Weekly incident summary

Week ending 31 March 2023

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	34
Summarised incident total	4

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0044382 Open cut coal mine	While using a pressure washer, the nozzle became blocked. The operator used their thumb to clean the tip. The operator was then hit by the stored water pressure in the lance. The operator was sent to hospital and cleared of any injury.	Workers must be trained and competent in the use of pressure washing equipment. Training and procedures must include awareness regarding fluid injection injuries.

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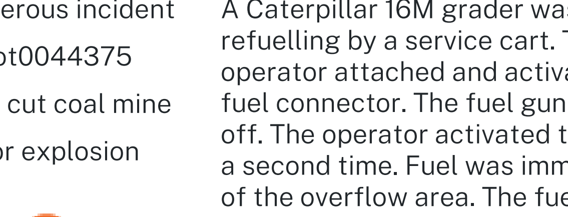
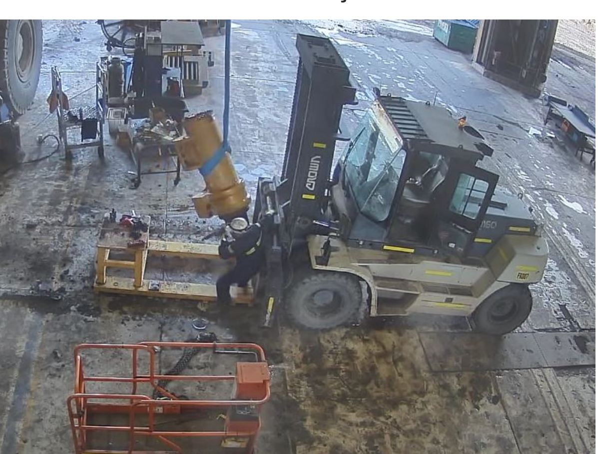
Incident type	Summary	Comments to industry
Dangerous incident IncNot0044375 Open cut coal mine Fire or explosion 	A Caterpillar 16M grader was parked-up for refuelling by a service cart. The service cart operator attached and activated the dry break fuel connector. The fuel gun immediately shut off. The operator activated the fuel dispense for a second time. Fuel was immediately sprayed out of the overflow area. The fuel ignited on the hot engine components. The fire suppression system on the machine was automatically activated. Two workers unsuccessfully tried to extinguish the fire with hand-held extinguishers. The fire was finally extinguished by water carts. 	Refuelling systems must be engineered and matched with the fuel tank, breather, and delivery systems. Confirm that overflow piping and breathers direct fuel away from ignition points. Refer to: SB21-01 Fires occur while refuelling plant SB15-03 Fires ignite while refuelling mobile plant with quick-fill fuel systems
Dangerous incident IncNot0044371 Open cut coal mine	A haul truck was in a workshop for maintenance. The position 1 strut was being replaced. The strut was removed using a custom forklift jib. A worker connected the overhead crane with a sling to the strut on the jib. The worker proceeded to undo the bolts holding the strut to the jib. While unbolting, the jib moved, so the worker applied more load with the overhead crane. When the last bolt was undone the strut started to swing and pushed the worker against the mast of the forklift as he tried to move away from the strut. He was not injured. 	When lifting activities are carried out, workers must always consider the potential for loads to swing and for potential crush zones. During lifting activities, if something unexpected occurs, such as unanticipated load movement, work should stop, and the task should be reassessed before proceeding.

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Incident type	Summary	Comments to industry
Dangerous incident IncNot0044368 Underground coal mine Ground or strata failure	A rib slump occurred in an underground coal mine. The slump was 4 metres long, floor to roof in height and 2.5 metres into the rib. At the time of the failure, the crew was preparing to use the miner to grade through a large reverse fault. Two workers in the heading were alerted to the failure when they heard coal being sucked along the ventilation tube. There were no indicators of outburst or seismic activity.	When mining towards predicted geological features, mine workers should take a proactive approach towards reviewing and enacting triggers on strata support trigger action response plans (TARPs).

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
	National (other, non-fatal)
Worksafe Victoria	Morning Star Gold NL was sentenced in the Mansfield Magistrates' Court last Wednesday after pleading guilty to a single charge of failing to provide or maintain plant that was safe and without risks to health. The company was also ordered to pay $4,098 in costs. In November 2020, an experienced worker was using a pneumatically powered machine known as a double drum scraper to stockpile rubble that had been blasted from a heading within the mine. The task involved operating levers connected to wire ropes that dragged a scraper bucket back and forth along the ground. As the worker momentarily paused operating the scraper to explain a safety risk to a trainee, a loose strand of wire rope tightened around his foot, ripping off the steel cap of his gumboot and taking part of his big toe with it. The court heard it was reasonably practicable for Morning Star Gold to have installed guarding to prevent access to the scraper's wire rope and drum. Details
WA Department of Mines, Industry Regulation and Safety	Information obtained by WorkSafe Mines Safety has identified a number of instances where workers have been exposed to the dangers from inrush, cutter or drill string failure and from falling objects while working on or near raisebore activities. Hazards that can occur from raisebore drilling • Hole or ground failure/rock fall (geotechnical failure risk) • Unplanned ingress of water/mud or gas (inrush risk) • Drill string failure/pre-mature cutter wear or failure

Publication	Issue/topic
	• Unplanned breakthroughs • Hazardous dust exposure and dust contamination of mine ventilating air during reaming • Cuttings removed from the active raisebore hole are dumped and/or stored in unsafe situations • Ventilation reversals and/or short circuiting • Crush injury or manual handling injury during reamer assembly and attachment to drill string. Details
Resources Safety & Health Qld	Resources Safety & Health Queensland have released their incident periodical for recent high potential incidents that occurred in December 2022 and January 2023. This report includes a lifting uncontrolled movement underground, a surface HME collision, frictional ignition underground, falling object at the surface, HME rollover and a finger crush injury during surface drilling. 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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