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.

<table>
<thead>
<tr>
<th>TYPE</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reportable incident total</td>
<td>3</td>
</tr>
<tr>
<td>Summarised incident total</td>
<td>38</td>
</tr>
</tbody>
</table>

**Summarised incidents**

<table>
<thead>
<tr>
<th>INCIDENT TYPE</th>
<th>SUMMARY</th>
<th>RECOMMENDATIONS TO INDUSTRY</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Potential</td>
<td>A haul truck reversed onto a waste dump. As it tipped its load, a large rock rolled down over the edge, breaching the catch windrow at the foot of the dump. Another worker notified the dozer operator and other road users of the hazard. After the shift, the area was</td>
<td>Mine operators should have specific procedures detailing correct handling of unevenly sized waste material. The proper design and construction of catch berms and windrows is critical where active roads are positioned at the foot of active dumps.</td>
</tr>
</tbody>
</table>
### WEEKLY INCIDENT SUMMARY
Week ending Friday 09 August 2019

<table>
<thead>
<tr>
<th>INCIDENT TYPE</th>
<th>SUMMARY</th>
<th>RECOMMENDATIONS TO INDUSTRY</th>
</tr>
</thead>
</table>
| Inspected, preserved and the production superintendent was made aware.  
The catch windrow at the foot of the dump was not constructed as per the specified design. |                                                                                                                                                                                                                                                                                                                                                   | Fires in underground environments present numerous significant risks with potential complexity.  
Operators need to be highly vigilant regarding standards of maintenance applied to mobile plant, to keep the risk of fire as low as reasonably practicable. |
| Dangerous Incident  | A fire occurred on an underground loader.  
The fire was in the exhaust area of the loader. The operator of the loader extinguished the fire with a fire extinguisher.  
The operator was not injured. |                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                       |
| Investigations are continuing, involving mine engineers, the truck manufacturer and Resources Regulator inspectors to establish why the truck lost propulsion. |                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                       |
| An electric-drive dump truck lost propulsion and began rolling backwards, due to the local gradient.  
The operator applied brakes to stop the rolling. This caused the truck to sit up on its tail, trapping the operator in the cabin.  
The operator was removed from the cabin by site emergency responders, with no injuries sustained. |                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                       |
**NSW RESOURCES REGULATOR PUBLICATIONS**

| Safety Bulletin | SB19-09 Lack of bunding on accessible edges |

**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.

<table>
<thead>
<tr>
<th>PUBLICATION</th>
<th>ISSUE/TOPIC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>International (fatal)</strong></td>
<td></td>
</tr>
</tbody>
</table>
| MSHA | **Underground coal – Fatal machinery accident (Report)**  
On 5 January 2019, a 55-year old contract labourer died when he was pinned between a pneumatic airlock door and a concrete barrier.  
[Details](#) |
| MSHA | **Mine fatality alert**  
On 17 July 2019, a 32-year old general manager/owner was killed when he was struck by a hydraulic breaker. The victim and the excavator operator were in the process of positioning the excavator for a motor exchange, when the hydraulic breaker attachment fell off the excavator and hit the victim.  
[Details](#) |
| **International (other non-fatal)** | |
| MinEx NZ | **Yet another ADT rollover**  
A loaded ADT was travelling down a haul road and as it negotiated a bend in the road the bin rolled onto its side. Although road conditions and the gradient of the decline may have been factors, the findings from the investigation indicated that speed at this corner was the major contributing factor.  
[Details](#) |
| MinEx NZ | **Nut failure on truck drawbar**  
A loaded truck and trailer was entering a quarry when a loader operator spotted the ‘A’ frame drawbar pin had dropped out. The loader operator alerted the truck driver.  
The drawbar pin was replaced and taken to the engineering workshop where it was discovered the lock-tight nut had failed. The pin was repaired, checked and put back into service.  
[Details](#) |
National (fatal)

DNRME  
Retractable access ladders – MSA no. 366  
An operator was fatally injured when he became entangled between the movable part of an excavator’s access ladder and the wall of the engine room.  
Details

National (other, non-fatal)

DNRME  
Serious injury to worker involving a mobile screening plant – MSA no. 365  
On 18 July 2019, an apprentice diesel mechanic became trapped between the rear of the incline conveyor and the chassis rail of a mobile screening plant. The worker sustained serious injuries.  
Two other quarry workers who were nearby saw the incline conveyor slide downwards and responded immediately to the trapped worker. They used an excavator and chains to pull the incline conveyor upwards to free the worker.  
Details

DMIRS  
Research study and review paper on diesel particulate matter, now available  
Research study  
Critical review paper

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 (August 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, Industry and Environment or the user’s independent advisor.

DOCUMENT CONTROL

CM9 reference  
DOC19/698243

Mine safety reference  
ISR19-31

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16 August 2019

Approved by  
Chief Inspector  
Office of the Chief Inspector