Weekly incident summary

Week ending 27 September 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
Serious injury IncNot0047697 Open cut coal mine	A worker was fitting the upper pin to the left-hand rear strut of a haul truck and thought it was secured in place. Workers detached the sling and removed the forklift and jib, which were being used to support the strut. They were in the process of realigning the cylinder with the mounting boss to allow the pin to fully engage when the cylinder fell/rotated back onto the worker, grazing the worker's abdomen, and seriously lacerating the worker's leg.	The potential for this incident to have a fatal outcome cannot be understated. It is vital that the hazards and risks associated with removing and replacing rear strut cylinders on haul trucks be fully assessed and documented with appropriate controls developed and implemented. Particular attention needs to be given to the robust restraint of suspended or partially suspended loads that could fall, slide or pivot. Ensure that clear and detailed directions for the methods of restraining strut cylinders are included in procedures and are communicated to the relevant workforce.

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Incident type	Summary	Comments to industry
		Consider developing or purchasing task-specific lifting jigs to assist in controlling the hazard of falling, sliding, slewing or pivoting components.
Serious injury IncNot0047722 Underground coal mine	A worker lost consciousness following an incident while installing a ventilation tube. The worker's fingers became sucked in between the flexi duct and a ventilation tube but he eventually managed to free himself. Following the incident, the worker went into shock and was in and out of consciousness for about a minute.	Control measures and procedures in relation to installing ventilation tubes while auxiliary fans are in operation should include identifying: • safe operating ranges for workers installing ventilation tubes • the sequence of steps to take to safely add ducting inline • guards on the most inbye tube, to minimise the risk of workers being sucked into or against the ducting while working adjacent to it (e.g. on continuous miner platforms). Refer to: SA20-05 Worker sucked into auxiliary fan ventilation tube
Dangerous incident IncNot0047703 Underground metals mine Fire or explosion	An integrated tool carrier (IT) was working in a decline when the operator smelt smoke. They checked the IT, but though it was steam. Another worker noticed the fire in the IT and alerted the operator, who then activated the fire suppression system, which extinguished the fire. All workers were evacuated to refuge chambers.	Mine operators are reminded that maintenance systems must be comprehensive and should consider all reasonably foreseeable risks of fire or explosion. Plant and equipment must be maintained in accordance with Work Health and Safety Regulation 2017, clause 213 Maintenance and inspection of plant.

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	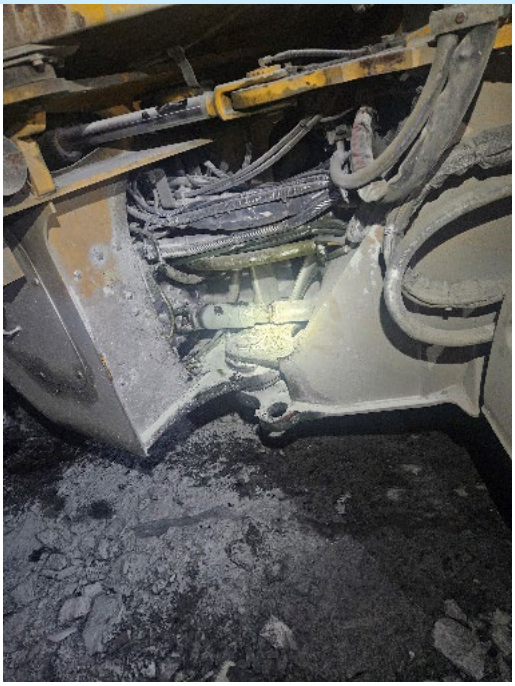	Non-destructive testing (NDT) inspections should be scheduled at pre-determined intervals to minimise the risk of equipment failure. AS5062:2022 Fire prevention and protection for mobile and transportable equipment, was published in November 2022. Mine operators should review this update to the Standard.

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 16, 2024, about 2.15 am, a 59-year-old contract excavator operator with 10 weeks of mining experience, died after the excavator he was operating travelled over a highwall and fell before coming to rest on top of spoil material in the pit below. The Operator was ejected from the operator's cab during the fall. The accident occurred because the mine operator did not establish and follow a ground control plan that insured safe working conditions. 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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Document control	
ISSN	2982-1010 (online)
CM reference	RDOC24/182912
Mine safety reference	ISR24-38
Date published	4 October 2024
Authorised by	Deputy Chief Inspector Office of the Chief Inspector