Weekly incident summary

Week ending 11 October 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	31
Summarised incident total	4

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0047788 Underground coal mine Ground or strata failure 	A large rib fall of about 5 m long x 3.1 m high x 1.2 m deep occurred when cutting in a herringbone mains panel. No one was present on the side of the continuous miner where the fall occurred, although a worker was on the opposite side platform. It did not appear to be a lubricated fault (greasy back). Rib support consisted of 1.2 m bolts at about 2.2 - 2.4 m above the floor.	When mining in an inferred area of geological disturbance strata, trigger action response plans (TARPs) are to be used as a proactive tool. That is, support should increase for both roof, and ribs. Cut-out distances should be adhered to for a higher-level TARP.

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Incident type	Summary	Comments to industry
		
Dangerous incident IncNot0047811 Underground coal mine Fire or explosion 	Heating occurred on an underground conveyor from a failed roller. While undertaking conveyor inspections, a deputy smelt something burning and found 2 x 5 mm glowing embers under the belt. The roller bearings had catastrophically failed, allowing the roller shell to run on the shaft, creating excessive friction and heat. 	Mine operators must have systems to identify and change-out defective conveyor rollers. Workers conducting conveyor inspections must be aware of the increased risk of roller failure at high tension areas of conveyors. They must also diligently inspect for fire risks such as accumulation of material, failing or collapsed idlers and contact between conveyor belts and fixed structures.
Dangerous incident IncNot0047797 Open cut coal mine Roads or other vehicle operating areas 	A loaded haul truck exceeded its retard window while descending an 8% ramp. The truck reached a speed of 60 kph before the operator made an emergency application of the service brake. The truck stopped within an estimated distance of 300 m. A working wheel dozer was positioned about 30-40 m from where the haul truck stopped.	When operating machinery, a worker's primary focus must remain on the operation and control of the vehicle. Excessive speeds can easily result in a fatality. All vehicle operators are required to adhere to the mine's road rules. Mine operators should review the triggers for competency assessment and the minimum level of competence required before workers are authorised for solo operations.

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Dangerous incident IncNot0047789 Open cut coal mine Roads or other vehicle operating areas 	An articulated truck rolled its dump body while negotiating a bend. The cabin remained upright, and no one was injured. 	Articulated truck rollovers continue to be a cause for concern on mine sites. The stability of articulated vehicles is a known risk that needs to be managed. When operating articulated equipment workers must drive at appropriate speeds, particularly when negotiating corners and turning the machine around.

Other Resources Regulator publications

Report released following fatality at Austar Coal Mine

An investigation information release has been published by the Resources Regulator following an incident where a contract worker was fatally injured when he fell through a mine shaft on 17 September 2024.

The incident occurred when contractors were preparing to attach steel plates to beams fixed to a shaft cover at the Austar Coal Mine's number 2 shaft. When the incident occurred, the mine was in a decommissioning phase and was being prepared for closure.

The mine is approximately 10 kilometres from Cessnock, in the NSW Hunter Valley.

The Investigation Information Release describes the initial investigations conducted by the Regulator into the cause and circumstances of the incident and provides safety information to industry. The mine operator and other parties are assisting with further investigations, and a report will be published when the investigation is concluded.

Read the investigation information release

Safety alert SA24-04 Haul truck rear strut injures worker

A swinging load hit a worker, resulting in injuries including a serious laceration to a leg. Other incidents of a similar nature where hydraulic cylinders, suspension or driveline components have not

been appropriately restrained, and have fallen, swung or slid, have occurred recently resulting in serious injuries or placing workers at risk.

Read the safety alert

Other publications of interest

The incidents are included for your review. The 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	On May 31, 2024, a 27-year-old roof bolter with over 3 years of mining experience, died when a portion of a mine roof fell on him. The incident occurred as he was traveling on foot through an area of unsupported roof. The accident occurred because the operator did not ensure that all miners were working or traveling under supported roof. Details
MSHA	On September 20, 2024, a miner died after he fell from a front-end loader while attempting to replace a bulb on the right front headlight. Best practices: • Develop and implement a safety program for surface mobile equipment that includes actions taken to identify hazards and risks to reduce accidents, injuries, and fatalities related to surface mobile equipment. • Identify hazards and risks. • Take corrective actions to eliminate/reduce risks. • Provide and maintain safe access to all workplaces and establish safe work procedures. 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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