

# Weekly incident summary

## Week ending 23 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	37
Summarised incident total	2

### Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0046389 Underground coal mine	<p>A worker was being lifted in a quick detach system (QDS) bolter basket attached to a load haul dump (LHD) when the crowd cylinder holding the platform levelled suddenly and unexpectedly extended.</p> <p>The basket was about 1.8 metres above the ground at the time.</p>	<p>Mechanical engineering control plans must set out the control measures for the unintended operation of plant. This must include function testing as part of the introducing plant to site process, and pre-use inspections by operators.</p> <p>Mine operators should ensure:</p> <ul style="list-style-type: none"><li>• all pieces of hired equipment have a thorough mechanical and electrical inspection to assess the plant's operation</li><li>• thorough pre-work inspections are carried out by competent people</li></ul>

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Incident type	Summary	Comments to industry
		<ul style="list-style-type: none"> <li>hired equipment is maintained in accordance with a suitable maintenance strategy considering the original equipment manufacturer's recommendations and relevant Australian Standards. For elevated work platforms (EWPs) this should include AS 1418.10 and AS 2550.10.</li> </ul>
<p>Dangerous incident</p> <p>IncNot0046399</p> <p>Underground metals mine</p>	<p>An integrated tool carrier overturned while 2 workers were in the basket installing mesh. The workers in the basket instructed the IT operator to turn the IT so that it was square to the wall. When turning to the left on a cross cut on the ramp (1 in 7) the operator felt the right hand rear of the machine lift and the IT slowly overturned. Both workers in the basket were wearing harnesses and were uninjured.</p> 	<p>Mine operators must have controls in place to manage the risk of EWPs overturning during activities.</p> <p>Mine operators must ensure that plant is fit for its intended purpose. This includes the stability of plant in all configurations and tasks it is undertaken.</p> <p>Operators must be trained in the limitations of the plant.</p>

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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
<b>International (fatal)</b>	
<b>MSHA</b>	<p>On September 12, 2023, at 2pm, Bruce Vernon, a 69 year-old laborer, with 23 years of experience, died when the haul truck he was operating travelled through a berm and became submerged in a pond. The incident occurred because the mine operator did not:</p> <ol style="list-style-type: none"><li>1. ensure the berm at a dump site impeded the haul truck from overtravel, and</li><li>2. conduct an adequate workplace examination.</li></ol> <p><a href="#">Details</a></p>
<b>National (other, non-fatal)</b>	
<b>Resources Safety &amp; Health Queensland</b>	<p>On Thursday 15 February 2024, an electrical worker at an underground coal mine in the Bowen Basin gained access to an 11kv electrical enclosure on a transportable substation. After accessing this enclosure an arcing event occurred and the worker suffered burns to their left arm and right hand. The worker was admitted to hospital for further treatment. It appears the worker opened and entered an 11kv enclosure without following site procedures for access to high voltage conductors.</p> <p>Initial investigations show that:</p> <ul style="list-style-type: none"><li>• high voltage isolation and access procedures may not have been followed.</li><li>• testing prior to accessing electrical enclosures may not have been adhered to.</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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