

WEEKLY INCIDENT SUMMARY

Week ending 12 April 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	30
Summarised incident total	3

Summarised incidents

INCIDENT TYPE	SUMMARY	RECOMMENDATIONS TO INDUSTRY
Dangerous incident IncNot0034360	<p>A fire occurred on a dozer in an open cut coal mine. The dozer was capping blasted ground when the operator noticed a fire. The operator decided to relocate the dozer to a lower level to get better access to a water cart when the dozer became bogged on the slope of the blast heap.</p> <p>The dozer's fire suppression system was manually operated, which appeared to extinguish the fire. A short time later, the fire reignited. Several workers attempted to put out the fire with hand-held extinguishers. A water cart arrived and</p>	<p>Within the site's emergency procedures, mine operators should consider access to work areas for emergency vehicles when designing work areas.</p> <p>Operators should follow emergency procedures without causing further risk to themselves and others from environmental hazards such as poor lighting, unstable ground conditions and toxic fumes.</p>

extinguished the fire. The operator slipped and suffered a hand injury.



Dangerous incident
IncNot0034359

A light vehicle hit a drill steel protruding from a jumbo drilling rig that was parked in the main decline.

The drill steel caught on the passenger side wing mirror and went through the rear window, narrowly missing the passenger. As the vehicle travelled forward, the drill steel started to bend before springing out of the cab and landing 13 metres down the decline. No workers were injured.



Mine operators should ensure that machine loads and items that are stored for transport do not protrude and pose any risk to other passing vehicles.

A S195 notice was issued to the mine preventing drill steels being transported on jumbo's while the machines are tramming between production areas.

Dangerous incident
IncNot0034334

A haul truck rolled onto its side at an open cut coal mine. The truck had travelled over the crest and was descending a ramp.

Mine operators should review whether ramp and cresting speed limits are appropriate for the retarder and braking systems fitted to haul trucks.

The operator tried unsuccessfully to slow the truck. The truck contacted a windrow and rolled onto its side. There were no other vehicles in the vicinity at the time. The operator was not injured.

The photographs of the incident site (below) graphically illustrate the potential severity of this incident as the out of control truck was approaching an intersection and a vertical drop at the time.



Mine operators should review the training provided to operators regarding the safe application of retarders and service brakes on haul trucks.

Mine operators should routinely download and review operating data from haul truck logging systems to verify trucks are being operated in a safe manner.

This incident is the subject of further investigation by the NSW Resources Regulator.

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
International (fatal)	
MSHA	<p>Metal/non-metal mine fatality</p> <p>On 11 November 2018, a 45-year-old underground technician, with four years' experience, was killed when the load haul dump machine he had been operating ran over him.</p> <p>Details</p>
MSHA	<p>U/G Metal - Miner buried by cemented rock fill</p> <p>Jason M. Holman, a 42-year-old powderman with eight years of experience, was fatally injured on 25 October 2018, when cemented rock fill (CRF) used to backfill previously mined areas fell from the back/roof and buried him while he was loading blast holes. Mr. Holman's body was recovered from the fallen material on 26 October 2018.</p> <p>Details</p>
MSHA	<p>Surface coal - Worker crushed while removing a push beam</p> <p>On 7 March 2019, a 38-year-old miner with 10 years of mining experience suffered fatal injuries while he was working on the pad of a highwall mining machine (HWM). The miner was in a pinch point between a post and a section of the HWM (i.e. push beam) that was being removed as part of the normal mining cycle.</p> <p>Details</p>
MSHA	<p>Surface rock – Worker crushed by heavy vehicle (final report)</p> <p>On 3 November 2018, a 44-year old shift supervisor with three years of experience was killed when a loaded Caterpillar 785B haul truck ran over her pick-up truck at the crusher site.</p> <p>Details</p>
MSHA	<p>Surface coal – Worker dies in highwall collapse (final report)</p> <p>On 11 December 2018, a 38-year-old miner was fatally injured at a surface coal mine. The miner was operating a front-end loader to move shot rock near the toe</p>

of a highwall. A large portion of the highwall collapsed onto the front-end loader, crushing the operator cab and fatally injuring the miner.

[Details](#)

MSHA

U/G coal – Worker suffers fatal high-pressure injury (final report)

On 29 November 2018, a mechanic with 29 years of mining experience was severely injured when hydraulic pressure propelled a piece of metal out of a hydraulic fitting that he was examining, and the metal penetrated his head. The miner died on 30 December 2018 because of his injuries.

[Details](#)

National (other, non-fatal)

DMIRS WA

Mentally healthy workplaces for fly-in fly-out (FIFO) workers in the resources and construction sectors – code of practice

[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 (April 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

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