Weekly incident summary

Week ending 2 June 2023

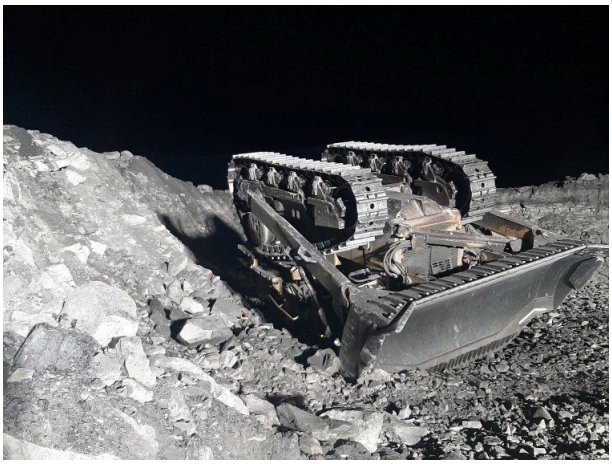
This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the NSW Resources Regulator: phone 1300 814 609 24 hours a day, 7 days a week.

At a glance

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

Type	Number
Reportable incident total	42
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous Incident IncNot0044783 Open cut coal mine Roads or other vehicle operating areas 	A dozer operator was preparing coal on a shared workbench. The operator was aware of the edge of the bench as the dozer trammed forward. The operator felt a track slump. The operator then tried to reverse but the whole side gave way, resulting in the dozer rolling onto its roof. The bench was about 4 metres high, and conditions were reported as dusty. 	When dozers are working parallel to edges, the risk of the dozer inadvertently breaching the edge must be considered, and controls put in place such as windrows. When determining lighting requirements, secondary tasks in the area must be considered. The impact of lighting and shadowing on edges near work areas should be factored into work planning and lighting placement.

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Dangerous Incident IncNot0044771 Underground coal mine	A worker was driving a load haul dump (LHD) that overheated on the main travelling road. The operator removed the header tank cap and was sprayed with hot coolant. The worker was taken to the surface and then to hospital where he was transferred to a specialist burns unit. The worker was treated for superficial burns to the arm, chest and thigh. 	Workers must not remove caps on coolant systems without first relieving the stored pressures. If there is any residual pressure at all in the cooling system, it may cause the coolant to vigorously boil when the system is open to atmospheric pressure. Mine operators should inspect all coolant systems to ensure warnings are in place and a means is available to dissipate the stored pressure to protect workers from exposure to hot coolant. Each radiator filler and radiator cap should be arranged or interlocked so that coolant pressure is safely released prior to the cap being able to be removed.
Dangerous Incident IncNot0044768 Underground coal mine Fire or explosion 	A continuous miner was cutting in a place change panel. A frictional ignition occurred as the miner sumped into the left hand side of the face and intersected a borehole. The ignition started at the cutter head with a loud pop. Orange flames then travelled over the miner to the rear of the miner body. The flames were extinguished after about 30 seconds. Workers at the crib room felt a pressure change and their ears popped. No workers were injured.	An investigation has commenced and further information may be released in future.

Other Resources Regulator publications

Safety Bulletin SB23-05 Contraband in underground coal mines

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)

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Publication	Issue/topic
Resources Safety & Health Queensland	While investigating the cause of a mine dozer shutting down, a coal mine worker opened a diesel particulate matter filter compartment and observed that the filters were beginning to ignite. The worker extinguished the fire. Smoke from the incident entered an inbye panel, workers in the panel subsequently retreated to a place of safety. It has been confirmed that the scrubber water feed isolation valve was in the off position and the safety circuit flow controller was nearly fully wound out. This has rendered the scrubber low water and it shut down to be ineffective. 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	
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