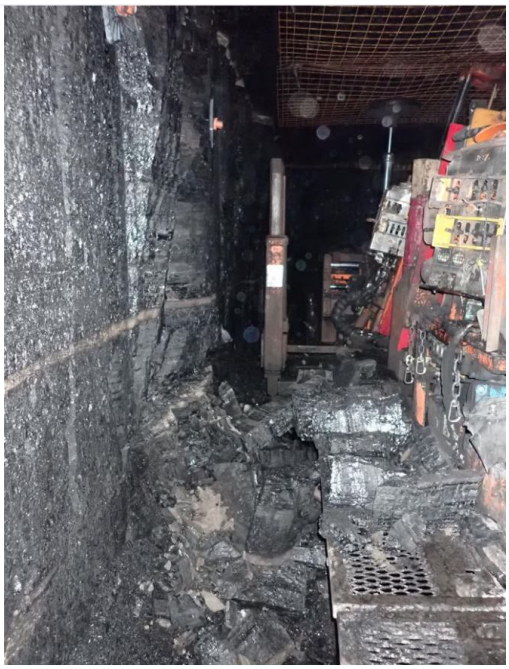
		Mine operators should ensure effective supervision and auditing of compliance with documented traffic management plans.
Dangerous incident IncNot0046675 Underground coal mine Ground or strata failure 	Following completion of rib support, a wedge of rib failed from between installed support. The wedge toppled onto the platform of a continuous miner in the vicinity of the rib bolting control box. The rib support was installed in accordance with the approved support plan. Noticeable jointing was evident on inspection after the incident. 	Underground mine operators should review the adequacy of their strata monitoring arrangements and associated trigger action response plans (TARPs) to ensure that workers are not exposed to unacceptable risks associated with strata failure.
Serious injury IncNot0046703 Underground metals mine	A driller's offsider on a diamond drilling rig was hit in the face by an object that ejected from the drill rig. The offsider was climbing the stairs to access the drilling platform. The object was suspected to be the drill's overshot (~1800 mm and 5-10 kg). The overshot was stored in the drilling frame and made contact with the drilling head, causing it to fall and hit the offsider. The impact from the object caused the offsider to fall about 1.5 m from the stairs of the drill platform below. The offsider was unconscious on the ground after the fall and suffered serious injuries.	This incident is under investigation and an investigation report will be published at a later date.

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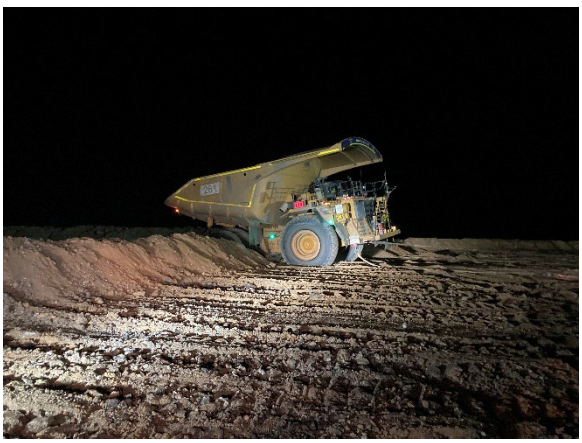
Dangerous incident IncNot0046705 Open cut coal mine Roads or other vehicle operating areas 	While reversing to the tip face to dump a load, the operator failed to stop on time and the position 5 and 6 tyres breached the windrow. The operator remained in the cab while the truck was pulled forward off the windrow. 	Windrow design, construction and maintenance is a critical factor in dump safety. Mine operators should: • design and construct windrows adequately to be a control for the hazard at the operation, paying specific attention to set-back distances, heights and material used • regularly inspect and maintain windrows through open cut examiner inspections and operator inspections. Refer to Safety bulletin: SB18-11 Windrow management and demarcation
Dangerous incident IncNot0046713 Open cut industrial minerals Roads or other vehicle operating areas	A front-end loader and road-going semi-tipper were loading crushed stone. The semi-tipper parked behind the loader without communicating. When the loader reversed, the operator failed to notice the semi-tipper behind him and the counterweight made contact with the truck body, damaging the guards.	To achieve positive communication, a clear direct message must be given. Additionally, the person receiving the message must actively reply with a clear understanding of the message. Supervisors should be continually monitoring pos coms compliance during every radio call on their shift.

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		Work Health and Safety Regulation 2017 clauses 35 and 36 require higher order risk controls be implemented and administrative controls only be used when no higher order controls can be implemented. Controls such as equipment segregation and proximity awareness systems should be implemented before pos coms are consider.

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 (other, non-fatal)
Resources Safety & Health Queensland	**Biannual Health Surveillance Report (mine dust lung disease focus) – March 2024** Understanding the incidence and types of occupational health harms across the resources industry is important for monitoring the effectiveness of exposure controls to manage risks to workers. This fourth biannual report expands on the trends in mine dust lung disease distribution and work history presented in our previous biannual reports. It provides greater analysis of disease cases where multiple conditions have been diagnosed, and their influence on disease distribution and trends. Ongoing analysis of disease demonstrates a clear increasing trend in chronic obstructive pulmonary disease (COPD) cases reported to RSHQ. COPD is now the most common form of occupational lung disease reported across all sectors, underground and surface, and in both current and former workers. This disease is also caused by smoking, however many workers with COPD reported to RSHQ have never smoked. Details

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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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