NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 20 May 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	5

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0042197 Underground metalliferous mine	A development face and a stope were loaded for firing in an underground metalliferous mine using electronic detonators. The system was set up to fire both shots simultaneously, however there was a communication issue and the system would not initiate. The development shotfirer went to the development face and replaced the electronic detonators with electric detonators. The stope detonators were not disconnected. The development shot was fired using the conventional 240 volt firing line in the mine.	A causal investigation has commenced. Additional information will be issued.

	The development face fired as expected but the stope partially initiated. This was not expected and should not have occurred. No-one was injured.	
Dangerous incident IncNot0042186 Underground coal mine	A worker suffered head and spinal injuries when air released unexpectedly from a 15cm pipe range. Another worker suffered minor injuries and a perforated ear drum.	An investigation has commenced into the incident. Further information will be issued shortly. Mine operators should remind all workers of the hazards associated with working on and around compressed air hoses and pipes. Workers must be trained in the mine's procedures. Implementation of controls need to be verified during all work associated with compressed air including isolation and energy dissipation.
Dangerous incident IncNot0042181 Open cut coal mine Roads or other vehicle operating areas 	A mine supervisor had a micro sleep while driving along a light vehicle road. The vehicle drove up onto a windrow and rolled onto the driver's side. The supervisor was not injured. The supervisor failed to preserve the scene and arranged for the vehicle to be righted and taken to a park-up area. 	Further investigations have commenced. Supervisors must be aware of their obligations when an incident or injury occurs. This includes preservation of the incident scene and notification requirements. Note that the Work Health and Safety Act 2011 Section 39 does permit any required action to assist injured persons, make the scene safe and to comply with police or inspector directions.
Dangerous incident IncNot0042170 Underground coal mine Ground or strata	A fall of roof occurred, extending above a bolted horizon. The roadway was supported with bolts and mesh. The fall was about 15 metres long, partial width and extended 500mm above the centre bolts.	Mine operators should have a process in place to identify changes in roof structure and the required support in that area (TARPS). Strata support should be

designed with a suitable factor of safety.
Workers must be trained in the correct installation of support to ensure 'gloving' does not occur and the chemical is correctly mixed. Regular verification of encapsulation needs to be completed and any bolt installation that does not meet the requirements of the support rules should be replaced.
Statutory officials must verify support placement is as per the support rules.

Dangerous incident
IncNot0042169
Underground coal mine
Fire or explosion

A deputy smelled and witnessed smoke coming down a drift in an underground coal mine and contacted the control room.
A dolly car operator immediately started an inspection and identified a small flame and smoldering coal under the drift belt. The fire was immediately extinguished.
An idler had collapsed, and the belt was rubbing on the frame. Excess coal around the roller had ignited.

Workers conducting inspections on conveyors must diligently inspect for fire risks such as accumulation of coal, failing or collapsed idlers and contact between conveyor belts and fixed structures.
Mine operators must have systems in place to assess issues and plan a response to avoid the risk of fire, including immediately stopping the conveyor when necessary. No worker should be hesitant to stop a conveyor if it poses a fire risk.

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 28 January 2022, while driving downhill, the 56-year-old driver of a concrete mixer truck was fatally injured after he lost control of the truck. The truck overturned and the driver was ejected. Another miner, who was in the truck, was also ejected and suffered serious injuries. This is the sixth fatality reported in 2022, and the second classified as 'powered haulage'. Details
MSHA	On 14 February 2022, a 34-year-old maintenance technician died while driving a lube truck underground. The truck over-travelled the edge of a stope and fell approximately 18 metres into the stope drift. This is the seventh fatality reported in 2022, and the third classified as 'powered haulage'. 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.

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