NSW GOVERNMENT

Weekly incident summary

Week ending 13 December 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	38
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0048197 Open cut coal mine Roads or other vehicle operating areas 	During the process of tipping a load, the position 5 and 6 wheels of a haul truck slumped, causing the position 1 wheel to raise about 1.5 metres off the ground. 	Dumping operations should conform to design and operational parameters that ensure stability and safe tipping operations. Mine operators must ensure a system is in place to monitor the compliance to these parameters at all times. Operators involved in dumping operations must be competent to do so, and have the knowledge and ability to raise timely compliance concerns when dump construction and/or operations are non-compliant.

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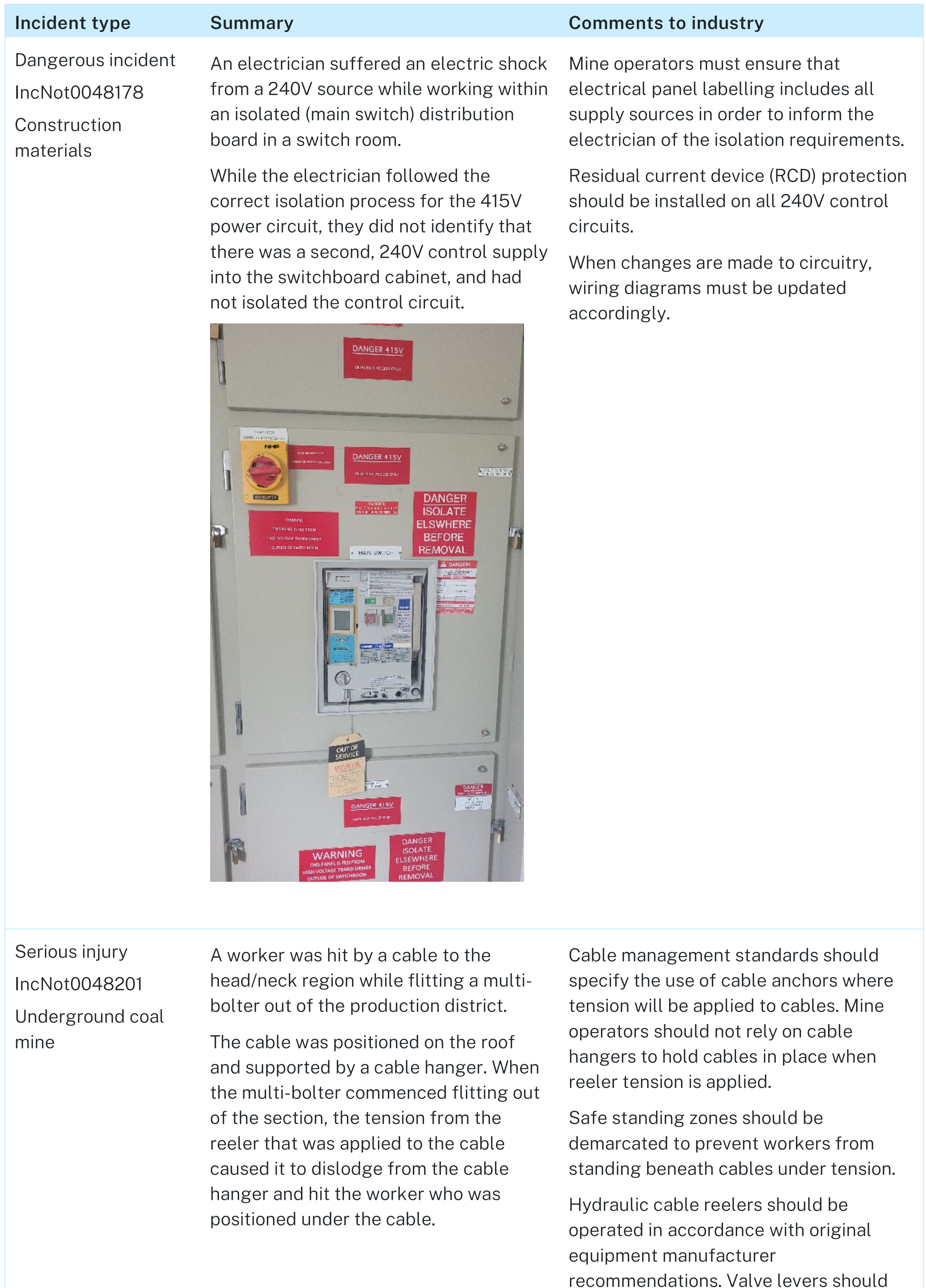
Incident type	Summary	Comments to industry
Dangerous incident IncNot0048178 Construction materials	An electrician suffered an electric shock from a 240V source while working within an isolated (main switch) distribution board in a switch room. While the electrician followed the correct isolation process for the 415V power circuit, they did not identify that there was a second, 240V control supply into the switchboard cabinet, and had not isolated the control circuit. 	Mine operators must ensure that electrical panel labelling includes all supply sources in order to inform the electrician of the isolation requirements. Residual current device (RCD) protection should be installed on all 240V control circuits. When changes are made to circuitry, wiring diagrams must be updated accordingly.
Serious injury IncNot0048201 Underground coal mine	A worker was hit by a cable to the head/neck region while flitting a multi-bolter out of the production district. The cable was positioned on the roof and supported by a cable hanger. When the multi-bolter commenced flitting out of the section, the tension from the reeler that was applied to the cable caused it to dislodge from the cable hanger and hit the worker who was positioned under the cable.	Cable management standards should specify the use of cable anchors where tension will be applied to cables. Mine operators should not rely on cable hangers to hold cables in place when reeler tension is applied. Safe standing zones should be demarcated to prevent workers from standing beneath cables under tension. Hydraulic cable reelers should be operated in accordance with original equipment manufacturer recommendations. Valve levers should

