Weekly incident summary

Week ending 7 March 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.

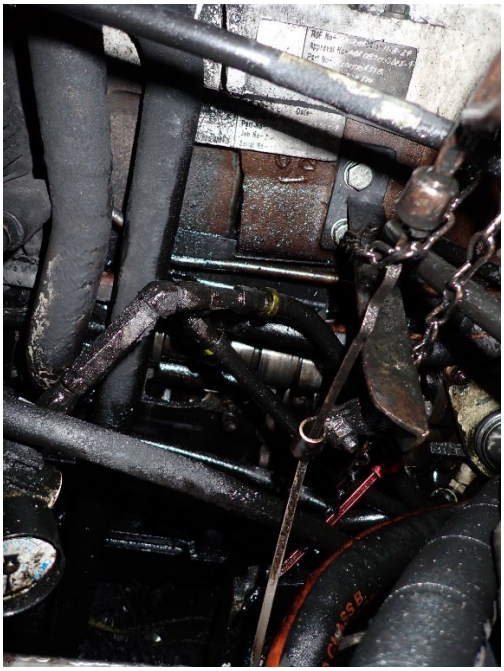
At a glance

High level summary of emerging trends and our recommendations to operators.

Type	Number
Reportable incident total	33
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0048672 Underground coal mine Fire or explosion 	A load haul dump machine (LHD), fitted with an explosion-protected diesel engine, was picked up from pit bottom in an underground coal mine. After driving a short distance, the LHD operator heard a ticking noise from the diesel engine. The operator stopped and returned towards pit bottom for maintenance to check the machine. After driving 3-4 pillars, the operator heard a loud bang and the LHD stopped. The top end of the explosion-protected diesel engine systems (ExDES) had catastrophically failed with a hole blown in the side of the diesel engine and internal engine components being exposed to the mine atmosphere. The machine was quarantined with a root cause investigation being conducted by the mine and the original equipment	The catastrophic failure of a diesel engine system presents a significant risk because the temperature of the ejected components created an ignition source that had the potential to cause an explosion. Persons conducting a business or undertakings in control of ExDES should ensure maintenance, inspection and testing is carried out in accordance with the manufacturer's recommendation, and thorough inspection and testing is undertaken before commissioning plant. In particular: • Ensure correct operation of automatic engine shutdown systems (loss of engine oil pressure).

Incident type	Summary	Comments to industry
	manufacturer. The lifecycle age of the diesel engine has not been established. 	• Engine oil should be maintained at the correct level. • Engine oil and filter changes should occur at a frequency recommended by the engine manufacturer. • Engine oil should be used to the engine manufacturer's specifications and suited for the ambient temperature range of the environment. • Engine oil should be stored and decanted to prevent contamination by dirt or water. • Oil sampling and analysis should be conducted regularly. Further information on a similar event can be found in causal investigation, Causal investigation: Catastrophic engine failure in underground coal mine.
Dangerous incident IncNot0048688 Underground metalliferous mine	An electrician and an apprentice electrician were performing electrical maintenance when the apprentice suffered an electric shock. The task included tightening the terminals on a magnet starter with 2 panels side-by-side. The apprentice was in one panel and the electrician in the other, tightening terminals. The apprentice touched the live side of the main isolator with a 1000 volt insulated screwdriver. A screwdriver was insulated with interchangeable heads, and the fingers on the right hand were used to access the terminal section, which was also insulated. The voltage was 415V 3 phase and the apprentice came in contact with a phase to earth voltage (240 volt). The isolations applied to the panel were incorrect (personal locks and tags applied to outgoing isolators not the main isolator of the board). The task of terminal tightening within the panel should have called for an upstream isolation.	Mine operators need to ensure safe systems of work are developed for people dealing with electrical plant and electrical installations that include the isolation, dissipation and control of all energy sources from electrical plant or electrical installations. The failure to isolate sources of electrical energy before undertaking electrical work exposes workers to a high level of risk from electrocution, electric shock, burns and/or injuries resulting from ignition of flammable gas or dust, unintended operation or movement of plant. It is important to note that while the activities of operating an isolation point, or multiple isolation points, dissipation of stored energy sources, and implementing the necessary tests for de-energised correctly will eliminate a hazard and create a safe environment for workers, these acts are procedural. A hazardous energy source can only be regarded as having been controlled when all the required actions have been implemented correctly.

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	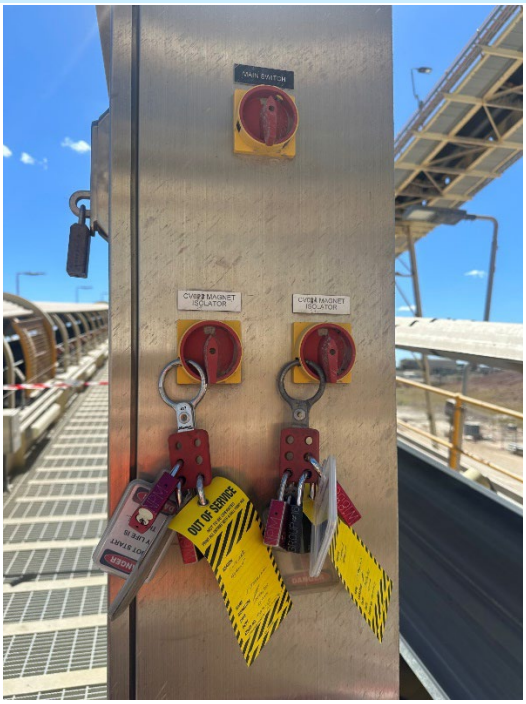	See the link below to view a video developed by the Resources Regulator to help workers on mine sites ensure isolation is carried out correctly to prevent incidents in mines and to ensure workers understand how it is done properly. www.resources.nsw.gov.au/news-articles/effective-isolation-procedure
Dangerous incident IncNot0048700 Underground coal mine Ground or strata failure 	A shearer was cutting back into the tailgate for a second shear of shift when the continuous miner worker noticed what appeared to be a roof fall adjacent to the tailgate drive. The longwall mining supervisor was contacted, who inspected and identified a roof fall that was impeding access from the tailgate. The area was barricaded to prevent access.  	This incident highlights that loading applied to an active tailgate roadway ground support increases immediately outbye the faceline as the face retreats and abutment loads are redistributed outbye. This increase in loading on the installed ground support, particularly if accompanied by the presence of a localised geological anomaly can result in a fall of ground. The improvement of geotechnical inputs into ground support design has significantly reduced such failures over the past 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 from the installed ground support.

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
	National (other, non-fatal)
WorkSafe Victoria	**Safety alert: Isolate, de-energise, lockout and tagout plant before maintenance** An incident has occurred where a quarry maintenance employee was removing screens from a mobile screening plant. This task required the employee to work on the output conveyor of the plant. During the maintenance activity another quarry employee started the screen plant to loosen grass caught in the screen. The employee working on the screen was ejected from the plant when the conveyor started, and was impaled by a 60 cm long metal tool around his chest and shoulders, resulting in significant injuries. The injured employee was taken to hospital in an air ambulance. 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.

Document control	
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