

## Week ending 18 January 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	34
Summarised incident total	5

### Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident IncNot0033646	<p>A load haul dump vehicle was descending a decline in an underground metalliferous mine when its bucket hit a wall. The door opened, activating the door interlock, which applied the park brake. The operator was ejected from the cab.</p> 	<p>Seat belts and door interlocks must be treated as safety-critical items on mobile plant. Where defects are identified, the plant must not be operated.</p> <p>The <a href="#">Work Health and Safety Act 2011 Section 28</a> details workers' requirements while at work. This includes complying and co-operating with directions and procedures given, as well as the wearing of seat belts and personal protection equipment.</p>

Dangerous incident  
IncNot0033643

A fire occurred on a haul truck at an open cut coal mine. A brake hose failed and sprayed oil into the engine bay, which ignited. The operator saw flames through the passenger side window. The operator stopped the truck, activated the fire suppression system and left the vehicle safely.



When conducting audits and assessing fuel sources, ensure hydraulic hoses outside the engine bay, as well as other ignition sources, are assessed and maintained to the same standards as those within the engine bay.

Dangerous incident  
IncNot0033627

A worker suffered an electric shock while cleaning behind computer monitors with a damp cloth.

The incident was only reported to a supervisor five days later.

All personnel on site must be trained to immediately report incidents. [WHS Act 2011 Section 28 \(b\)](#) requires workers to take reasonable care not to affect the safety of other workers. This requires all workers to report hazards and incidents.

Dangerous incident  
IncNot0033599

A fire occurred on a charge-up machine in an underground metalliferous mine. The machine was parked at the bottom of the decline when a solenoid caught fire. The fire was extinguished with a hand-held fire extinguisher. This is the second fire on this machine within two weeks.

When conducting investigations into incidents, all potential root causes should be identified and addressed, not only those deemed most likely.

Dangerous incident  
IncNot0033598

A collision occurred between a dump truck and dozer at a dump in an open cut coal mine. The truck driver stated the dozer driver gave him permission to reverse to the tip behind the dozer. The dozer driver stated he

Supervisors need to regularly monitor compliance with mine site rules for vehicle interactions.

thought the truck was dumping further away and that he should have waited for the truck to pass behind the dozer. The dozer driver continued to reverse and made contact with the truck. No injuries were sustained.

The safety management system should detail the minimum requirements for supervisor inspection and monitoring of work areas and practices.



## Resources Regulator recent publications

- [IIR19-01 Investigation Information Release Shotfiring incident at Albury Quarry](#)

## Other publications of note

These 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	<p><b>Coal mine fatality</b></p> <p>On 20 December 2018, a mobile bridge carrier operator, with five years and 21 weeks of mining experience, was killed while operating his detached, remote-controlled machine during the mining process. As the continuous haulage system pulled forward in preparation of mining, he was crushed between the coal rib and the No. 2 mobile bridge conveyor that was between both mobile bridge carriers.</p> <p><a href="#">Details</a></p>

MSHA

**Coal mine fatality**

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. The metal penetrated his head. The miner died on 30 December 2018 from his injuries.

[Details](#)

MSHA

**Coal mine fatality**

On 7 September 2018, a 60-year-old haul truck operator with one year of total mining experience suffered burn injuries while attempting to escape from the cab of the burning haul truck he was operating. Due to complications associated with his injuries, the operator died five days later.

[Details](#)

MSHA

**Coal mine fatality**

On 29 December 2018, a 25-year-old dredge operator, with 21 weeks of experience, was fatally injured at a coal mine. The victim drowned when the dredge he was operating sank.

[Details](#)

**National (fatal)**

Media release  
NSW  
government  
(Finance)

**Workers warned of confined space killers**

In May, a 28-year-old man and a 35-year-old man died in an incident at a paper mill at Ettamogah. Initial inquiries indicate the men were working in the basement area of the mill when they were overcome by hydrogen sulphide gas and collapsed.

In August, a 58-year-old man died on a rural property near Dyraaba with initial inquiries indicating the man was repairing a damaged water tank on the property when he was overcome by fumes and was unable to be revived.

[Details](#)

**National (other, non-fatal)**

WA Dept of  
Mines

**Sinkhole in open pit floor engulfs mine vehicles after collapse of backfilled stope**

In October 2018, a working pit floor subsided into a backfilled stope, forming a 13 metre deep sinkhole. The stope had previously self-mined to near surface and had been backfilled in stages since 2016. At the time of the incident, surface drill and blast activities were occurring in the vicinity. The subsidence event resulted in the loss of an integrated tool carrier and an explosives truck that were parked on the blast pattern. Several charged blast holes were also engulfed in the sinkhole.

The vehicles were unoccupied at the time of collapse, however four people were working nearby.

[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.

### Disclaimer

The information contained in this publication is based on knowledge and understanding at the time of writing. However, because of advances in knowledge, users are reminded of the need to ensure that information on which they rely is up to date.

#### Office use only

CM9 reference	DOC19/61846
Mine safety reference	ISR 19-03
Date published	25 January 2019