

# Weekly incident summary

## Week ending 16 February 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.



| Type                      | Number |
|---------------------------|--------|
| Reportable incident total | 58     |
| Summarised incident total | 2      |

### Summarised incidents

| Incident type  | Summary   | Comments to industry   |
|--|---|--|
| Dangerous incident<br>IncNot0046370<br>Underground coal mine<br>Ground or strata failure | <p>A large piece of stone broke from a roof, fell over the mesh landing on the temporary roof support (TRS) and hit a worker.</p> <p>The miner had been grading up in stone for a belt chamber and cutting a full face of stone 3500 mm high in a seam split area.</p> <p>The piece of stone was reported as being 1000 mm x 700 mm x 200 mm thick.</p> | <p>Additional hazards must be considered when strata conditions change during the production cycle. In such situations, strata support designs should be reassessed to ensure they are adequate.</p> |



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| Incident type  | Summary   | Comments to industry  |
|--|---|---|
| <p data-bbox="124 813 264 882">Dangerous incident</p> <p data-bbox="124 902 328 934">IncNot0046359</p> <p data-bbox="124 956 352 1025">Underground coal mine</p> <p data-bbox="124 1048 312 1108">Ground or strata failure</p>  |  <p data-bbox="394 813 839 882">A significant roof fall occurred in an underground coal mine.</p> <p data-bbox="394 902 944 972">The fallen material was about 1.8 m high and the full width of the panel.</p> <p data-bbox="394 994 944 1099">It occurred 60 m into a runout in the herringbone panel. No workers were present at the time.</p> | <p data-bbox="1013 813 1414 1032">Mine operators are required to have a principal hazard management plan for ground or strata failure and to ensure that the plan is implemented as designed.</p> <p data-bbox="1013 1055 1394 1346">A system should be in place to update the incoming shift supervisor of trigger action response plans (TARP) risk changes, active TARPs and geotechnical hazards so that relevant information can be relayed to all workers.</p> <p data-bbox="1013 1368 1334 1473">Refer to the NSW code of practice: <u><a href="#">Strata control in underground coal mines.</a></u></p> |

## 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        | Final report – drowning at Twin State Mine |

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| Publication  | Issue/topic   |
|--|---|
|  | <p>On August 18, 2023, at 9:40 p.m., Christopher Finley, a 39-year-old section foreman, with 15 years of mining experience, drowned while installing a discharge waterline for a dewatering pump. The accident occurred because the mine operator did not:</p> <ol style="list-style-type: none"> <li>1) comply with the approved ventilation plan to prevent accumulations of water affecting safe travel, and</li> <li>2) conduct an adequate weekly examination of the return air course.</li> </ol> <p><a href="#">Details</a></p>  |
| <b>International (other, non-fatal)</b>                |   |
| <p><b>MSHA</b></p>                                     | <p><b>USA Safety alert: Rotating conveyor rollers</b></p> <p>Danger – Three miners were permanently disabled since the beginning of 2024.</p> <p>Serious and fatal injuries occur when miners clean or adjust conveyor rollers, pulleys, and idlers while the belt is in motion. Injuries vary from broken bones to loss of fingers, hands, and arms. Some accidents have resulted in fatal injuries. Injuries result from unsafe actions like:</p> <ul style="list-style-type: none"> <li>• using aerial lifts to access elevated bend, snub, and take-up pulleys, or removing or reaching around guards to work on moving conveyor components.</li> <li>• using scrapers, shovels, pry bars, hammers, and torches to remove ice, mud, or build-up. The tools can be caught in pinch points between the conveyor belt and rollers and pull in the tools and miners' hands, arms, and bodies.</li> </ul> <p>Best practices:</p> <ul style="list-style-type: none"> <li>• Keep guards in place. Do not defeat or circumvent any protective system.</li> <li>• Have an effective lock-out program. Shut down, de-energize and lock out power switches and block conveyor parts against hazardous motion prior to performing belt roller or pulley cleaning, belt tracking or other maintenance.</li> <li>• Establish policies and procedures to ensure proper and safe cleaning and maintenance of conveyor components.</li> <li>• Provide task and site-specific hazard training that prohibits cleaning or working on or around moving conveyor components.</li> <li>• Follow safe cleaning and maintenance policies and procedures. Supervisors, miners, and contractors are all responsible for working safely.</li> </ul> <p><a href="#">Details</a></p> |
| <b>National (other, non-fatal)</b>                     |   |
| <p><b>Resources Safety &amp; Health Queensland</b></p> | <p><b>Coal mine worker hit by rotating dragline</b></p> <p>On Sunday 14 January 2024, a worker was hit by a rotating dragline upon completion of cable relocation works, within the operational swing boundaries of the dragline. The worker luckily avoided serious injury. In 2021 a coal mine worker died after being injured in a similar incident. Preliminary investigations suggest the worker undertook cable relocation works, while the dragline was stationary, but the worker has re-entered or remained in the operational swing boundary when the dragline became</p>   |

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| Publication                                     | Issue/topic  |
|---|--|
|   | <p>operational as they were checking the shoe clearance over the cable. The worker was hit by a dragline light on the underside of the house area.</p> <p><a href="#">Details</a></p>  |
| <b>Resources Safety &amp; Health Queensland</b> | <p><b>Uncontrolled movement of longwall transformer cart</b></p> <p>On 21 December 2023, an underground coal mine longwall transformer cart was being trammed into position when it moved down the grade in an uncontrolled manner for approximately 20 metres until it came to rest against a stationary load haul dump (LHD) machine. Four coal mine workers (CMWs) were in the vicinity of the longwall transformer cart at the time of the incident. None were in the travel path of the out-of-control cart, however, the potential for a serious incident was evident.</p> <p>The mine investigation identified that:</p> <ul style="list-style-type: none"><li>wander hoses from the LHD to the transformer cart were incorrectly sized and connected to the wrong manifold. This resulted in increased back pressure in the return hydraulic oil circuit. The increased back pressure in the return circuit caused the transformer cart brakes to release. The cart then moved down the grade in an uncontrolled manner.</li><li>CMWs were not familiar with the functionality of the LHD power take-off circuit or the transformer cart traction brake circuit.</li><li>CMWs had no ability to identify excessive back pressure in the return oil circuit.</li></ul> <p><a href="#">Details</a></p> |

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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|-----------------------|--|
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