

WEEKLY INCIDENT SUMMARY

Week ending Friday 18 March 2022

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	41
Summarised incident total	4

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0041814 Underground coal	A worker was struck on the hand with pressurised material that was ejected when a non-return valve was removed from a poly pump-out line. The worker assumed the line was depressurised because the pumps were off and drain valves on the line were open. However a material blockage had caused a volume of air to be captured in the line, resulting in coal fines being ejected under high pressure when the line was separated.	Relief valves should be installed at inspection points in reticulation systems to dissipate pressure. Mine operators should review how workers and supervisors are trained to recognise the potential hazards associated with trapped pressure.

Dangerous incident
IncNot0041856
Underground
metals
Fire or explosion



A spray rig was being trammed up the decline when it stopped to allow traffic to pass. The operator exited the rig and noticed smoke coming from the offside near the exhaust. The operator extinguished the fire using a hand-held fire extinguisher.



Hose management and protection is critical in preventing fires on mobile plant. Rubbing hoses are a well-known cause. Mine operators must have a system in place to identify defects and poor hose standards, assess the criticality and put controls in place to prevent a fire. [MDG15 Guideline for mobile and transportable plant for use at mines \(other than underground coal mines\)](#) and [AS 5062 Fire protection for mobile and transportable equipment](#) provide guidance for mines. For more resources, refer to our webpage: [Fires on mobile plant safety](#)

Dangerous incident
IncNot0041851
Underground
metals

A compressor supplying instrument air tripped, causing the level control valves on the rougher cells to fully open. This allowed a cyanide solution to drain into a catchment bund. This initial bund filled and overflowed into a secondary diversion bund. No personnel were present in the area. The solution was recovered and the area was cleaned.

When a system fails, it must fail to a safe state. The impact of a system failure on the equipment and environment must be assessed to confirm no other hazards are created. Formal processes such as a hazard and operability analysis (HAZOP) are available to facilitate this style of assessment.

Dangerous incident
IncNot0041812
Underground coal
Fire or explosion



A longwall crew smelled smoke while underground. A 150 mm flame was discovered on the centre roller of a carry set above the loop take-up. The fire was immediately extinguished using a hose. The conveyor was inspected earlier in the shift and no defects were identified in the area.

Mine operators must have a system to identify and change-out defective conveyor rollers. Workers conducting conveyor inspections must be aware of the increased risk of roller failure at high tension areas of conveyors.

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 (other, non-fatal)	
Engineers & Geoscientists British Colombia	<p>Engineers and Geoscientists British Columbia, the regulatory and licensing body for the professions of engineering and geoscience in BC, has concluded its disciplinary proceedings against three individuals in relation to their work at the Mount Polley Mine. The multi-year investigations were initiated following the breach of the mine's tailings storage facility on August 4, 2014. Three current and former engineers involved at the Mount Polley Mine Tailings Storage Facility (TSF) face a range of penalties arising from the disciplinary proceedings.</p> <p>In the course of these disciplinary proceedings, Engineers and Geoscientists BC did not make allegations or findings as to the cause of the embankment failure. That matter was separately addressed in reports of the Mount Polley Independent Expert Engineering Investigation and Review Panel and the Chief Inspector of Mines.</p> <p>Details</p>
National (other, non-fatal)	
Resources Safety & Health Queensland	<p>On 10 March 2022, a severe weather event occurred in the regional areas of Moranbah. Records have identified that between 4pm and 8pm, 852 cloud to ground lightning strikes occurred in the region. Lightning is believed to have struck one or more of three goaf gas blower skids, igniting the gas on one of them.</p> <p>The gas burned at the top of the evasee for an unknown period of time before being discovered by a seam gas operator who applied an emergency shutdown of the plant. The three goaf gas blower skids were in close proximity to each other and were operating on a sealed goaf at the time of the incident. The plant was running high purity of 100% methane and nil oxygen.</p> <p>A mine evacuation was ordered, and the plant scene was secured.</p> <p>Details</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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DOCUMENT CONTROL

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