NSW GOVERNMENT

NSW Resources Regulator

WEEKLY INCIDENT SUMMARY

Week ending Friday 1 July 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

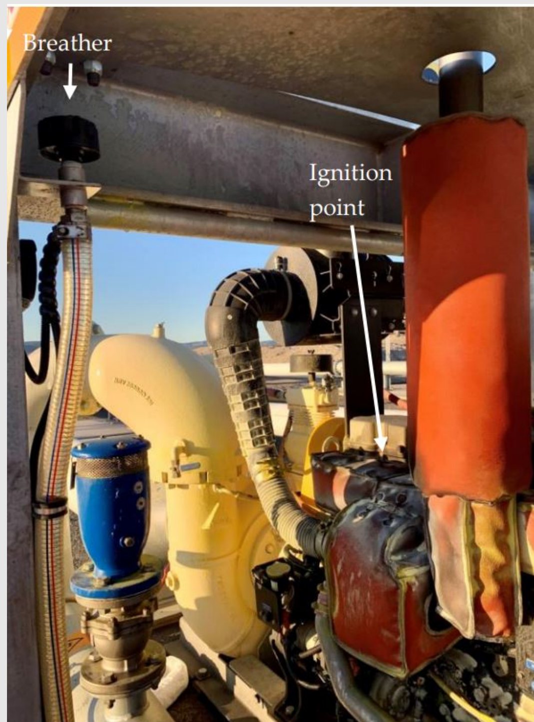
High level summary of emerging trends and our recommendations to operators.

TYPE	NUMBER
Reportable incident total	39
Summarised incident total	3

Summarised incidents

INCIDENT TYPE	SUMMARY	COMMENTS TO INDUSTRY
High potential incident IncNot0042461 Underground coal mine	There were three recent incidents of lost portable electrical apparatus in underground coalmines: 1. A deputy identified that their XAM5600 was missing from their leather pouch. The XAM was found damaged after a machine drove over it. 2. A worker misplaced his XAM. The worker had the device in a pouch attached to their belt. At the end of an inspection the XAM and pouch were missing. The XAM and pouch could not be found.	Mine operators must assess the risk involved in using portable electrical apparatus (PEA). Systems must be in place to manage using PEA and include details of how PEA should be secured. Operators should review the method of tethering and storing PEA while in use. Workers must follow site systems for using PEA, including responsibly storing and retaining the device.

3. A deputy lost a Kestrel that fell from its pouch. The Kestrel was not found.

Dangerous incident IncNot0042452 Open cut coal mine Fire or explosion 	A diesel pump was being refuelled during commissioning. The auto-fill nozzle clicked off indicting the system was full. The fuel gauge indicated the tank was 87% full, so the operator pushed the nozzle back on and held it in position to continue filling the diesel tank. The operator noticed diesel flowing from the breather so disconnected and reeled the hose back to the truck. Fuel made contact with the exhaust lagging and ignited. The flame was extinguished using a fire extinguisher.  	Workers must never override safety devices when refuelling. This includes repeatedly filling after the nozzle has clicked off, tying the nozzle handle back to avoid holding it or modifying nozzles to fill machines that are not compatible. Breathers should be position clear of ignition points and hot surfaces. Refer to: Safety Bulletin SB15-03 Fires ignite while refuelling mobile plant with quick-fill fuel systems Investigation Information Release IIR17-10 Serious burns while refuelling mobile plant

High potential incident IncNot0042472 Open cut coal mine Airborne dust and other contaminants 	A truck driver was exposed to respirable silica above occupational exposure limit (OEL) during routine Order 42 monitoring.	Mine operators should ensure that control measures are implemented and maintained for minimising dust in operator cabins. This includes filtration of incoming air and sealing of cabs. Mine operators have a duty to manage risks and implement a range of control measures including: • a principal hazard management plan for air quality or dust or other airborne contaminants • ensuring the exposure standards for respirable and inhalable dust is not exceeded • implementing air quality, monitoring and ventilation arrangements

