

Weekly incident summary

Week ending 12 January 2024

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

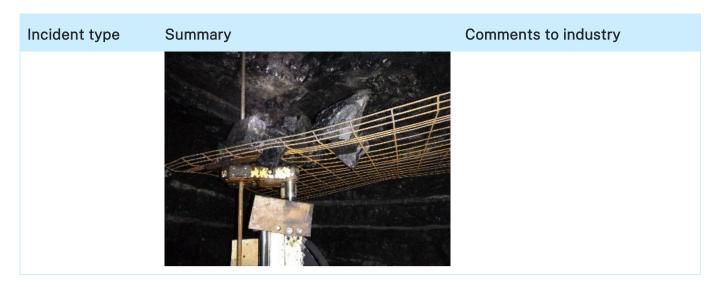
High level summary of emerging trends and our recommendations to operators.

Туре	Number
Reportable incident total	32
Summarised incident total	1

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0046138 Underground coal mine Ground or strata failure	An operator on a bolting platform was hit on the left shoulder when a drill steel dislodged a piece of roof coal that was about 2 m x 1 m x 0.6 m. The coal made contact with the temporary roof support, slid down the mesh and hit the centre console bolting rig controls before a second piece of coal that was 250 mm x 400 mm x 100 mm hit the operator - standing about a metre from where the coal was dislodged.	Mine operators must provide safe systems of work. The work methods and controls used must consider the risk of falling material, the positions of workers, and the use of mechanical aids. Whenever there is a possibility that objects can fall, appropriate no-go zones should be established to protect workers. No-go zones should be clearly delineated and communicated to all workers in the vicinity. When establishing a no-go zone, as a control for falling objects, bouncing or ricocheting must be considered.

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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
	National (other, non-fatal)
Resources Safety & Health Queensland	An AB-triple combination fully loaded with security sensitive ammonium nitrate (SSAN) emulsion, parked at a mine security gate, had a failed alternator bearing resulting in a fire. The operator called an emergency as per mine site procedure, and successfully deployed a fire extinguisher against the fire. An investigation identified that a failed bearing in the original equipment manufacturer (OEM) fitted alternator caused the fire. This incident highlights the potential for the alternators to prematurely fail, leading to an unexpected fire.
	Further enquiry by RSHQ identified 5 other cases of similar bearing failure in alternators with less than 12 months service. Details

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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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