

# Weekly incident summary

## Week ending 24 November 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	45
Summarised incident total	2

### Summarised incidents

Incident type	Summary	Comments to industry
<p>Dangerous incident IncNot0045860 Underground coal mine Ground or strata failure</p> 	<p>A load haul dump (LHD) was cleaning out a cut through to access a seal for repairs. Two workers were inspecting the cut through when they noticed a change in rib conditions. The workers moved to the opposite side of the roadway. Soon after, the rib slumped.</p> 	<p>Workers must remain aware of strata conditions.</p> <p>When cleaning up, workers need to be aware of the risk of destabilising the rib support.</p>

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Incident type	Summary	Comments to industry
Dangerous incident IncNot0045867 Underground coal mine	During a routine inspection, a deputy measured a general body gas reading of 2.6% methane at an install road behind a holing stopping. The stopping was built to segregate the 2 districts, before holing with the continuous miner on the face road. A venturi was set up in the stub to maintain ventilation, however, the air hose had been removed.	Workers must not interfere with ventilation devices such as venturis, fans, regulators and stoppings without a thorough understanding of the impacts of the ventilation system.  Compressed air lines supplying ventilation devices should be marked with an information tag to inform workers to prevent use of the hoses for other tasks.

### 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
	<b>National (other, non-fatal)</b>
<b>WorkSafe Victoria</b>	<p>An employee was injured while performing maintenance activities on a large operating rotary dryer. The employee was close to the main drive gear of the rotary dryer when their right arm became entangled. The employee's arm was partially amputated. The main drive gear was approximately 230 mm wide.</p> <p>Mining and quarry sites may present significant risks to the health and safety of employees, including access to danger areas of plant such as rotary dryers. Body parts can be entangled, crushed, or amputated and fatalities can occur.</p> <p><u><a href="#">Details</a></u></p>
<b>Resources Safety &amp; Health Queensland</b>	<p>Fluid injections are incredibly serious and can lead to the loss of limbs. It's important that all workers at Queensland coal mines follow the recommendations below to avoid serious injuries occurring on site. Fluid injection occurs when a substance (i.e. fluid which may be air, water, oil, solvent, paint, etc) punctures the skin and enters the body tissue.</p> <p>In the past week, 2 fluid-system incident reports were received by the mines inspectorate:</p> <ul style="list-style-type: none"> <li>- Incident 1</li> </ul> <p>On 8 November, a CMW was injected with fluid while rehousing a powered roof support. The hydraulic system had been isolated and confirmed. The injured CMW received a fluid injection injury to the wrist when they attempted to replace a hose which proved to be charged with system pressure. The injured CMW was transported to Brisbane and had surgery to treat the injury. Investigations are continuing.</p> <ul style="list-style-type: none"> <li>- Incident 2</li> </ul>

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Publication	Issue/topic
	<p>A CMW identified an emulsion leak on a powered roof support. Attempting to find the exact location of the leak, the CMW operated individual powered roof support functions. Upon operating the side shield function, emulsion vented from a failed hydraulic hose, drenching the CMW. The CMW was transported to hospital and checked for fluid injection. Fortunately, no injury was sustained. Investigations are continuing.</p> <p><a href="#">Details</a></p>
<b>Resources Safety &amp; Health Queensland</b>	<p>On 1 November 2023, 2 coal mine workers (CMWs) at a site in the South Burnett region were de-rigging a mobile crane after completing a dragline maintenance task. During the relocation of the scissor lift, the machine has hit the ankle and foot of one of the CMWs breaking multiple bones. The worker was treated at site before being taken to hospital.</p> <p>Key issues:</p> <ul style="list-style-type: none"><li>• There was no physical barrier between the moving scissor lift and the CMW on the ground.</li><li>• The scissor lift was operated near a CMW on the ground.</li><li>• There appears to be inadequate communication and response between the CMWs.</li><li>• CMWs did not adequately assess and control the risk of operating plant near another CMW.</li></ul> <p>N.B. Maintenance tasks had been planned and scheduled. The site was well laid out and additional supervisors allocated to the assist in the supervision and management of the shutdown. Experienced CMWs were involved in the incident.</p> <p><a href="#">Details</a></p>
<b>Resources Safety &amp; Health Queensland</b>	<p>On 17 September 2023, at a chemical processing plant in North West Queensland, a release of pressurised hydrogen gas resulted in an explosion and fire injuring three workers and causing damage to plant. The incident occurred during the recommissioning of equipment after routine scheduled maintenance. The injured workers included 2 workers who were completing the recommissioning and a store worker who was approximately 40 m from the location of the incident. The injured workers did not require hospitalisation; however, the event had the potential to cause a more significant adverse effect.</p> <p>Based on available information, several contributing factors have been identified, including:</p> <ul style="list-style-type: none"><li>• the failure of a butterfly valve, under hydrogen header-pressure of approximately 2000kPa, is the direct cause of the incident.</li><li>• - the bearing bush bolts of the butterfly valve may not have been correctly installed at the time of overhaul resulting in separation of valve bearing bush.</li></ul> <p><a href="#">Details</a></p>

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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Document control	
CM9 reference	DOC23/383227
Mine safety reference	ISR23-46
Date published	1 December 2023
Authorised by	Director Regulatory Operations Office of the Chief Inspector