NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 30 September 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

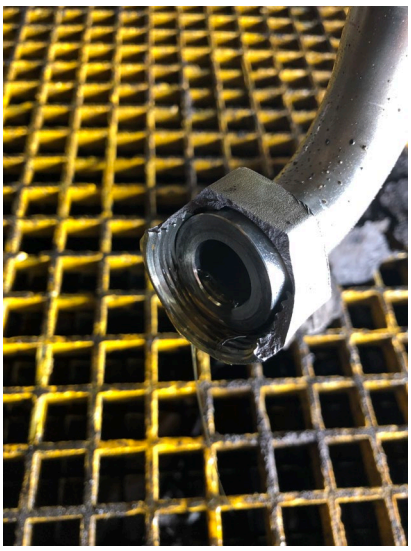
High level summary of emerging trends and our recommendations to operators.

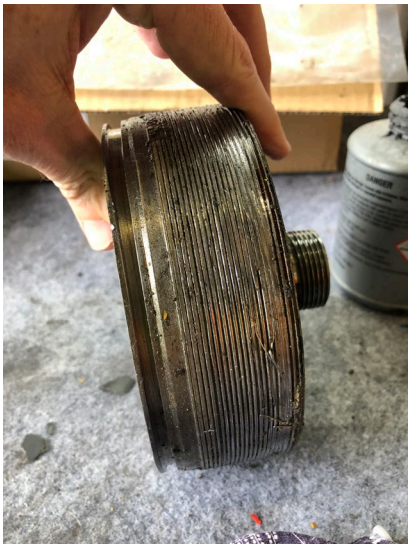
TYPE	NUMBER
Reportable incident total	29
Summarised incident total	4

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
Dangerous incident IncNot0043099 Underground coal mine Ground or strata failure	An outburst occurred during remote mining that resulted in approximately eight tonnes of coal being thrown. Power was tripped to the continuous miner when gas monitors peaked. The ventilation system was not overwhelmed, gas monitors in the return peaked at CO_2 1.2% and CH_4 1.37%. The likely cause of this is the presence of a 100mm strike-slip fault (containing up to 50mm mylonite & calcite) which acted as a barrier to gas drainage. The increased gas content was due to the inability for effective drainage holes to stay open and be drilled through this highly structured area.	This incident is a reminder of the danger posed by outbursts and the necessity of having appropriate controls in place to protect workers, including remote mining practices, exclusion zones and sound ventilation practices.

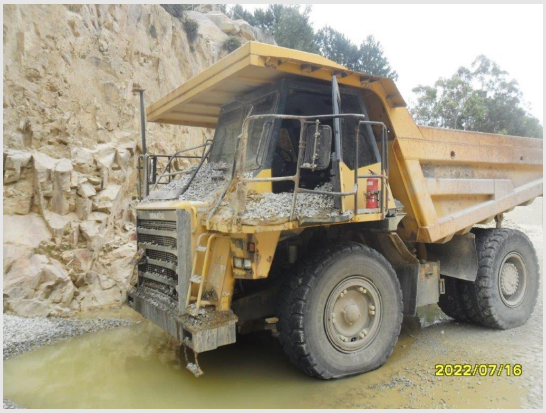
Dangerous incident IncNot0043103 Underground coal mine	A worker sustained a laceration to his leg from a flailing water hose while setting up water supply to a continuous miner. Three workers were in the process of removing a ball valve tap in order to join two bull hoses. After checking that the line was isolated two workers held the hose while another attempted to flush the line by opening the ball valve. When the valve was opened the pressure has whipped the hose out of the workers hands allowing it to flail around. 	Mines should consider including fixed drainage points to prevent workers from releasing stored pressure from loose hoses. Consider using gate valves in place of ball valves to better control the release of energy. Workers are reminded of the risks involved in whipping hoses.
Dangerous incident IncNot0043119 Open cut coal mine	During pressure checks on a refurbished steering accumulator on a haul truck, the centre accumulator failed. The piston and cap were ejected under pressure and mounts were damaged. The cap was found 3 m from the truck while the cylinder piston was found 20 m from the truck. Nobody was injured.	This incident is under investigation to determine the root cause and further information may be published later. This incident highlights the importance of considering component failure and having no-go zones in place when commissioning hydraulic systems.





