# Weekly incident summary

## Week ending 31 May 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

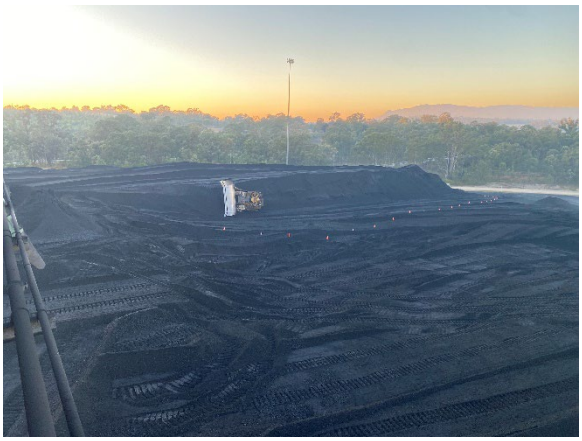
High level summary of emerging trends and our recommendations to operators.

| Type | Number |
|---|---|
| Reportable incident total | 50 |
| Summarised incident total | 3 |

### Summarised incidents

| Incident type | Summary | Comments to industry |
|---|---|---|
| Dangerous incident<br>IncNot0047015<br>Underground metals<br>Fire or explosion<br>  | A worker was refilling a water cart at the refill point on the main decline when they saw the glow of a flame. The worker removed the wheel chock and drove forward under the flowing water to extinguish the flame.<br>Preliminary investigation shows that water ingress corroded an electrical connector. The connector combusted due to excessive heat generated due to the poor connection. | Mine operators should ensure that risk control measures to prevent the occurrence of fires on mobile plant are implemented and remain effective. Inspection regimes and housekeeping standards should be routinely examined to ensure minimum standards are met or exceeded. Mine operators should ensure stringent monitoring and quality control of maintenance and repair activities. |

# Weekly incident summary week ending 31 May 2024

| Incident type | Summary | Comments to industry |
|---|---|---|
| |  | |
| Dangerous incident<br><br>IncNot0047000<br><br>Open cut coal<br><br>Roads or other vehicle operating areas<br><br>  | A dozer was reclaiming for a train on the thermal product feeders. The operator came close to the edge of an adjacent stockpile boundary which was cut to the floor, leaving a vertical bench to the stockpile where the dozer was working. The vertical bench was about as high as a dozer-blade. The dozer slid off the bench onto its side.<br><br>The workers failed to complete a job hazard analysis (JHA) for working on abnormal stockpile conditions as identified in the site's procedure.<br><br>  | Site procedures are developed to help protect workers from injury or illness. Where a procedure exists for a particular task, workers should follow the procedure. Any deviation from a procedure should first be discussed with a supervisor and appropriate risk control measures put in place.<br><br>Refer to safety bulletin SB19-01 Rise in dozer incidents putting operators at risk. |

## Weekly incident summary week ending 31 May 2024

| Incident type | Summary | Comments to industry |
|---|---|---|
| Dangerous incident<br>IncNot0046987<br>Underground coal | A fitter was removing a DN13 hose from the double-acting ram on a longwall install face. Upon removing the staple, the hose popped out of the fitting under pressure, releasing fluid which struck the fitters left arm and hand. | Mine workers must be trained and competent in isolation. Correct isolation includes the identification of all energy sources and the complete dissipation of the energy. Training must include all steps in the isolation process. Workers undertaking isolation procedures on plant should be familiar with the plant's hydraulic circuit and manufacturer's guidance for depressurisation of the circuit. |

## 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, at 11:00 a.m., Brandon Frederick, a 37-year-old roof bolter with 13 years of mining experience, was fatally injured when he was struck by a shuttle car and pinned against the coal rib. The accident investigation team conducted an analysis to identify the underlying causes of the accident.<br>Root Cause: The accident occurred because the mine operator did not have adequate procedures to protect miners in haulage ways from mobile equipment.<br>Details |
| MSHA | Since 2019, two miners have died, and six miners have suffered lost time injuries from the sudden release of stored energy while working near belt conveyor systems.<br>Best Practices<br>• Develop safe work procedures that eliminate or safely control stored energy in belt conveyors. The procedures must include lock out/tag out, blocking against motion, and securing the belt conveyor.<br>• Ensure belt conveyor moves, maintenance, and repairs are performed with the correct replacement parts, proper tools, and suitable rigging.<br>• Train miners on the safety aspects and safe work procedures for moving, maintaining, and repairing belt conveyors.<br>• Train miners to stay in safe locations while in a belt conveyor entry, away from the belt drive and take-up winch, when miners start or stop the belt.<br>• Install properly designed safety restraints for moving parts such as movable carriages, bridles, and take-up sleds as a backup in case primary components fail. |

| Publication | Issue/topic |
|---|---|
| | • Perform a risk assessment prior to beginning work to identify and control stored energy: mechanical, electrical, hydraulic and gravity.<br><br>Details |
| MSHA | Since 2020, six miners have died and 61 have suffered lost time injuries from being struck by mobile equipment in underground production areas.<br><br>Best Practices:<br><br>• Mine operators should evaluate currently available and emerging technologies, such as Proximity Detection Systems, and consider adopting them to enhance safety.<br><br>• Slow down and sound audible devices when approaching hazardous areas and before proceeding through ventilation curtains or flypads, intersections, and blind corners.<br><br>• Always communicate your position and intended movements to mobile equipment operators and wait for their acknowledgement before moving.<br><br>• Wear reflective clothing and lighted visual indicators, such as strobe lights.<br><br>• Install and maintain clear ventilation curtains or flypads in all intersections.<br><br>• Provide hand-held radios for persons on foot or when dismounting a vehicle; make sure these devices are used.<br><br>• Minimize pedestrian traffic in known haulage routes.<br><br>Details |
| MSHA | On May 8, 2024, a miner was electrocuted while unloading a roll of belt from a trailer. The miner was performing rigging duties when the crane boom contacted an overhead high-voltage powerline.<br><br>Best Practices:<br><br>• Ensure that booms or masts of equipment are not operated within 10 feet of any energized overhead powerline.<br><br>• Designate one person on the ground, located in a safe location, to give signals to the crane operator and watch placement and proximity of the boom.<br><br>• Use non-conducting tag lines to steady loads when operating cranes where overhead power lines are present.<br><br>• Post warning signs at all approaches to overhead powerlines; install barricades where necessary.<br><br>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.

# Weekly incident summary week ending 31 May 2024



## Document control

| | |
|---|---|
| CM9 reference | RDOC24/125528 |
| Mine safety reference | ISR24-22 |
| Date published | 7 June 2024 |
| Authorised by | Director Technical Operations Mine Safety<br>Office of the Chief Inspector |