Incident type	Summary	Comments to industry
		not be left at the mid-point if the valve is designed to be in either the 'on' or 'off' position.

Other Resources Regulator publications

Investigation information release IIR24-11 Worker exposed to serious risk of injury while refuelling petrol-powered water pump that ignited

A worker suffered minor burns but was exposed to the risk of more serious injury when a petrol-powered water pump he was refuelling ignited. The incident occurred at Glenella Quarry, Cowra, NSW on 25 November 2024

Read the full report

Investigation information release IIR24-12 Worker suffers serious injuries while working under truck trailer

A worker suffered multiple serious injuries when a truck trailer that he was working under rolled onto him. The incident occurred at Possum Brush Quarry, Possum Brush on 3 December 2024

Read the full report

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	**USA - Fatality, 5 August 2024 – fatal powered haulage accident, final report** On August 5, 2024, at 5.55am, William Crandall, a 57-year-old locomotive operator with 11 years of mining experience, was seriously injured when airbags suddenly dislodged while work was being performed to rerail a longwall electrical power car. The unanticipated movement of the airbags caused the power car drawbar to strike Mr Crandall in the head. He died from his injuries on August 7, 2024. The accident occurred because the mine operator did not: 1. properly install the track rails to accommodate all equipment that would use them,

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Publication	Issue/topic
	2. properly train all miners on the use of airbags to rerail track mounted equipment, and 3. have adequate written guidance to ensure the proper use of airbags to rerail track mounted equipment. Details
MSHA	**USA - Fatality alert: 27 November 2024 – powered haulage** On November 27, 2024, an electrician died when a load haul dump (LHD) machine hit him. The electrician was outside of his mine utility vehicle and was struck by the LHD loader tire. Details
MSHA	**USA - Fatality, 6 September 2024 – fatal fall of roof or back accident, final report** On September 6, 2024, at approximately 5:55pm, Gary Chapman, a 33-year-old continuous mining machine operator with over 12 years of mining experience, died when he was hit by falling rock from the mine roof. The accident occurred because the mine operator did not: 1. comply with the approved roof control plan 2. conduct adequate examinations of the I-5 working section, and 3. have procedures in place to prevent miners from working or traveling under unsupported roof. Details
MSHA	**USA - Fatality alert: 16 November 2024 – machinery** On November 16, 2024, a miner died when he became entangled in a log washer. The miner was last seen standing on a deck and using a water hose to wash material out of the log washer to clear a blockage. Details
	International (other, non-fatal)
MSHA	**USA - Safety alert: dump point and stockpile safety** Recent accidents highlight the risks associated with dump points and stockpiles, especially where stockpile stability and visibility are of concern. Fatalities and serious injuries have occurred when heavy equipment operators travelled or dumped material too close to a stockpile edge or worked too close to the toe of an over-steepened stockpile. Details
	National (other, non-fatal)
Resources Safety & Health Queensland	**QLD - Uncontrolled movement of service truck module** During the commissioning of a new service truck, a worker was emptying the main diesel tank of a service truck to access a faulty level sensor. The service module then unexpectedly tilted backward, nearly causing the hose pod to touch the ground. The worker was uninjured but was exposed to significant risk during the incident.

Publication	Issue/topic
	Details
Government of Western Australia	**WA - WorkSafe Mines Safety releases animation video where an operator was trapped between an EWP and overhead structure** An operator and a surveyor were in a mobile elevated work platform (EWP), taking survey measurements on a stacker structure to improve conveyor belt alignment. They were working in close proximity to the underside of the stacker conveyor frame, located about 27 metres above the ground. When the operator moved the EWP basket upward, his head became trapped between the stacker frame and the secondary guarding sensor bar in the basket. The alarm at the EWP base alerted the spotter, who then proceeded to lower the basket. The operator suffered injuries that had the potential to be serious, and he lost consciousness for a few minutes. 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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