

# WEEKLY INCIDENT SUMMARY

Week ending Friday 20 September 2019

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	57
Summarised incident total	8

## Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Serious incident IncNot0035540	<p>Workers were lifting the lid of a cone crusher at a quarry using an excavator. The lid weighed about 1.5 tonnes. As the lid was lifted, it swung and hit a worker, who then made contact with a conveyor leg.</p> <p>The worker was given first aid and was taken to hospital, where it was confirmed the worker had broken ribs.</p>	<p>Work procedures and controls must consider the risk of workers being in proximity to equipment. No-go zones and safe standing zones for workers should be implemented and communicated to all workers involved in lifting tasks.</p>



Serious incident  
IncNot0035550

While a loader at a surface coal mine was travelling down a pit ramp at 25km/h, a steel pin was rolling around on the floor of the cab.

The worker was distracted when he tried to pick up the pin. The loader hit a soft area in the haul road, causing the loader to jar the worker.

The worker's arm hit the bucket hoist lever, causing the bucket to dig into the ground and suddenly stopping the loader.

The worker's forehead hit the windscreen, causing cuts to his nose and ear and also damaging the windscreen.

The worker was taken to hospital and kept in overnight for observation and scans.

Machine operators must carry out pre-use inspections of machines. This should include the operator's cabin to confirm that any loose items are either restrained or removed before operating.

Mine workers are reminded of the importance of wearing seat belts while operating equipment, even at low speeds.



Dangerous incident  
IncNot0035551

An underground coal mine worker sustained a laceration injury between the eyes when the worker was hit by a plastic rib bolt while driving a shuttle car. The worker drove the car around hose reels that were stored in the roadway. The shuttle car struck a plastic rib bolt which snapped, and the bolt and/or plate struck the worker in the face.

Mine supervisors should conduct frequent physical inspections of mine roadways to ensure there is adequate clearance for plant to operate.

Mine operators should consider the recommendations from the [Investigation report into the serious injury of an operator at the Mannering Colliery, Doyalson, NSW on 22 January 2016](#).

High potential  
incident  
IncNot0035570

A dozer reversed over a light vehicle at a surface coal mine. The light vehicle was parked on a bench about 30 minutes before the incident occurred. No-one was in the vehicle at the time of the incident.

An inspector attending the mine identified that pre-use checks were not being completed on light vehicles. He also noticed that light vehicles that were not parked in park-up areas, were not

Mine operators are reminded that light vehicles are to be parked in designated park up areas and are to have functioning flashing lights when in use on mine sites.

When light and heavy vehicles are likely to interact, all operators are to be trained and assessed on the sites safety procedure.

using flashing lights and light vehicles were not parked in a fundamentally stable condition.

A 195 prohibition notice was issued to the mine requiring all workers (including supervisors) to be retrained.

Ongoing monitoring of compliance with site park-up procedures should be included as part of the duties of supervisors.



Serious injury  
IncNot0035593

A loaded road truck left a weigh bridge at a quarry. The truck had travelled about 300 metres when the driver reportedly suffered a medical episode causing him to lose control of the truck, which hit a tree. The driver suffered a broken leg. The truck was owned and operated by a quarry customer.

Mine operators should review and consider the findings from reports published by the NSW Resources Regulator in relation to non-work related deaths, for example the [Investigation report into the Bulga Open Cut dump truck collision](#), the [Investigation Information Release into a non-work related death at a mine site in May 2019](#) and also the [Investigation Information Release relating to a fatality that occurred at an open cut coal mine in 2018](#).



Dangerous incident  
IncNot0035597

At a surface coal mine, the operator of a light vehicle lost control of the vehicle in wet conditions. The light vehicle slid sideways into a bank and rolled onto its side. The driver was not injured.

Mine operators should assess road conditions and review training, or other instruction provided to workers to react to changes in conditions that may impact on their ability to operate equipment in a safe manner.



Serious injury  
IncNot0035603

Two contractors were installing 8 metre mega bolts in an outbye area of an underground coal mine. While pushing the last 3 metres of a bolt into the hole, a worker's hand slipped causing the bolt plate to hit his face.

The worker was taken to hospital where testing confirmed he had a fracture to the face between the nose and cheek.

Bolting work injuries are not uncommon. Mine operators should consider how workers are trained to think about how environment conditions at their workplaces might make the possibility of injury more likely. Good housekeeping practices, such as keeping surfaces dry will help to prevent injuries from occurring.

Dangerous incident

A mechanical fitter suffered an electric shock when he made contact with a cable joint and

Mine operators must have high voltage testing procedures in

IncNot0035609

the chassis of an electric haul truck at a surface coal mine. The haul truck was undergoing maintenance when the incident occurred. Electrical high voltage tests were being conducted at the same time as mechanical work.

place that exclude other workers from the areas being tested and reduce exposure to the risk of receiving an electric shock when testing is being undertaken.



## 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>
--	------------------------------

MSHA	<b>Mine fatality alert</b>
------	----------------------------

	On 29 August 2019, a 25-year-old section foreman with six years of mining experience was fatally injured while exiting the longwall face. The worker was struck and covered by a portion of mine rib.
--	---

[Details](#)

**International (other non-fatal)**

MSHA

**Fire safety alert – underground diesel equipment**

On 14 May 2019, an underground equipment fire occurred on a diesel-powered water car. No workers were injured in the incident.

[Details](#)

**National (fatal)**

DMIRS WA

**Haul truck over open pit wall edge SIR No 277**

A fatality occurred on 20 June 2019 when a 110-tonne haul truck crossed a windrow and fell down a pit wall. At this stage of the investigation, the following was evident:

- the loaded truck entered a single-lane section of roadway with two narrow points. When it reached the second narrow point, the truck's right-side wheels rode up and over the windrow.
- As it straddled the windrow, its forward movement was initially arrested with the right-side wheels over the crest edge, but the truck then slid over the edge, falling 15 metres to the lower bench.

[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.

© State of New South Wales through the NSW Department of Planning, Industry and Environment 2019.

This publication is copyright. You may download, display, print and reproduce this material in an unaltered form only (retaining this notice) for your personal use or for non-commercial use within your organisation. To copy, adapt, publish, distribute or commercialise any of this publication you will need to seek permission from the NSW Department of Planning and Environment.

Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing (September 2019). 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 the NSW Department of Planning and Environment or the user's independent advisor.

**DOCUMENT CONTROL**

**CM9 reference** DOC19/830180

**Mine safety reference** ISR19-37

**Date published** 27 September 2019

## WEEKLY INCIDENT SUMMARY

Week ending Friday 20 September 2019

**Approved by**

Chief Inspector

Office of the Chief Inspector