

Weekly incident summary

Week ending 9 May 2025

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	Comm to industry
Dangerous Incident IncNot0049042 Underground metals mine Ground or strata failure	<p>Two workers were charging a face when a large rock around 2 to 3 tonnes dislodged from a height of about 2.5 metres, grazing one workers' head, and striking him on the shoulder.</p> <p>The face was scaled earlier prior to work commencing.</p>	<p>Mine operators must assess the risk associated with ground and strata to identify all foreseeable hazards. Identified hazards must be managed in accordance with the hierarchy of controls.</p> <p>Face inspections should identify intersections of geological structures at risk of forming wedge failures and appropriate controls should be implemented to minimise the risk to workers.</p>

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Incident type	Summary	Comm to industry
		
<p>Dangerous Incident IncNot0049044</p> <p>Underground coal mine</p> <p>Fire or explosion</p>	<p>While undertaking a conveyor and thermography inspection, a deputy noticed haze and smoke coming from the ground.</p> <p>There was a glow from the ground and the thermography camera measured 264 degrees at that point.</p> <p>It was discovered that the return conveyor belting was rubbing on the return structure frame.</p> <p>The conveyor was shut down and the area was doused with water.</p> 	<p>This incident illustrates the importance of conveyor inspections following work where changes have been made to the conveyor. Mine operators must plan to monitor and inspect conveyors after events such as bulk roller change out or conveyor belt replacement.</p> <p>Further information:</p> <p><u>Code of practice Mechanical engineering control plan</u></p>
<p>Severe Incident IncNot0049070</p> <p>Underground coal mine</p> <p>Mine shafts and winding systems</p>	<p>A worker was struck on the head by a man cage as it travelled through the work stage in the shaft.</p> <p>The worker placed his head and shoulders through a hatch into the kibble well to communicate with the mucker operator below him.</p> <p>The worker was struck when the man cage was being lowered through the stage, with the chamfered edge of its base colliding with the worker's hard hat. The worker rapidly pulled his</p>	<p>This incident is currently under investigation.</p>

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Incident type	Summary	Comm to industry
	<p>head back scraping his neck on the hatch sill causing a small abrasion, and neck soreness.</p> 	

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)
SafeWork SA	<p>SA - Underground fire ignites explosives warning</p> <p>A fire in a licensed explosives storage area at a South Australian mine has prompted a SafeWork SA warning about the importance of functional fire safety systems. The affected explosives articles – gas generating cartridges for secondary blasting – were past their shelf life and scheduled to be destroyed later that week. The magazine's fire detection system alerted the mine's control centre, prompting a site evacuation and triggering the deluge system which extinguished the fire. The Emergency Response Team monitored temperatures in the magazine and separated unaffected pallets.</p> <p>Safety recommendations:</p> <ul style="list-style-type: none">*Ensure that explosives are within their recommended shelf life*Ensure that explosives are stored in accordance with the temperature and humidity requirements in the Safety *Data Sheet or Technical Data Sheet*Ensure that fire safety systems are maintained and functional. <p>Read More</p>
SafeWork SA	<p>SA - Safety Alert: Serious burns prompt storage drums warning</p> <p>Two separate explosive fires causing serious burns to workers have prompted SafeWork SA to warn employers about the dangers of cutting into used storage drums. In both of the recent incidents, the drums had previously contained flammable substances but had been empty for a long period of time.</p> <p>In January 2025, a worker in Murray Bridge was cutting into a 166-litre storage drum with an angle grinder to repurpose it. The drum – although empty – had previously contained oil.</p>

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Publication	Issue/topic
	<p>Sparks from the angle grinder and residual vapours caused an explosive fire, resulting in serious burns and lacerations to the man's hand, arm and torso, requiring treatment at a nearby medical clinic.</p> <p>In March 2025, a worker in Tailem Bend was cutting into a storage drum with an angle grinder to repurpose it. The drum had previously contained a carcinogenic and flammable liquid and was clearly labelled with a red flammable liquid diamond warning. Sparks from the angle grinder caused an explosive fire, resulting in serious burns to the man's torso.</p> <p>Read More</p>

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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