NSW Resources
Resources Regulator

Weekly incident summary

Week ending 30 August 2024

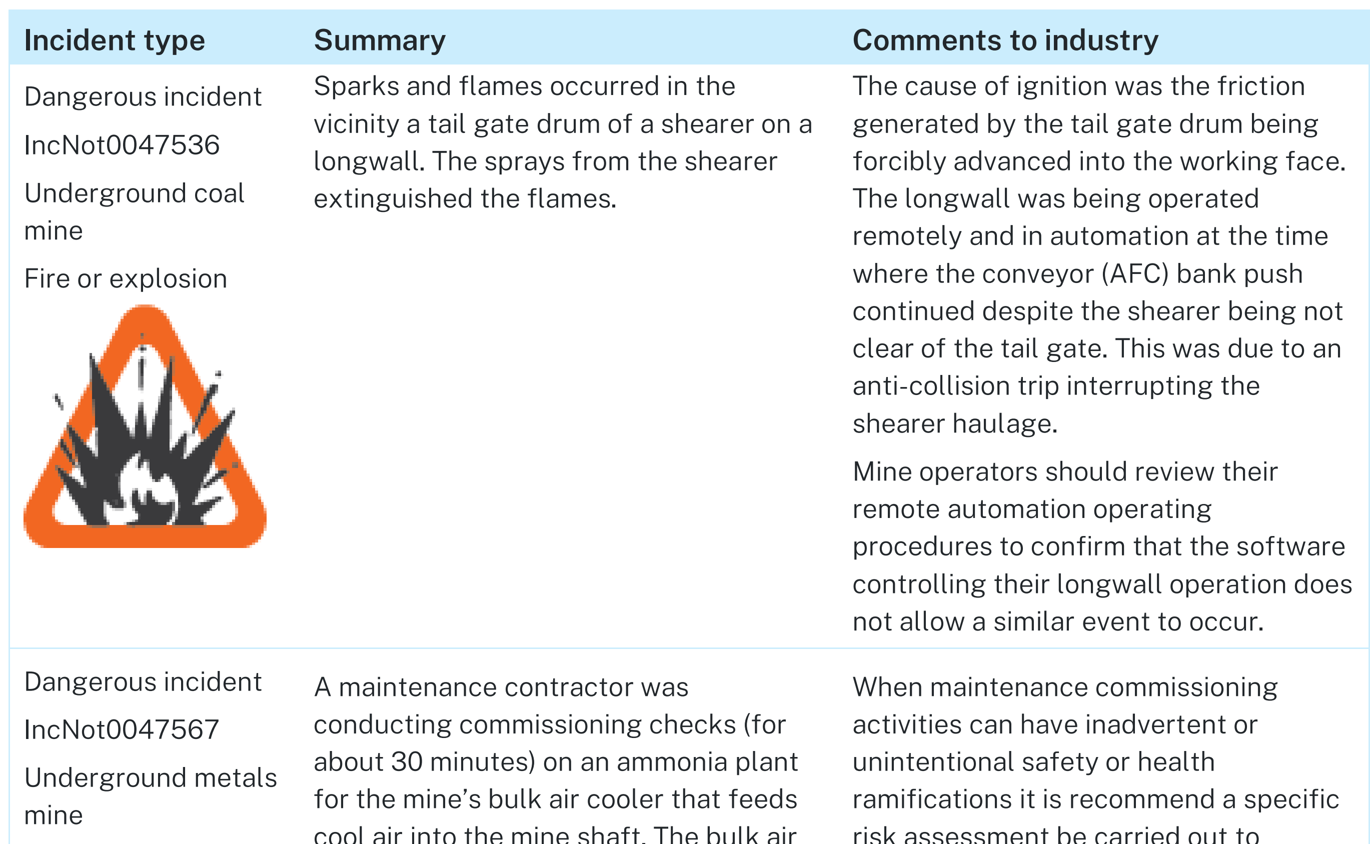
This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the Resources Regulator: phone 1300 814 609 24 hours a day, 7 days a week.

At a glance

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

Type	Number
Reportable incident total	46
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0047536 Underground coal mine Fire or explosion 	Sparks and flames occurred in the vicinity a tail gate drum of a shearer on a longwall. The sprays from the shearer extinguished the flames.	The cause of ignition was the friction generated by the tail gate drum being forcibly advanced into the working face. The longwall was being operated remotely and in automation at the time where the conveyor (AFC) bank push continued despite the shearer being not clear of the tail gate. This was due to an anti-collision trip interrupting the shearer haulage. Mine operators should review their remote automation operating procedures to confirm that the software controlling their longwall operation does not allow a similar event to occur.
Dangerous incident IncNot0047567 Underground metals mine	A maintenance contractor was conducting commissioning checks (for about 30 minutes) on an ammonia plant for the mine's bulk air cooler that feeds cool air into the mine shaft. The bulk air	When maintenance commissioning activities can have inadvertent or unintentional safety or health ramifications it is recommend a specific risk assessment be carried out to

