# Weekly incident summary

## Week ending 14 June 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

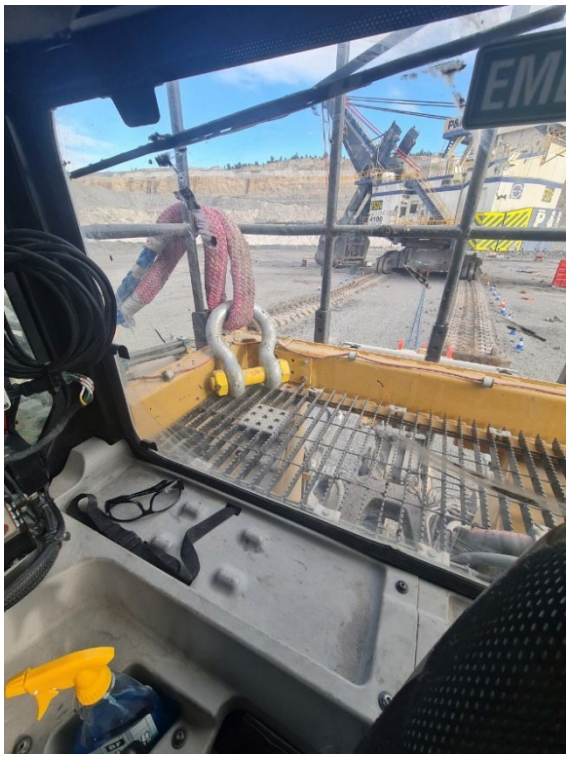
High level summary of emerging trends and our recommendations to operators.

| Type | Number |
|---|---|
| Reportable incident total | 31 |
| Summarised incident total | 3 |

### Summarised incidents

| Incident type | Summary | Comments to industry |
|---|---|---|
| Dangerous incident<br>IncNot0047058<br>Open cut coal mine | A haul truck collided with the support structure of a reject bin.<br>The truck was travelling under the bin at low speed when it slid to the right and pushed over the protective bollard in front of the bin beam. The eyebrow on the tray made contact with the bin beam. | When rain causes dangerous road surface conditions, roads should be closed until they are made safe for travel.<br>Workers should immediately notify supervisors if they consider a work area is dangerous or not compliant with site standards.<br>Principal hazard management plans for roads or other vehicle operating areas should consider factors that may affect an operator's ability to control a vehicle. |

# Weekly incident summary week ending 24 May 2024

| Incident type | Summary | Comments to industry |
|---|---|---|
| |  | |
| Dangerous incident<br><br>IncNot0047067<br><br>Open cut coal mine | While attempting to tow a face shovel back onto its tracks using 2 dozers, one of the synthetic slings snapped and recoiled towards the dozers. The shackle hit the shovel track and ricocheted onto a dozer handrail coming to rest on the deck at the back left-hand corner.<br><br>  | When towing plant, special attention should be given to the attachment of slings and shackles to minimise the likelihood of generating a hard projectile in the event of a sling failure.<br><br>Avoid loading soft slings against hard edges on attachment points. |

# Weekly incident summary week ending 24 May 2024

| Incident type | Summary | Comments to industry |
|---|---|---|
| Dangerous Incident<br><br>IncNot0047076<br><br>Open cut coal mine<br><br>Roads or other vehicle operating areas<br><br>  | When approaching a T-intersection, a haul truck crossed onto the right-hand lane to pass a grader.<br><br>At the same time, a light vehicle approached the intersection up a ramp to turn left. The haul truck proceeded through the intersection on the wrong side of the road as the vehicle attempted to turn left.<br><br>Before turning left, the vehicle driver looked to the right for oncoming traffic. The driver began the left hand turn but had to quickly apply the brakes to avoid a collision with the oncoming haul truck.<br><br>  | Mine operators must ensure all roadway intersections are designed, constructed, and maintained to safely manage interactions between mobile plant and light vehicles.<br><br>Intersections should be positioned at 90 degrees to haul roads to allow clear visibility for vehicles when travelling through them. |

## 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)** |
| MSHA | **Fatality - Final report (handing material)**<br><br>On November 17, 2023, at 3.55 pm, Modesto Montes, a 50-year-old miner with over 4 years of mining experience, died when the leg support structure of a stone saw stand that he was assisting to unload, shifted, and hit him.<br><br>The accident occurred because the mine operator did not:<br><br>• ensure that the leg support structure was unloaded in a manner that did not create a hazard to miners from falling or shifting<br>• provide new task training for unloading the leg support structure from a non-typical delivery method.<br><br>Details |
| | |

# Weekly incident summary week ending 24 May 2024

| Publication | Issue/topic |
|---|---|
| MSHA | **Final report (powered haulage)**<br>On August 30, 2023, at 6.50 am, Aaron Haley, a 34-year-old belt foreman with over 13 years of mining experience, died when a longwall belt conveyor take-up unit component, the bridle, broke and struck him. The accident occurred because the mine operator did not maintain components of the take-up in safe operating condition.<br>Corrective action: The mine operator:<br>• installed a new bridle on the moveable carriage. The new bridle was provided with gussets, which prevent the bridle from dropping down and contacting the track frame of the take-up when there is slack in the winch cable,<br>• installed a two-inch diameter plasma rope to the moveable carriage and bridle to prevent the bridle from breaking free if the connections break again<br>• developed and implemented a written policy prohibiting any miner from being in the belt conveyor entry between the belt drive and take-up winch when the belt conveyor is intentionally started or stopped, to reduce exposure.<br>Details |
| | **National (other, non-fatal)** |
| Resources Safety & Health Queensland | **Haul truck hits excavator**<br>While conducting top-loading operations at the base of a ramp, a fully loaded dump truck rolled backwards into an excavator that had been loading it, severely damaging the excavator cabin.<br>How did it happen?<br>• The excavator was operating on a slope at the base of the ramp and had not created a flat bench to work from.<br>• A safety bund had not been established in front of the excavator to create a barrier between the excavator and truck.<br>• When the excavator sounded the horn, the dump truck operator attempted to drive forward. The rear dump truck then rolled back into the excavator.<br>Key issues:<br>• The excavator had not established a safety bund prior to the trucks being loaded.<br>• The excavator was operating on a slope, instead of operating on a flat bench.<br>Details |
| Resources Safety & Health Queensland | **Unplanned initiations of loaded blast holes**<br>There have been 2 incidents in which electronic detonators experienced unplanned initiation during the energising process, directly before firing a blast. A formal investigation into the incidents is underway to identify what caused the unplanned initiation.<br>Key issues:<br>• A blast hole fired during the energisation process immediately before the firing key was applied.<br>• Blast holes firing before expected can generate projection and vibration hazards causing serious injury. |

| Publication | Issue/topic |
|---|---|
| | • Premature firing can impact other blast holes in the shot causing misfires, hole dislocation, and damage to other explosives in adjacent holes.<br><br>Note: The exclusion zone had been cleared and suitably guarded before the energisation process in both incidents.<br><br>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 | |
|---|---|
| CM9 reference | DOC24/138446 |
| Mine safety reference | ISR24-24 |
| Date published | 21 June 2024 |
| Authorised by | Director Technical Operations Mine Safety<br>Office of the Chief Inspector |