Weekly incident summary

Week ending 23 May 2025

This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the 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	39
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0049152 Open cut coal mine Roads or other vehicle operating areas 	A dozer was doing a clean-up for an excavator while the excavator was loading a dump truck. A second dump truck entered the area and went into the queue about 30 metres from where the truck was being loaded. The dozer operator reversed to turn and leave the work area, and collided with position 6 tyre of the queued truck. The dozer operator had not identified that the second truck had entered the work area.	Situational awareness is a key control when operating mobile equipment. Workers should be trained in the importance of this control and include it in their pre-task risk assessments. Mine operators should continually review the suitability of collision avoidance technology as it evolves, and new products become available. Operators should prioritise segregation between dozers and haul trucks over lower order controls such as positive communication and work procedures. Refer to: Safety bulletin SB24-01 Bulldozer incident increase

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Incident type	Summary	Comments to industry
		
Dangerous incident IncNot0049141 Underground coal mine Roads or other vehicle operating areas 	An old shearer body (with no counterweight or ranging arms) was loaded onto a heavy haulage truck using a forklift. The left and right shearer haulage sprockets and trapping shoes were positioned on the gate end/transition pans that have a larger clevis arrangement on the back of the pan set. Once the load was dogged down and cleared for transport, the truck was driven about 300 metres and rolled, while driving at slow speed on flat ground around a left-hand corner. The driver was uninjured. Two gate/transition pans were used instead of run-of-face (ROF) pans for the sprockets to sit on. This shifted the load towards one side, shifting centre of balance. 	Operators must identify the risk of loads shifting due to an imbalance, especially when there is steel-on-steel contact. Mine operators should have a procedure for transporting shearers that specifies the appropriate pans to use for transport purposes. Secure loading should not be the sole responsibility of the transport driver who may not be familiar with the equipment. In this instance, the load was well secured but the centre of balance was off.

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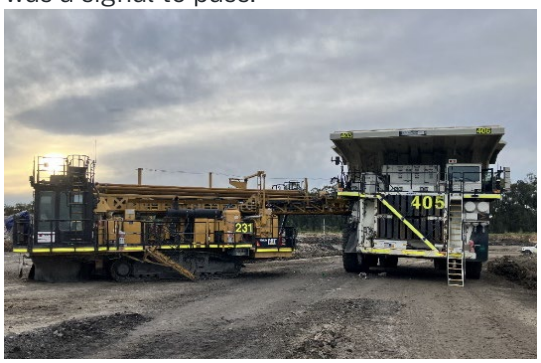
Incident type	Summary	Comments to industry
		
Dangerous incident IncNot0049157 Open cut coal mine Roads or other vehicle operating areas 	A haul truck was passing a drill rig that was tramming along a haul road when the position 2 tyre and the mast of the drill rig collided. The truck operator saw an indicator light flash on the drill rig and assumed that it was a signal to pass. 	To achieve positive communication, a clear direct message must be given. Additionally, the person receiving the message must actively reply with a clear understanding of the message. Supervisors should be continually monitoring positive communication compliance during every radio call on their shift. Work Health and Safety Regulation 2017 section 35 and 36 require higher order risk controls to be implemented and administrative controls such as positive communication, only to be used when no higher order controls can be implemented. Controls such as equipment segregation and proximity awareness systems should be implemented before positive communication are considered.

Other Resources Regulator publications

Recent increase in heavy vehicle rollovers

The Resources Regulator in NSW has issued a safety bulletin following a concerning increase in heavy vehicle rollovers in the past 12 months throughout all sectors of the NSW mining industry.

Vehicle interactions are showing an increasing trend as evidenced by 40 incidents that were notified to the Resources Regulator. Of the 40 incident notifications, 21 were from coal mines, 12 were from construction, 5 were from metalliferous mines and 2 were from industrial minerals.

Read the full safety bulletin and recommendations. (PDF, 721.26 KB)

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Investigation report published after entanglement incident

The Resources Regulator in NSW has published an investigation report into an incident in which a worker suffered the amputation of his left arm when it became entangled on the rotating drill steel of a jumbo drill rig on 19 June 2023.

The incident occurred at Cadia East Underground Mine near Orange in NSW. The investigation found a number of factors contributed to the worker being exposed to the risk of serious injury or death.

Read the full report and recommendations to industry (PDF, 791.68 KB).

Other publications of interest

The incidents are included for your review. The 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)
Business Queensland	**Mineral Mines and Quarries quarterly report published** The latest Queensland Mineral Mines and Quarries inspectorate quarterly report has been released with updates on: • regulator activity • statistics • serious accidents • high potential incidents • incident focus – worker received leg injury from fall of suspended load • incident focus – unplanned movement of load • incident focus – dump truck brake failure • interstate and global updates • health hub – underground mines: respirable dust and respirable crystalline silica • people to controls electrical work forum 2025 • key training • key engagement and activities. 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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