

Incident summary

From 15 December 2024 to 4 January 2025

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	86
Summarised incident total	7

Summarised incidents


Incident type	Summary	Comments to industry
Dangerous incident IncNot0048218 Surface coal mine Roads or other vehicle operating areas	<p>At 6.37am on December 15, a dump truck, travelling south on Western Highwall Road, failed to give way at an intersection to another dump truck approaching from the left.</p> <p>The operator of the first dump truck took evasive action, stopped to secure the scene, and repeatedly called the other operator, who was on the maintenance channel and continued through the intersection, unaware of the situation.</p> <p>The senior open cut examiner on shift did not secure the incident.</p>	Human and organisational factors continue to be a contributing factor in near miss traffic incidents. The mine should consider a human and organisational factors analysis when undertaking their investigation to ensure all performance shaping factors are considered including personal, job, environment, team and organisational factors.



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	<p>The apparent cause was the operator being distracted when entering the intersection.</p> 	
<p>Dangerous incident IncNot0048254 Surface coal mine Roads or other vehicle operating areas Fatigue</p>  	<p>A worker driving a light vehicle experienced a micro-sleep, causing the vehicle to hit a windrow on the left side of the haul road and overturn onto the driver's side.</p> <p>The worker was uninjured and safely exited the vehicle, with no other occupants involved. The apparent cause was fatigue-related.</p> <p>An investigation has been initiated.</p> 	<p>Mine operators should undertake a review to ensure all workers including supervisors and contractors are adhering to the mine's fatigue management plan.</p> <p>Mine operators should be aware of their legislative obligations regarding fatigue. This includes:</p> <ul style="list-style-type: none"> • having effective control measures for minimising the risk that workers will be impaired by fatigue. (Schedule 2 (1)(b) Work Health and Safety (Mines and Petroleum Sites) Regulation 2022) • implementing control measures to either eliminate or where reasonably practicable minimise the risk with regards to systems of work, including how the work is managed, organised, and supported. (Division 11, Cl 55D (2)(d) Work Health and Safety Regulation 2017. <p>For more information on identifying controls to management the complexity and variability of fatigue please refer to the Safety bulletin – Fitness for work- Fatigue.</p>

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<p>Dangerous incident IncNot0048272 Surface coal mine</p>	<p>A mine worker participating in emergency training using an emergency chute module in the open-cut workshop fell about 2 metres when the chute failed.</p> <p>Initially reporting back pain and a sore elbow, the worker later underwent scans, revealing an acute fracture to the T12 vertebra.</p> 	<p>Height rescue equipment must undergo regular inspection by a competent person.</p> <p>Mine operators must ensure that equipment selected to be used on the mine site is fit-for-purpose and must ensure that new risks are identified and controlled.</p>
<p>Dangerous incident IncNot0048279 Surface coal mine Roads or other vehicle operating areas</p> 	<p>A Komatsu HD325 rigid haul truck overturned after making contact with raw material while exiting a corner. The operator suffered minor injuries, including a crush injury to the fingers on their left hand and a small knee laceration, and received treatment at hospital.</p> <p>A potential mechanical issue or speed factor is being investigated.</p>	<p>This matter is under investigation and further information may be published later.</p>

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<p>Dangerous incident IncNot0048291 Surface processing plant</p>	<p>In a processing plant, a pressurised elution column valve opened, releasing heated solution that hit a worker on the front and back.</p> <p>The worker received first aid on-site, required no further off-site treatment, and returned to work the following morning. Preliminary investigations suggest the incident was not due to a mechanical issue. The mine operator is conducting an investigation and findings will be provided to the Regulator.</p>	<p>The cause is yet to be determined, however, mine operators should review their plant risk assessments and ensure workers are unable to access areas of high risk unless appropriate controls are identified and implemented.</p> <p>Mine operators should also design their equipment to ensure inadvertent opening of valves by operators cannot occur.</p>
		

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<p data-bbox="113 203 395 371">Dangerous incident IncNot0048298 Underground coal mine</p>	<p data-bbox="395 203 1011 763">At longwall 203, a fitter removing armoured face conveyor (AFC) chain joiners as part of a replacement program was squatting in the AFC/BSL (bootstrap loader) interlace area when the top chain suddenly moved 300 to 400 mm toward the tailgate, trapping his leg against a step. The workgroup freed the fitter, who was transported to the surface and then to Narrabri Hospital. He suffered muscle damage to his right calf but no broken bones, with a potential crush injury. The apparent cause was stored energy in the chain, likely caught across the pans, releasing as the tailgate slow runner pulled the chain to free up slack for joiner removal.</p> 	<p data-bbox="1011 203 1479 707">Trapped energy and recoil are known and foreseeable risks associated with working on AFCs that have resulted in fatalities. Mine operators are to ensure that their systems of work include confirmation of dissipation of energy from a system before work is to be undertaken.</p> <p data-bbox="1011 562 1479 707">Mine operators are to remain cautious and alert to the possibility that unknown energy may be stored in AFC chain.</p>
<p data-bbox="113 1265 395 1518">Dangerous incident IncNot0048301 Underground metalliferous mine Inundation or inrush of any substance</p> 	<p data-bbox="395 1265 1011 1675">While exploration drilling underground toward an abandoned mine, workers encountered an inrush event as water and tailings flowed from the drill hole. About 6 to 9 metres of water emerged, prompting the team to plug the hole overnight. Drilling into old workings revealed water and unconsolidated tailings, with an estimated flow of 15–20 litres per second at 40 PSI, accompanied by mud. The area was excluded from access while an engineering solution was developed.</p>	<p data-bbox="1011 1265 1479 1603">There are many regions in NSW where abandoned mines interact with active mines. It is the duty of the mine operator to ensure that robust mine planning considers the likelihood of water bearing abandoned workings and develops systems to avoid those workings.</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.

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