Weekly incident summary

Week ending 19 April 2024

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	40
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0046719 Underground metals mine	While driving an articulated haul truck at low speed on flat ground the position 2 tyre and rim left the wheel hub, causing the front right underside of the truck to make contact with the ground.	Mine operators should ensure stringent monitoring and quality control of maintenance and repair activities. Plant and equipment must be maintained in accordance with Work Health and Safety Regulation 2017 clause 213 Maintenance and inspection of plant. Original equipment manufacturer (OEM) recommendations on torque settings must be followed when tightening wheel nuts.
Dangerous incident IncNot0046739 Open cut coal	A haul truck was going around a grader on the side of a roadway, but instead of returning to the correct side of the road, the haul truck continued to the other side of the centre bund onto the wrong side of the road before	Following a recent awareness campaign on vehicle interactions, the Regulator published a video that can be used for training purposes and toolbox talks. Mine operators are

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Incident type	Summary	Comments to industry
Roads or other vehicle operating areas 	passing close to 2 light vehicles travelling in the opposite direction.	encouraged to use this resource. You can watch the video on YouTube
Serious injury IncNot0046757 Underground metals mine	A service crew was sent to unblock an air header, so the crew isolated the services before starting work on the pipe. They accessed a dropper and opened it. Nothing came from the dropper, so the crew assumed that the service residual pressure was dissipated and began to take the header off using C spanners. Once the header was loose enough to start removing it by hand, it ejected forcefully. The poly pipe whipped around and hit one of the operators. The operator suffered a deep cut to the cheek and a shoulder injury. 	Effective isolation and energy dissipation practices are critical risk controls when working with high pressure air systems. Where stored pressure can remain in a circuit (such as check valves and gate valves), appropriate methods must be available to safely dissipate pressure. Mine operators' risk assessments on pressure systems must identify and provide effective controls for areas of trapped pressure. Refer to: Investigation information release (IIR22-01) Two mine workers injured during pipe installation work

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
	National (other, non-fatal)
Cancer Council	Cancer Council - diesel engine exhaust occupational cancer risk There may be hazards where you work that increase your risk of developing cancer. This fact sheet discusses occupational hazards related to diesel engine exhaust. 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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