

Weekly incident summary

Week ending 15 March 2024


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 | 63 |
| Summarised incident total | 3 |

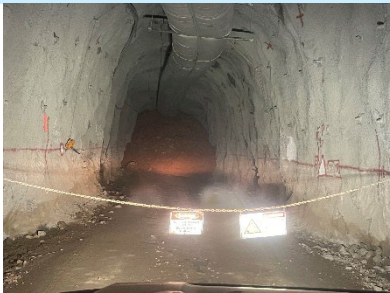
Summarised incidents

| Incident type | Summary | Comments to industry |
|--|---|--|
| Serious injury IncNot0046499 Underground metals | <p>An agitator operator sustained a laceration to his left thumb that resulted in partial amputation. The operator was pushing material into the rear of the agitator bowl when his thumb was caught by the rotating fin.</p>  | <p>All mines must have a system where workers isolate equipment before working near rotating parts.</p> <p>Workers have a legislative duty to care for their own health and safety and that of others (Section 28 of the <i>Work Health and Safety Act 2011</i>). One of the duties is to cooperate with any reasonable policy or procedure. Failure to comply with a duty is an offence and penalties apply.</p> <p>Entanglement between moving parts is a foreseeable risk. Mine operators must identify hazards and manage risks to health and safety associated with the operation, maintenance and cleaning of plant.</p> |

Weekly incident summary week ending 15 March 2024

| Incident type | Summary | Comments to industry |
|--|--|---|
| <p data-bbox="113 226 268 300">Dangerous incident</p> <p data-bbox="113 315 328 353">IncNot0046525</p> <p data-bbox="113 369 296 443">Underground metals</p> | <p data-bbox="384 226 938 376">A sulphide dust explosion occurred underground after a heading was fired. Approximately 70 metres of ventilation bag was either blown down or melted.</p>  | <p data-bbox="991 217 1495 472">Mine operators should manage risks to health and safety arising from combustible dust. In the presence of an ignition source, sulphide dust, when at the right concentration, can ignite and/or explode uncontrollably. Mine operators should:</p> <ul data-bbox="1007 479 1495 1350" style="list-style-type: none"> <li data-bbox="1007 479 1495 584">• identify geological settings likely to contain sulphides and other combustible dusts <li data-bbox="1007 591 1495 665">• identify processes that generate dust <li data-bbox="1007 672 1495 710">• identify sources of ignition <li data-bbox="1007 716 1495 790">• prepare combustible dust hazard maps <li data-bbox="1007 797 1495 992">• develop and implement processes or procedures to communicate combustible dust risk in a timely manner, and to manage risk effectively <li data-bbox="1007 999 1495 1104">• identify, implement and monitor the effectiveness of the risk control measures. <li data-bbox="1007 1111 1495 1350">• Procedures should be developed for re-entry into the mine, this should include controls for the exposure of workers to potentially hazardous atmospheres. |
| <p data-bbox="113 1366 268 1440">Dangerous incident</p> <p data-bbox="113 1456 328 1494">IncNot0046529</p> <p data-bbox="113 1509 296 1583">Underground metals</p> <p data-bbox="113 1599 316 1673">Ground or strata failure</p> | <p data-bbox="384 1366 954 1480">After firing a draw point to shake the ore down, approximately 70 linear metres of clay type material flowed down the drive.</p> <p data-bbox="384 1496 954 1646">It appears that the shockwave of the percussion blast caused the clay material in the old block cave to liquefy and push down the drive.</p> <p data-bbox="384 1662 954 1736">There was nobody in the mine when the blast took place.</p> | <p data-bbox="991 1366 1495 1516">Mine operators must assess the risk of inrush and inundation. When the risk exists, a principal hazard management plan must be in place.</p> <p data-bbox="991 1532 1495 1720">When developing the control measures to manage the risks of inundation or inrush of any substance, mine operators must consider:</p> <ul data-bbox="1007 1727 1495 2020" style="list-style-type: none"> <li data-bbox="1007 1727 1495 1800">• the failure or blocking of the flow channels <li data-bbox="1007 1807 1495 2020">• the potential for the accumulation of water, gas or other substances, or materials that could liquefy or flow into other workings or locations. |

Weekly incident summary week ending 15 March 2024

| Incident type | Summary | Comments to industry |
|---------------|---|--|
| |  | <p>Refer to the code of practice: <u>Inundation and inrush hazard management</u></p> |

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 |
|---|--|
| <p>US Mine Safety and Health Administration (MSHA)</p> | <p>International (fatal)</p> <p>Fatality alert - 'Powered Haulage'</p> <p>On January 29, 2024, a miner died when his haul truck travelled over the edge of a stockpile and overturned.</p> <p>Best practices:</p> <ul style="list-style-type: none"> • Examine dumping locations before work begins to identify hazardous conditions, especially after heavy rain, or other significant weather changes. • Always wear a seatbelt. • Provide adequate illumination at dumping locations. • Ensure dumping locations are properly designed, constructed, and maintained. • Dump material at a safe distance from the edge and push the material over the edge with a bulldozer. • Construct substantial berms as a visual indicator to prevent overtravel at dumping locations. Clearly mark dumping locations with reflectors and/or markers. • Do not remove material from the toe of stockpiles when it would create instability at dumping locations. <p><u>Read more</u></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

Weekly incident summary week ending 1 March 2024

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.

© State of New South Wales through Regional NSW 2024. You may copy, distribute, display, download and otherwise freely deal with this publication for any purpose, provided that you attribute Regional NSW as the owner. However, you must obtain permission if you wish to charge others for access to the publication (other than at cost); include the publication in advertising or a product for sale; modify the publication; or republish the publication on a website. You may freely link to the publication on a departmental website.

Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (March 2024) and may not be accurate, current or complete. The State of New South Wales (including Regional NSW), the author and the publisher take no responsibility, and will accept no liability, for the accuracy, currency, reliability or correctness of any information included in the document (including material provided by third parties). Readers should make their own inquiries and rely on their own advice when making decisions related to material contained in this publication.

| Document control | |
|-----------------------|--|
| CM9 reference | DOC24/53734 |
| Mine safety reference | ISR24-11 |
| Date published | 22 March 2024 |
| Authorised by | Director Technical Operations Mine Safety Office of the Chief Inspector |