

Weekly incident summary

Week ending 12 May 2023

This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the NSW 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.

Туре	Number
Reportable incident total	46
Summarised incident total	1

Summarised incidents

Incident type Summary Comments to industry Dangerous Incident A feeder breaker was being trammed up a grade The operating limits of machines in a development panel by a trainee operator and such as grade and speed, and IncNot0044657 trainer. The feeder breaker rode up onto a rock position of workers must be Underground coal on the ground that started to crack and break. considered when planning tasks The trainee operator stopped tramming. When such as flits. mine the trainee started tramming again, the breaker Trainees must have a clear feeder moved down the hill towards the workers. understanding about the The feeder breaker rolled about 4 metres before operating parameters and it stopped. The trainee dropped the pendant. The characteristics such as braking cable was caught under the tracks and the performance. power tripped. Pendants and remote controls must have functions and their operating direction clearly marked. Pre-use inspections should include checking that these markings are legible.

Weekly incident summary week ending 12 May 2023

Other publications of interest

The incidents are included for your review. The NSW 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	On March 22, 2022, at 9:30 a.m., Tony Killian, a 44 year-old heavy equipment operator, with over 6 years of mining experience, died when a pump raft he was working on capsized, causing him and another miner to fall into a stormwater retention pond. Killian became entangled with the pump raft, causing him to drown.	
	The accident occurred because the mine operator:	
	 did not provide safe access for miners to repair the pump and pump raft equipment, did not properly train miners working on pump raft equipment and safe work procedures, and used pump raft FVT-1 beyond the designed capacity intended by the manufacturer by allowing miners to use pump raft FVT-1 as a work platform while performing maintenance and repairs. 	
	<u>Details</u>	

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.

© State of New South Wales through Regional NSW 2023. You may copy, distribute, display, download and otherwise freely deal with this publication for any purpose, provided that you attribute Regional NSW as the owner. However, you must obtain permission if you wish to charge others for access to the publication (other than at cost); include the publication in advertising or a product for sale; modify the publication; or republish the publication on a website. You may freely link to the publication on a departmental website.

Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (May 2023) and may not be accurate, current or complete. The State of New South Wales (including Regional NSW), the author and the publisher take no responsibility, and will accept no liability, for the accuracy, currency, reliability or correctness of any information included in the document (including material provided by third parties). Readers should make their own inquiries and rely on their own advice when making decisions related to material contained in this publication.

Document control	
CM9 reference	RDOC23/103541
Mine safety reference	ISR23-18
Date published	19 May 2023
Authorised by	Deputy Chief Inspector Office of the Chief Inspector