Weekly incident summary

Week ending 7 April 2023

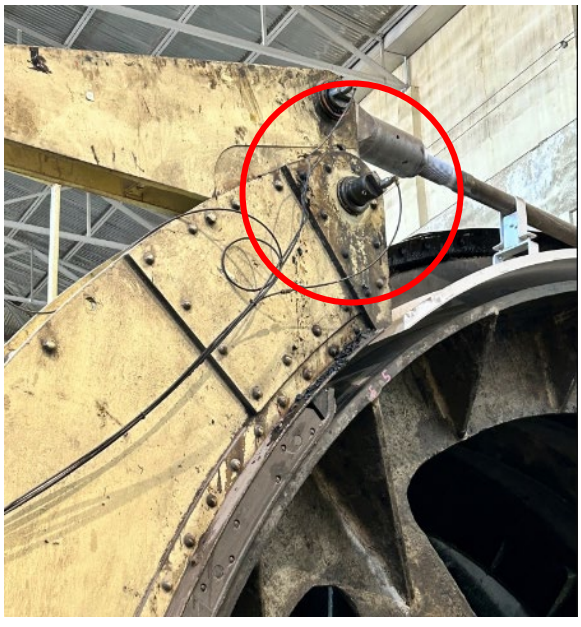
This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the NSW Resources Regulator: phone 1300 814 609 24 hours a day, 7 days a week.

At a glance

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

Type	Number
Reportable incident total	37
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0044421 Underground metal mine Mine shafts and winding systems 	During a walk around inspection of a man-riding shaft winder, it was noticed that an upper brake calliper pin had worked its way out about half the length of the pin. The split pin and retaining washer were missing. The opposite side calliper was still intact. 	Mines that operate winders should review maintenance inspection and testing schemes, including pre-use inspections, to ensure components related to safety-critical functions such as brakes are fit to operate.

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Incident type	Summary	Comments to industry
Dangerous incident IncNot0044422 Underground metal mine Fire or explosion 	A contractor was using a grinder to cut an empty 1000 litre plastic container. An ignition occurred that knocked the work back approximately 4 metres and ignited the workers' clothes. Another worker smothered his clothes to extinguish any flames. The worker cutting the container suffered serious burns to their arm and side. The worker who rendered assistance suffered minor burns as well.	This incident is under investigation. Further information may be released in the future.
Dangerous incident IncNot0044412 Underground metal mine Ground or strata failure 	A Jumbo operator and an offsider were marking up a development face. A piece of stone fell from the face and struck the Jumbo operator on the back of the head and shoulder. The offsider helped get the Jumbo operator back from the face and rendered first aid. The injured worker was transported to hospital via ambulance where the laceration was stitched, and scans cleared the worker of any fractures. 	Mine operators should review their risk assessments and principal hazard management plans for ground and strata to ensure that controls are identified and implemented to prevent rocks falling from development faces that could cause serious injury or kill mine workers. Controls should be focussed on the engineering level or higher. The use of engineering controls to manage the risks at a development face are widely used across the underground hard rock industry.

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)
Resources Safety & Health Queensland	In the past 12 months, there have been 15 reported incidents involving the rollover of a truck or trailer while travelling at metalliferous mines and quarries across Queensland. Although a number of different factors have contributed to these incidents, recurring factors include: • driver distraction, fatigue and mobile device usage • not driving to the conditions • operator familiarity with the haulage environment (grades, speeds, tight curves etc.) and competency to operate the combinations being driven • adverse weather conditions • mechanical defects, in particular with trailer braking systems. Details
Resources Safety & Health Queensland	During a night shift on 14 September 2021, 2 coal mine workers arrived at an overburden drill rig to inspect and repair a reported oil leak. In preparation for the repair, the machine was washed and jacked to near full height with the mast raised. The 3 workers were standing on the deck of the machine and the operator was in the cab when the drill began to slowly topple, coming to rest on the drill cab side, and making contact with an adjacent light vehicle. The operator and one maintainer exited the drill safely. The other maintainer was trapped between the deck handrail and the light vehicle parked beside the drill. An emergency was initiated, and the emergency response team assisted with the safe recovery of the trapped worker. Details
Government of Western Australia	A mining company has been fined $35,500 and ordered to pay $10,000 in costs after an integrated tool carrier and blast truck fell into a 13-metre deep sinkhole in October 2018. The cavity was formed after ground subsided in the floor of an open-cut gold pit. Minjar Gold Pty Ltd appeared in the Perth Magistrates Court on 29 March 2023 after pleading guilty to failing to provide and maintain a safe work environment. While no one was injured in the incident, 4 workers from a blast crew had been working in close proximity to the bomb truck minutes earlier. The sinkhole also engulfed a number of charged blast holes. Investigations found the mining operators had not treated backfilled underground workings as a void, allowing work to be carried out above an area of unknown stability. Details
Resources Safety & Health Queensland	An unplanned detonation of misfired explosives occurred when an excavator fitted with a rock-breaker attachment impacted explosives. The operator was shaken but unharmed. An unbroken toe in the floor was identified more than a year after a shot was fired in the quarry. Several secondary blasts were fired to break oversize fragments in the same area. The unbroken toe was blasted along with another secondary blast for oversize rocks. Misfire in the toe was not identified and hence not marked for subsequent digging or rock breaking operations. Inadequate records of secondary blasting meant the operator did not know the ground being broken contained misfired explosives, and subsequently the rock breaker hit the booster/detonator. Details

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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	
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