Dangerous incident IncNot0043131 Construction materials	While loading a dump truck from a silo, the driver noticed there was material coming out of the silo near the top of the cone. The driver closed the clam shells and drove out from under the bin. In order to open the clam shells to empty the bin, the truck driver positioned the truck to the bin to have access to the clam shell controls from the truck's platform. The driver then opened the clam shell slightly. As the truck driver returned to the cabin and started to reverse, the silo failed and material rilled	This incident is under investigation to determine the root cause and further information may be published later. Mine operators should review the adequacy of their structural integrity audits and ensure that remedial actions that have been identified as being required during such audits, are carried out in a timely manner.

over the front of the truck smashing its windscreen. The operator was uninjured.



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 August 17, 2022, a general inside laborer died when he was caught between a supply car and its coupler. The victim was sitting on the supply car which was coupled to a locomotive parked in a track spur. The locomotive was struck by another locomotive pulling three loaded cars into the mine. The impact knocked the victim off the supply car, killing him. Details

MSHA	On August 23, 2022, a contract mechanic received fatal injuries while performing maintenance on the bucket (dipper) of an electric rope shovel. A plastic block, used to prop open the dipper door, dislodged causing the dipper door to close and pin the victim against the back edge of the dipper. Details
MSHA	Wooten Sand - On 4 August 2022, a mine manager died while performing maintenance on a bulldozer. While kneeling on the bulldozer's track, the victim accidentally engaged the lever that put the bulldozer in reverse. The bulldozer track moved the victim to the rear of the bulldozer where he was run over. Operators should train miners on safe maintenance procedures such as turning off the engine and blocking equipment against motion. Details
	National (other, non-fatal)
Resources Safety & Health Queensland	Operations were recently suspended at an underground coal mine in Queensland upon discovery that the mine was not compliant with legislation relating to the required number of certified Emergency Response Team (ERT) members available to respond to a potential emergency situation. Coal mine operators and Site Senior Executives (SSEs) should be aware that any future breaches of legislative requirements will result in the Inspectorate taking immediate compliance action. Details
Government of Western Australia	Dampier Salt Limited was today fined $20,000 and ordered to pay $6,283 in costs after a worker's head and neck became trapped while working at height at the company's Port Hedland salt operations. In July 2018, two contractors were using an elevating work platform (EWP) to inspect the underside of a large salt stacker. A third man was working at ground level as the leading hand and spotter. One of the men inadvertently raised the EWP which caused his head and neck to become caught between the platform's control panel and the salt stacker. The injured contractor temporarily lost consciousness and was taken by ambulance to the Hedland Health Campus. He was discharged later that day. While the workers completed a Job Hazard Analysis and a Critical Control Checklist before starting the job, neither report identified the crush hazard as an applicable risk. The company also failed to verify the workers' competency to operate the relevant make and model of EWP. This lack of familiarisation caused a delay in lowering the platform after the contractor lost consciousness. Dampier Salt pleaded guilty in the Perth Magistrates Court for failing to provide a safe working environment. Details

Government of Western Australia	From 2018 to 2021, six serious incidents relating to air conditioning flushing canisters have been reported on mine sites in Western Australia. In five of these incidents, the flushing canister had been over-pressurised and subsequently ruptured. In all reported incidents, the involved flushing canisters were assumed to be in working order at the beginning of the task. Injuries from these events included lacerations to the lower arm and workers being hit by the canister and/or fragments. 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.

DOCUMENT CONTROL	
CM9 reference	DOC22/280612
Mine safety reference	ISR22-39
Date published	7 October 2022
Approved by	Deputy Chief Inspector Office of the Chief Inspector