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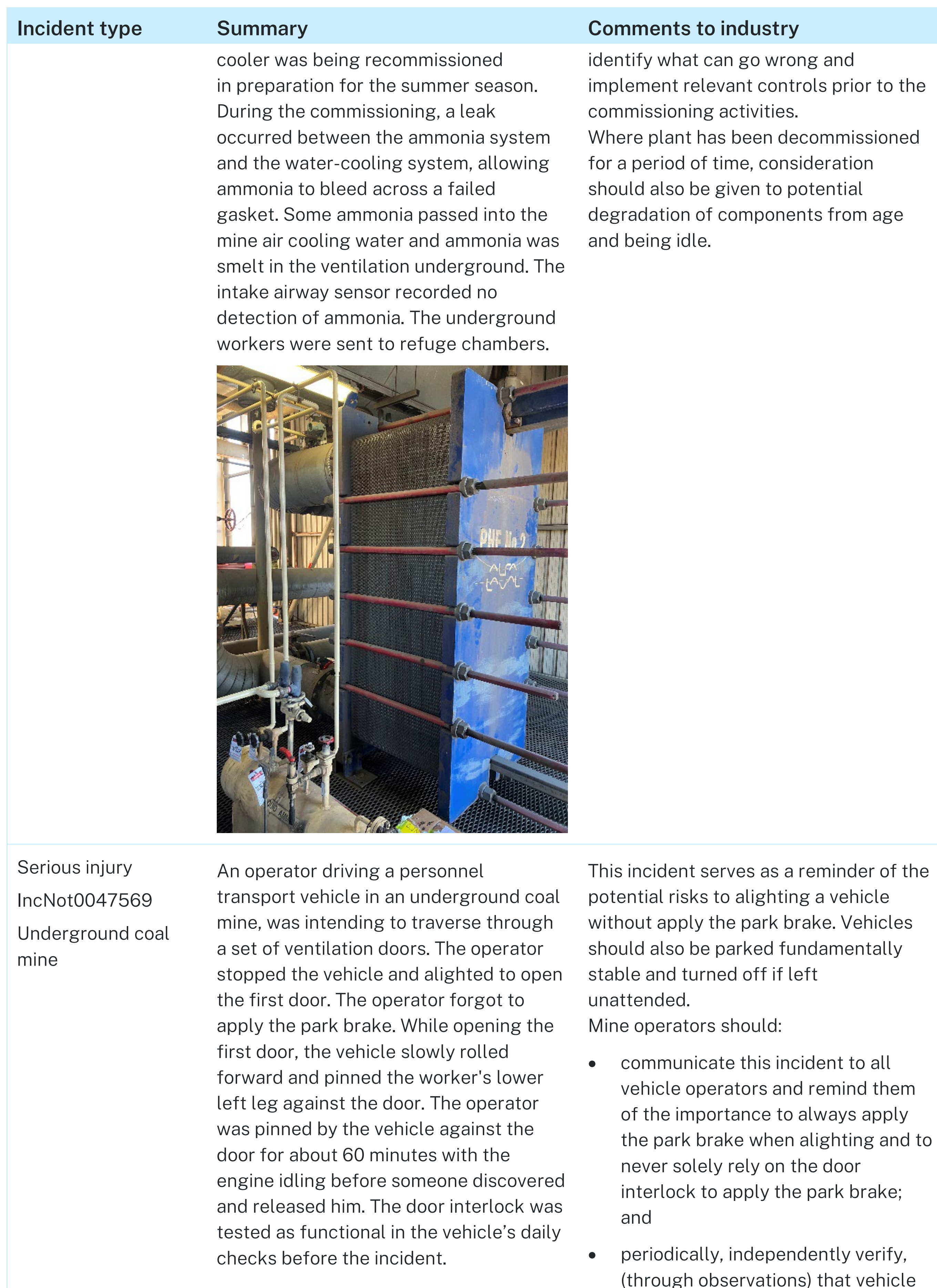
	cooler was being recommissioned in preparation for the summer season. During the commissioning, a leak occurred between the ammonia system and the water-cooling system, allowing ammonia to bleed across a failed gasket. Some ammonia passed into the mine air cooling water and ammonia was smelt in the ventilation underground. The intake airway sensor recorded no detection of ammonia. The underground workers were sent to refuge chambers.  	identify what can go wrong and implement relevant controls prior to the commissioning activities. Where plant has been decommissioned for a period of time, consideration should also be given to potential degradation of components from age and being idle.
Serious injury IncNot0047569 Underground coal mine	An operator driving a personnel transport vehicle in an underground coal mine, was intending to traverse through a set of ventilation doors. The operator stopped the vehicle and alighted to open the first door. The operator forgot to apply the park brake. While opening the first door, the vehicle slowly rolled forward and pinned the worker's lower left leg against the door. The operator was pinned by the vehicle against the door for about 60 minutes with the engine idling before someone discovered and released him. The door interlock was tested as functional in the vehicle's daily checks before the incident.	This incident serves as a reminder of the potential risks to alighting a vehicle without apply the park brake. Vehicles should also be parked fundamentally stable and turned off if left unattended. Mine operators should: • communicate this incident to all vehicle operators and remind them of the importance to always apply the park brake when alighting and to never solely rely on the door interlock to apply the park brake; and • periodically, independently verify, (through observations) that vehicle

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		operators do in fact apply the park brake when alighting.

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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