

## Week ending 4 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	73
Summarised incident total	6

### Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident IncNot0033518	<p>A trailer-mounted generator fell from the back of a tilt-tray truck. Two generators were being delivered. The rear generator was unstrapped, and the truck was repositioned. When the truck stopped, the generator rolled off the back of the truck. A spotter was clear of the area where the generator fell.</p> 	<p>Mines must have procedures in place for unloading deliveries to sites. This should include procedures for unloading by tilt tray, Hiab, forklift/telehandler, crane, as appropriate. Systems should be put in place to ensure this is available to delivery drivers.</p>

Dangerous incident  
IncNot0033509

A skid street loader knocked over a wall at a large quarry. A worker was using the loader to clean up spilled material and was loading against a shed wall. As the worker raised the bucket for the third load, the wall bowed and collapsed. No other workers were in the area.



Spills should be eliminated as far as is reasonably practicable. In areas where spills cannot be avoided, the area should be designed to allow for safe cleaning and removal of material. The risk of falling material must also be controlled.

When establishing no go zones around mobile equipment, adjacent work areas should be considered.

Dangerous incident  
IncNot0033495

A fire occurred on a loader in an underground metalliferous mine. A worker was in a work basket when a spotter saw smoke and flames coming from the loader. As the worker went to lower the basket, the fire intensified. The worker jumped from the basket to help extinguish the fire. It was identified that the fire was coming from a hydraulic solenoid.



Mines must consider the methods used for evacuating workers from work baskets when they are elevated. Scenarios must be considered where rapid escape from the work basket is required.

Dangerous incident  
IncNot0033494

A haul truck was reversed to a tip head and the rear wheels sank into soft material on the edge of the dump. The incident occurred at night.



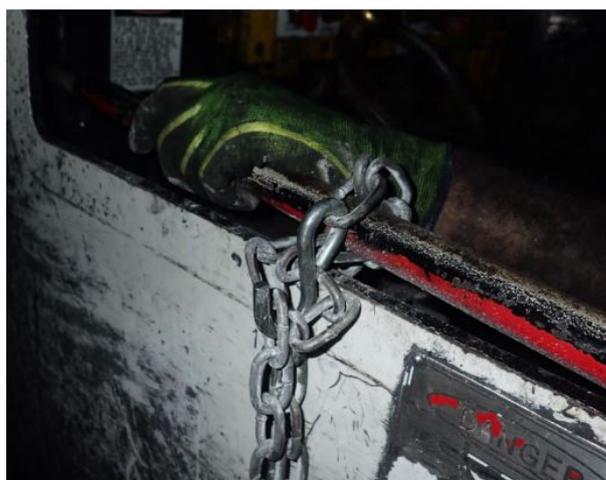
Supervisors must monitor and assess worker compliance with dump procedures on an ongoing basis. When changes are made to procedures, workers must be involved and informed.

Bunds must be designed, constructed and maintained to a standard that is suitable to protect workers.

Lighting must be positioned to create a safe work area and shadows must be assessed when determining the position of lighting.

Serious injury  
IncNot0033433

A worker suffered two fractured fingers while driving a shuttle car at an underground coal mine. After a shuttle car was used to pull a hose, a vent tube chain was left hanging on the rail next to the cab. The worker had his hand under the rail when the chain was driven over - the rail bent down squashing his fingers.



A vent tube chain should only be used for the intended purpose - not for lifting or towing.

Operator's compartments must be kept clean and free of hazards.

Dangerous incident  
IncNot0033387

A dozer rolled onto its side while operating on a coal stockpile, at night, in light rain. The coal was sticky at the time of the incident. The dozer operator was about one metre from the edge of a 6.6 metre drop when coal slumped, rolling the dozer. The worker was not injured.



When working at night, work areas must be inspected, and potential hazards must be identified and communicated to relevant workers.

The nature of wet and sticky material on stockpiles should be considered when establishing work procedures.

**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 and to check the currency of the information with the appropriate officer of NSW Department of Planning and Environment or the user's independent advisor. 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.

### Office use only

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