Weekly incident summary

Week ending 18 October 2024

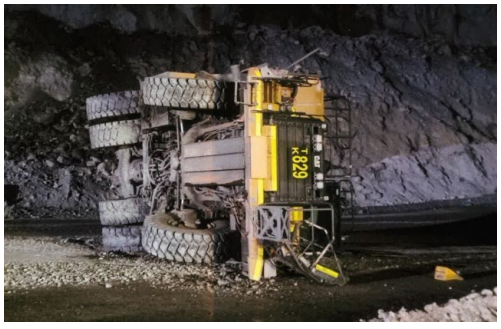
This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the Resources Regulator: phone 1300 814 609 24 hours a day, 7 days a week.

At a glance

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

Type	Number
Reportable incident total	36
Summarised incident total	4

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0047820 Open cut coal mine Roads or other vehicle operating areas 	A service cart overturned when completing a U-turn. The cart transitioned from a wet to a dry line and overturned onto its left side. There were no injuries to the operator. Speed has been established as a major contributing factor. 	Service cart operators need to take extra care when turning their vehicles as the movement of fluid in tanks mounted on mobile plant can significantly influence the centre of gravity and overall stability of the vehicle. Extra caution is needed when changing from a wet to a dry line and vice versa. U-turns should be executed at a low speed.

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Incident type	Summary	Comments to industry
Dangerous incident IncNot0047836 Underground coal mine	A fitter disconnected a hydraulic hose while replacing the transmission spool valve on a load haul dump machine (LHD). The valve was replaced but the hydraulic hose was not reconnected. The electrician confirmed with the fitter that he was finished and that was okay to start the machine. The electrician turned the machine on and pulled the parking brake off. There was a release of fluid that narrowly missed the electrician. The pressure in the circuit was up to 2500 psi 17.2 mpa. 	A safety bulletin in relation to the prevalence of incidents involving the release of stored energy from pressurised systems was published recently. Refer to: SB24-06 Incidents involving pressurised systems increase
Serious injury IncNot0047849 Open cut coal mine	A worker suffered a serious laceration to his hand in the process of removing a radiator from a dozer. While lifting the radiator out vertically with slings and an overhead crane, a plant mechanic was manipulating the radiator by hand when the radiator moved, causing his left-hand thumb to be crushed between the radiator and a bracket. A tag line or alternative was not used. It was found that the job hazard analysis (JHA) was inadequate for the task and failed to detail high risk steps and suitable controls. A step-up supervisor had signed off on the JHA after review.	Inadequate procedures and poor supervision are precursors to serious injuries. Safe systems of work are designed to prevent the type of injury associated with this incident. A safe system of work for the removal and replacement of dozer radiators should include a risk assessment that addresses the following: • Dozer set up with reference to access around the radiator and clearance for lifting. • Worker positioning with reference to line of fire. • Techniques for safely manipulating/moving the radiator. • Working at heights. The risk assessment should be developed by suitably qualified tradespersons,

Incident type	Summary	Comments to industry
		supervisors, and the mines mechanical engineer.
Serious injury IncNot0047855 Underground coal mine	A worker suffered a fractured eye socket, cheekbone and jaw when his head was caught between a set of ventilation doors. An experienced ventilation crew was finalising the installation of double steel doors at a cut-through. An emergency egress lifeline was disconnected during the process. While the adjacent outbye doors were both in the open position, a worker in the process of reestablishing the escape lifeline temporarily opened one of the closed doors about half-way, without restraining it. As he was reconnecting the lifeline the unrestrained steel door closed and caused the workers head to become trapped, requiring assistance by another worker to be released. 	Ventilation pressure is a known hazard and mines' procedures for major ventilation changes should identify controls for the associated risks. Workers need to be made aware of the controls and the effects of ventilation pressure when opening self-closing steel doors, while not having the adjacent door set fully closed, and allowing a short circuit of fresh air to return airways.

Other publications of interest

The incidents are included for your review. The 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)
Safe Work Australia	**Safe Work Australia consultation on the impacts of the proposed introduction of new workplace exposure limits for 9 chemicals** Safe Work Australia is consulting on the proposed workplace exposure limits (WELs) for 9 chemicals (respirable crystalline silica, benzene, chlorine, copper, formaldehyde, hydrogen sulphide, nitrogen dioxide, titanium dioxide, hydrogen cyanide).

Publication	Issue/topic
	This consultation will seek feedback from stakeholders on the economic, social and health impacts of the proposed WEL for each of the 9 chemicals. In addition, WHS ministers have asked Safe Work Australia to conduct a Regulatory Impact Analysis on the proposed WELs for the 9 chemicals. In response to this request Safe Work Australia is required to prepare an Impact Analysis. This consultation will be used to prepare the Impact Analysis. Details
Resources Safety & Health Queensland	**Report - MMQ Quarterly Report FY25Q1 (July to September 2024)** The latest Qld Mineral Mines and Quarries Inspectorate quarterly report has been released with updates on: • regulator activity • statistics • serious accidents • high potential incidents • incident focus - valve assembly detachment under pressure • incident focus - finger injury whilst using pneumatic torque tool • incident focus - worker nearly struck by maintenance truck rolling down ramp • interstate and global updates.

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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