

# WEEKLY INCIDENT SUMMARY

Week ending Friday 24 April 2020

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	36
Summarised incident total	2

## Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0037197 Open cut coal mine	<p>A fitter suffered an electric shock while using a Hytorc unit to torque bolts on the chassis of a truck.</p> <p>At the same time, a welder was carrying out air arc gouging on the truck.</p> <p>A mine investigation showed that air arc gouging generates an induced voltage into the frame of the truck.</p>	<p>When undertaking welding activities on truck bodies in a workshop, an earth bond cable should be installed between the truck body and the building earth. It is also recommended that when air arc gouging is being undertaken on truck bodies, no other tasks involving contact with the truck should be undertaken simultaneously.</p>



Refer to:

- Safety Bulletin [SB19-03 Welding-related electric shocks increase](#)
- NSW Resources Regulator [Information Sheet No.2: Basic welding practices](#)

Dangerous Incident  
IncNot0037201  
Metals mine processing plant

A boilermaker suffered an electric shock while operating a 15A TIG welder in a surface hot work area. The electric shock occurred when the worker made contact with the welder electrode.

A preliminary investigation showed that the output voltage of the welder was 130 VDC while the nameplate output was 68 VDC. This suggested a potential internal fault.

Also, the operator was in contact with the electrode and metallic workbench with a suspected hand-to-hand current path.



All welding equipment should be inspected before use and should be properly maintained.

Workers involved with welding activities should remain insulated from the welding job. Welding gloves are not electrical insulators and if they are damp, they can enhance the effect of an electric shock.

Refer to:

- Safety Bulletin [SB19-03 Welding-related electric shocks increase](#)
- NSW Resources Regulator [Information Sheet No 2: Basic welding practices](#)

## 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>International (fatal)</b>
<b>MSHA</b>	<p><b>Mine fatality</b></p> <p>A truck driver was found unresponsive near his bulk trailer, where it appears he fell from the top of the trailer. The driver was taken to hospital and underwent emergency surgery, however, he died from his injuries.</p> <p><a href="#">Details</a></p>
<b>MSHA</b>	<p><b>Mine fatality</b></p> <p>A miner was repairing a personnel carrier while standing between a rib and the carrier. A section of the adjacent rib corner, weighing about 566 kilograms, fell on the miner causing severe injuries. The miner died 16 days later.</p> <p><a href="#">Details</a></p>
<b>MSHA</b>	<p><b>Mine fatality – final report</b></p> <p>On 23 December 2019, about 4.15 pm, a 21-year old worker was fatally injured when he was caught between the 182 centimetre-wide belt and the steel frame of the belt tailpiece.</p> <p><a href="#">Details</a></p>
<b>MSHA</b>	<p><b>Mine fatality – final report</b></p> <p>A 71-year-old contract truck driver, with more than 48 years of mining experience, fell from the top of his bulk trailer on January 23, 2020. While the driver was standing on the body of the vehicle opening the bulk trailer lids, he fell and suffered a fatal head trauma. He died three days later.</p> <p><a href="#">Details</a></p>
	<b>National (other non-fatal)</b>
<b>DNRME Qld</b>	<p><b>Driver's foot pinned by ladder</b></p> <p>A maintainer was completing post service checks while seated in a grader with the cabin door open. The grader was fitted with a dynamic rotating access ladder. On completion of testing, the maintainer initiated a machine shutdown, and the</p>

ladder activated, swinging up. The maintainer was caught half out of the cabin when the ladder struck his foot.

[Details](#)

**Worksafe NT**

**Serious crush injury**

A worker suffered serious crush injuries when a self-dumping bin, full of building rubble, tipped forward onto his leg. The worker was standing in front of the bin when it tipped forward.

[Details](#)

**Queensland  
Mines (minerals  
and quarries)  
Inspectorate**

**April 2020**

Incidental periodical high potential summary – Mineral mines and quarries.

[Details](#)

**Queensland  
Mines (minerals  
and quarries)  
Inspectorate**

**April 2020**

Incidental periodical high potential summary – Coal.

[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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Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (May 2020). However, because of advances in knowledge, users are reminded of the need to ensure that information upon which they rely is up to date and to check currency of the information with the appropriate officer of Regional NSW or the user's independent advisor.

**DOCUMENT CONTROL**

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**Mine safety reference** ISR20-17

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Office of the Chief Inspector