

# Weekly incident summary

## Week ending 17 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	48
Summarised incident total	3

### Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0048373	An operator was injured when a rib slump occurred during rib support installation.	The potential for a fatal outcome from rib failure is well understood.
Underground coal mines Ground or strata failure	Two operators were using an air track when installing secondary rib support.  A hole was drilled in the rib and chemical was installed. The operator retracted the drill rig head plate off the rib to install a rib bolt. The rib slumped, and as the operator pulled his hand away, it was caught between the rig mast and the falling rib. The wedge of rib coal that fell was about 1500 mm high, 700 mm wide and 300 mm deep.  Before the work started, there was no sign of any deformity and no visual sign of fracture or failure while the drilling was taking place.	While there may be no visible signs of potential rib failure, it is nonetheless imperative that consideration is given to this possibility. Any risks to operators should be mitigated by implementing appropriate controls.  The method of bolting that affords the most protection to operators by minimising the risk of coming into contact with a slump or fall of rib should be used at all times.



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Incident type	Summary	Comments to industry
<p data-bbox="124 607 368 853">           Dangerous incident            IncNot0048381            Open cut coal mine            Roads or other            vehicle operating            areas         </p> 	 <p data-bbox="419 607 916 880">           A wheel dozer was working on a dump when it reversed 30 metres and collided with the front of a stationary haul truck. The truck operator was waiting for direction from the wheel dozer operator. The wheel dozer operator did not look behind him while reversing.         </p> 	<p data-bbox="967 607 1463 752">           Workers have a duty to take reasonable care for themselves and others while in the workplace. Operators should always check their path when reversing.         </p> <p data-bbox="967 775 1463 954">           Mine operators should prioritise segregation between dozers and haul trucks on dumps over lower order controls such as positive communications and work procedures.         </p>
<p data-bbox="124 1323 368 1480">           Dangerous incident            IncNot0048366            Underground coal mine         </p>	<p data-bbox="419 1323 927 1686">           While using a battery-powered grinder, a tradesperson lacerated his thumb through his glove. The worker was grinding a workpiece when he removed his left hand from the grinder's hand-hold to support the workpiece. During this process the grinding disk grabbed on the work piece allowing the grinding blade to cut through the glove and into his left thumb.         </p>	<p data-bbox="967 1323 1401 1424">           Angle grinders can be a dangerous power tool. Kickbacks can result in severe cuts.         </p> <p data-bbox="967 1447 1441 1592">           When carrying our grinding activities, mine operators should have safe work practices in place and workers trained in those practices.         </p> <p data-bbox="967 1615 1441 1794">           During grinding activities, the work piece should be held firmly. To reduce the likely hood of kickback, minimum pressure should be applied from the grinder to the work piece.         </p>

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## Other Resources Regulator publications

### Worker suffers serious injury while working on an unguarded section of a fixed conveyor

The Resources Regulator has published an investigation information release after a worker suffered a serious injury while working on an unguarded section of a fixed conveyor at Clarence Sands Quarry, near Lithgow on 2 December 2024.

A worker was adjusting a conveyor belt alignment arm when his right arm became entangled with the belt and rollers. This resulted in a serious injury to his arm, where the worker was transferred to hospital and later underwent surgery.

The Regulator has commenced an investigation to determine the cause and circumstances of the incident.

Quarry and mine operators are reminded of their duty to identify hazards and manage risks to health and safety in accordance with the provisions of the *Work Health and Safety Act 2011* and *Work Health and Safety (Mines and Petroleum Sites) Act 2013* and Regulations.

Read the full [investigation information release \(PDF, 464.63 KB\)](#)

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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