Weekly incident summary

Week ending 27 October 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.

Type	Number
Reportable incident total	61
Summarised incident total	5

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0045641 Underground coal mine	While in the process of recovering a compressed air pipe range, the range was isolated and de-energised before work commenced. However, a 13 metre section of pipe that had a closed gate valve was still energised. When the worker started to remove the quick release clamp his left forearm was hit with compressed air.	Effective isolation and energy dissipation practices are critical risk controls when working with high pressure air systems. Where stored pressure can remain in a circuit (such as check valves and gate valves), appropriate methods must be available to safely dissipate pressure. Mines' risk assessments on pressure systems must identify and provide effective controls for areas of trapped pressure. **Refer to:** Investigation information release (IIR22-01) Two mine workers injured during pipe installation work
Dangerous incident IncNot0045653 Underground metals mine Ground or strata failure	While securing mesh with a multibolter the temporary roof support (TRS) was pushed to the roof and then released to preposition the last sheet of mesh. When the TRS was lowered, it caused a parting layer of tops to fall onto the walkway of the multibolter. There were 2 workers on the multibolter. No-one was injured.	Underground mines should review the adequacy of their strata monitoring arrangements and associated trigger action response plans (TARPs), to ensure that workers are not exposed to unacceptable risks associated with strata failure. **Refer to:** NSW code of practice - Strata control in underground coal mines

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	The piece of stone was about 750 mm wide, 1000 mm long and 180 mm thick.	
Dangerous incident IncNot0045655 Open cut coal mine Roads or other vehicle operating areas 	A rear dump truck reversed into a tip area to tip its load. The truck backed up to and through a dump windrow with both sets of dual tyres, causing the truck to become stuck on the dump edge with its belly on the ground and duals over the edge. 	Windrow design, construction and maintenance is a critical factor in dump safety. Mines operators should: • design and construct windrows adequately to be a control for the hazard at the operation, paying specific attention to set-back distances, heights and material used • regularly inspect and maintain windrows through open cut examiner inspections and operator inspections. **Refer to:** Safety Bulletin SB18-11 Windrow management and demarcation
Dangerous incident IncNot0045656 Underground metals mine	A truck tyre was being transported underground on the forks of an integrated tool carrier (IT). While driving down the decline, the tyre came off the forks and rolled down the decline striking the rear of a popping rig that was tramming down the decline. The tyre continued rolling before stopping 500 metres from where it dislodged from the forks. 	Workers should ensure that loads are adequately secured to prevent unplanned movement. Using slings, support cradles or suitable jigs appropriately rated for the load, should be considered. Documented procedures providing step-by-step instructions for the task should be provided to workers. Supervisors should ensure that the approved procedures are followed.
Dangerous incident IncNot0045666 Open cut coal mine Fire or explosion	An excavator caused an unintended initiation of explosives while filling an excavator bucket with overburden. Fly rock from the explosion hit the windscreen of the excavator resulting in laminated glass inside the operator's cabin. No rock penetrated the glass. An adjacent haul truck sustained damage to the side mirror and some debris on the	Sites must maintain effective explosives management systems. These systems should include safe work procedures and signed off checklists that minimise the potential for misfires and/or unaccounted explosives devices. There must be a process in place to ensure any misfires are identified, logged and communicated to workers.

Incident type	Summary	Comments to industry
	walkway. A nearby dozer also had fly rock material impact the machine. The haul truck and dozer were about 5-10 metres from the bucket when the incident occurred. There were no injuries suffered by any of the operators. 	

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 October 2, 2023, a miner died after he was pinned between a shuttle car and a coal rib. This is the 35th fatality reported in 2023, and the 10th classified as powered haulage. Best practices: • When working around mobile equipment, communicate your presence and intended movements to equipment operators. Wait for acknowledgement before moving. • Avoid red zone areas where equipment operators cannot readily see you. • Increase the visibility of miners by using reflective clothing and/or strobe light devices. Details
MSHA	On September 17, 2023, contractor driller helper died while driving a service truck to transport a rod handler on the bed. The service truck left the road, overturned, and the

Publication	Issue/topic
	driver was ejected. The passenger, who was wearing his seat belt, was injured, treated and released from the hospital. Best practices: • Wear seat belts when operating mobile equipment. • Conduct pre-operational inspections and correct any safety defects before operating mobile equipment. • Maintain control of equipment. • Operate mobile equipment at speeds consistent with the conditions of roadways, tracks, grades, clearance, visibility, curves, and traffic. Details
	National (other, non-fatal)
Resources Safety & Health Queensland	Resources Safety and Health Queensland is urging coal mines operators to be more hands on when it comes to preventing one of the mining industry's most common serious accidents. Since 2021, 55 serious accidents involving fingers have been reported at Queensland coal mines; of these 28 happened this year (2023). A quarter of the reported serious accidents involve considerable risk activities associated with lifting, slinging and towing. Additionally, approximately another 20 high potential incidents involving fingers have been reported. 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.

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