

# Weekly incident summary

## Week ending 23 August 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	42
Summarised incident total	4


### Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0047482 Construction materials	<p>Operators were using a mobile crushing plant to feed material through a transportable conveyor system when one conveyor broke from its mount and fell approx. 2.5 m to the ground.</p> <p>An oversized belt on the system caused overspill during operation. The plant was shut down at one stage and cleared before it was restarted.</p> <p>Ultimately too much material fed onto the cone belt causing the hopper to fill and the excess weight led to the conveyor collapse.</p>	<p>Plant needs to be fit-for-purpose with regular maintenance and inspection systems in place.</p> <p>After maintaining and repairing plant, the plant should be inspected, tested and verified as fit-for-purpose before being returned to service.</p>



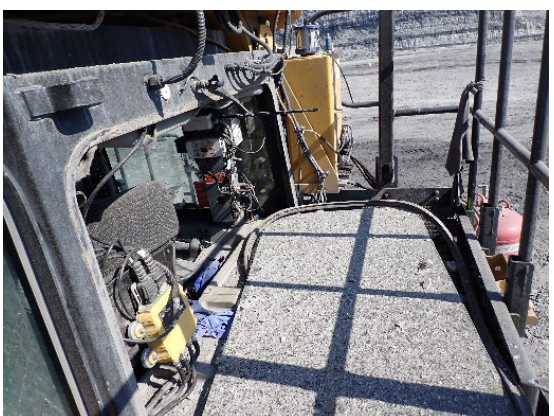
# Weekly incident summary week ending 23 August 2024

Incident type	Summary	Comments to industry
	<p>Two workers were standing beside a bolting rig, with their backs to the rib, at the corner of a cut-through intersection when a large piece of coal fell from the roof/rib interface and hit one of the workers on the shoulder.</p> <p>The worker suffered a fracture.</p> <p>The mechanism of the cornice failure was the formation of a block of coal that had 2 weak/free faces.</p>	
<p>Dangerous incident IncNot0047488 Underground coal mine Ground or strata failure</p> 		<p>Mine operators should have a procedure for supporting exposed cornices, or the installation of mechanical protection from exposed cornices.</p>

## Weekly incident summary week ending 23 August 2024

Incident type	Summary	Comments to industry
		
<p>Serious injury IncNot0047508 Underground coal mine</p>	<p>Contract mine workers were reclaiming a 300 x 30 cm pipe using a workbasket attached to a load haul dump machine (LHD). Two workers were in the basket and one was in the LHD.</p> <p>The recovered pipe was lying horizontally across the basket, unsecured. When the LHD moved forward the pipe hit a gate valve from a dropper and rotated in the basket hitting one worker in the back and knocking him forward. The worker's face hit the basket railing resulting in a laceration from his nose to his chin and the loss of 2 teeth.</p>	<p>This incident highlights the consequences of not using fit-for-purpose equipment for tasks and not having procedures that identify the risks in undertaking such tasks and how they are to be avoided.</p> <p>The risk of unsecured objects hitting a person is an easily identifiable risk for which controls need to be put in place before work begins.</p>

## Weekly incident summary week ending 23 August 2024

Incident type	Summary	Comments to industry
		
<p data-bbox="113 618 411 808">           Dangerous incident            IncNot0047505            Open cut coal mine            Fire or explosion         </p> 	<p data-bbox="419 618 975 741">           An uncontrolled explosion occurred due to a misfire adjacent to an excavator and a dozer.         </p> <p data-bbox="419 752 975 875">           Material from the dozer blade was blown off the blade and the windows on the dozer were damaged in the incident.         </p>  	<p data-bbox="983 618 1477 741">           This incident is under investigation and further information may be published later.         </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.

© State of New South Wales through the Department of Primary Industries and Regional Development 2024. You may copy, distribute, display, download and otherwise freely deal with this publication for any purpose, provided that you attribute the Department of Primary Industries and Regional Development 2024 as the owner. However, you must obtain permission if you wish to charge others for access to

## Weekly incident summary week ending 23 August 2024

the publication (other than at cost); include the publication in advertising or a product for sale; modify the publication; or republish the publication on a website. You may freely link to the publication on a departmental website.

Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (August 2024) and may not be accurate, current or complete. The State of New South Wales (including the Department of Primary Industries and Regional Development 2024), the author and the publisher take no responsibility, and will accept no liability, for the accuracy, currency, reliability or correctness of any information included in the document (including material provided by third parties). Readers should make their own inquiries and rely on their own advice when making decisions related to material contained in this publication.

Document control	
ISSN	2982-1010 (Online)
CM reference	RDOC24/156685
Mine safety reference	ISR24-33
Date published	30 August 2024
Authorised by	Director Technical Operations Mine Safety Office of the Chief Inspector