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 (non-fatal)
MSHA	One person died after a mine collapse in Giles County, Virginia. Authorities said that 911 was called just before 4 pm. for the incident at Lhoist Chemical Lime Plant in Ripplemead. When crews arrived, they were reportedly told about an incident inside the mine where an excavator was engulfed by materials inside the mine. As a result, one person was trapped inside the cab of the excavator. Authorities said first responders went into the mine to help workers get the operator of the excavator out of the cab of the equipment, which had been knocked on its side and engulfed by materials. Details

MSHA	On 17 June 2022, a contract miner died when the compactor he was operating overturned, pinning him beneath the cab. As the miner was backing up, the left tyre went off the edge of an embankment, causing the compactor to overturn. This is the 13th fatality reported in 2022 and the fourth classified as 'machinery'. Details
	National (other, non-fatal)
WA Department of Mines, Industry Regulation and Safety	DMIRS has released two information sheets entitled 'Gendered violence: Sexual harassment' and 'Gendered violence: Sexual assault'. These information sheets are intended to assist persons conducting a business or undertaking (PCBUs) to prevent and respond to incidents of workplace gendered violence. Accompanying these documents is the information sheet dealing with notifying Mines Safety of sexual harassment and/or assault which has been recently updated to align with the WHS laws. WA DMIRS - Information sheet - Gendered violence: Sexual assault WA DMIRS - Information sheet - Gendered violence: Sexual harassment Also refer to the NSW Resources Regulator fact sheet: Workplace bullying and inappropriate conduct
Resources Safety & Health Queensland	The Mineral Mines and Quarries Inspectorate has produced a report to provide an overview of the key reporting elements it has tracked during the 2021/22 financial year. This report is part of the inspectorate's focus on improving reporting in the sector, in line with the recommendations from the Brady Heywood report, and to improve safety outcomes for mineral mines and quarry workers. The report noted that over the past twelve months, underground, surface and quarry sectors had all increased their reporting of HPIs. Details
WA Parliament - Community Development and Justice Standing Committee	The Western Australian inquiry into sexual harassment in the state has found that the mining industry perpetuated a culture that failed to protect women employees, who continued to face sexual harassment and sexual assault at various sites. The findings of the year-long investigation into the mining sector were released following concerns about a culture of sexism and bullying. Titled 'Enough is Enough', the report details how sexual harassment was ‘generally accepted or overlooked’ and describes the ‘failure’ of miners to recognise what was happening in their workplaces. Female FIFO workers had long complained of sexual harassment in mining camps, temporary accommodation set up at remote mines to house workers. The Resources Regulator are currently undertaking a review of the ‘Enough is Enough’ report.

	Details
WA Department of Mines, Industry Regulation and Safety	Golden Grove Operations Pty Ltd was fined $35,500 after an integrated tool carrier and blast truck fell into a 13-metre-deep hole at the company's Golden Grove precious metals mine southeast of Yalgoo in October 2018. While no-one was injured in the incident, three workers from a blast crew were working in close proximity to the bomb truck minutes earlier. A number of charged blast holes were also engulfed in the sinkhole. Investigations found the root cause of the incident was backfilled underground workings had not been treated as a void, allowing work to be undertaken above an area of 'unknown stability'. Details
Resources Safety & Health Queensland	Recent high potential incidents and serious accidents reported to the mines inspectorate have raised concerns about lifting and rigging activities, especially where chain blocks and lever hoists were used and/or loads were being drifted (refer Figure 1). Drifting loads refers to moving loads horizontally while being suspended. The high potential incidents reported have involved coal mine workers (CMWs) being struck, or nearly struck by loads that were being lifted, lowered, or suspended. Incidents reported include: Incident 1. On 16 June 2022, workers were replacing a crushing and screening plant conveyor belt when a rope snapped and struck a worker in the face. A worker suffered serious injuries including the loss of an eye. The Resources Regulator will conduct a compliance priority program on lifting and cranage activities at mines during between July and December 2022. 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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