Weekly incident summary

Week ending 24 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	21
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0048434 Open cut coal mine Fire or explosion 	While driving up a ramp in an open cut pit, a truck operator noticed a failed turbo and reported it on the maintenance channel. As the truck ascended, flames erupted from the right-hand side, prompting the operator to call an emergency. Dispatch activated a site-wide emergency response. The operator stopped, exited the truck via the stairway, but went back to retrieve his hard hat and exited the burning truck again. The operator did not shut down the truck, and fire suppression was not triggered. Engine oil from the failed turbo ignited on the exhaust, spreading to the right-hand fender's sound suppression material. A mining supervisor activated the emergency stop and fire suppression from the front bumper. A water cart attended the scene and extinguished the fire.	Mine operators should regularly assess the emergency preparedness capabilities of their heavy vehicle operators. Understanding what the appropriate actions are when a fire breaks out on a heavy vehicle and implementing the actions immediately can significantly reduce the risks that the operator may be exposed to during egress from the vehicle. Understanding the best method of rapid activation of onboard fire suppression systems is an essential item of competence for all heavy vehicle operators.

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Dangerous incident IncNot0048425 Surface of underground coal mine Fire or explosion 	A battery on a surface skid pump pressurised and split the casing - releasing battery fluid in an uncontrolled manner. After an operator completed refuelling a dewatering skid pump, the operator started the diesel engine. During the starting process, the operator heard a loud bang as one of the 2 sealed lead acid batteries on the skid pressurised and split the battery casing causing plastic pieces of the battery to eject outward, along with battery fluid. The pressure release pushed open the unsecured hinged battery enclosure lid. An internal battery fault caused the battery fluid to vaporise while the engine started and drew current, pressurising the battery casing and causing the plastic casing to fail.	When developing maintenance strategies, mine operators need to ensure they are appropriate to each item of plant at the mine and that the overall life cycle is taken into consideration. Recommendations of designers and manufactures must be followed when determining maintenance requirements.

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High potential incident IncNot0048421 Underground coal mine Ground or strata failure 	Monitoring a section of roof in a mining place showed movement on a tell-tale. This movement was continually monitored by the panel deputy and undermanager on shift. Mining proceeded until monitoring indicated an increase in displacement to a level which started a trigger action response plan (TARP). About 9am, the undermanager, in accordance with the TARP, withdrew the continuous miner back to the 10 metre chainage mark and commenced upgrading the roof support to code red. At this point, senior management was notified and confirmed the actions being taken. At 12.45pm, the undermanager notified the geotechnical engineer that the tell-tale had moved to 40 millimetres and continued installing additional support with the concurrence of the geotechnical engineer. At 5pm, the undermanager notified the geotechnical engineer that the tell-tale had continued to move to 60 millimetres and that roof deformation was noticeable. As a precaution, the continuous miner was pulled back to the intersection and the erection of additional support was stopped. The geotechnical engineer and inspected workings at 9pm and saw visible signs of	This incident highlights the need for prompt action when strata monitoring equipment indicates that roof convergence is occurring. Site specific ground support TARPs should incorporate the timely installation of appropriate standing support where rates of convergence indicate accelerating deterioration in the stability of the monitored area. The ongoing improvement of geotechnical inputs into ground support design has significantly reduced the incidence of such failures over the last decade, however strata failure remains a fundamental risk with localised geological anomalies potentially affecting the adequacy of the ground support as it was designed and installed. Ground support designs will ideally be able to tolerate localised changes that demand more load-carrying ability than the installed ground support.

Incident type	Summary	Comments to industry
	active roof deformation, roof support loading and audible strata noise. The tell-tale at this point read 110 millimetres. All workers and machinery were withdrawn and a breaker line chock timber was installed on the inbye side of the intersection and the place was barricaded. About 9am, a fall occurred inbye of the tell-tale at 28 metres chainage. The fall extended towards the face. The fall occurred about 12 hours after all workers were withdrawn.	

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.

Document control	
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