Weekly incident summary

Week ending 20 June 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

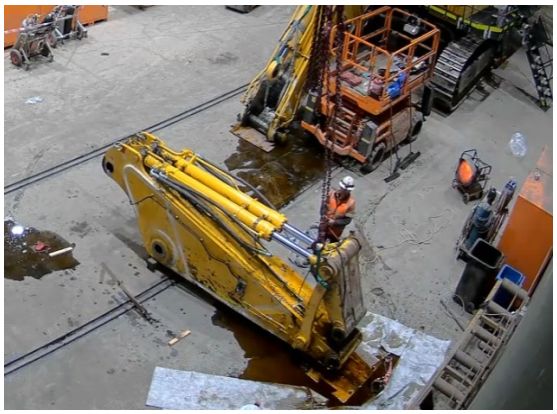
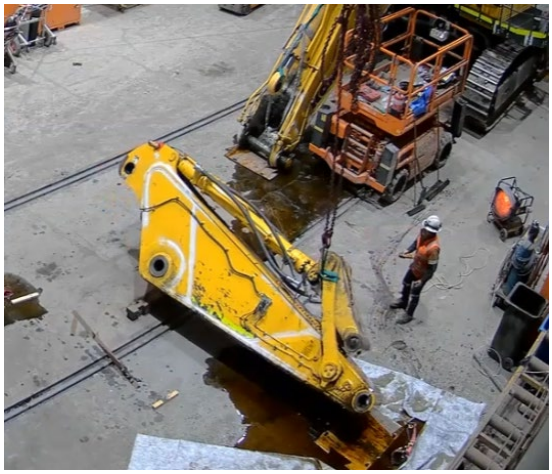
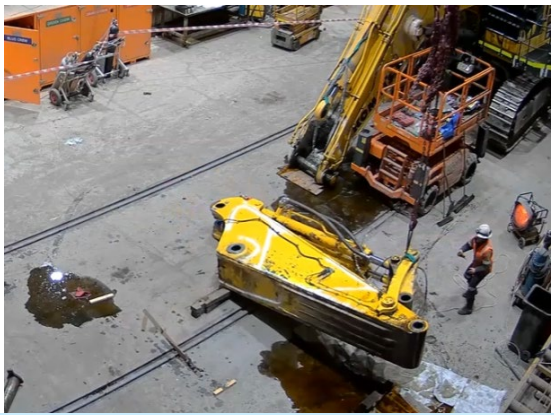
High level summary of emerging trends and our recommendations to operators.

Type	Number
Reportable incident total	48
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0049303 Open cut coal mine	Two fitters were working on an excavator stick assembly after line boring works. The stick assembly and H-link had been removed from the excavator to carry out these works. The fitters were in the process of pulling the bucket cylinders back to the retracted position by an overhead crane attached the to the H-link, when they suddenly retracted at speed causing the stick assembly to unbalance. The fibre-lifting sling was overloaded and snapped, allowing the stick assembly to fall to the ground. One of the fitters took evasive action to avoid being hit by the assembly.	Site procedures are developed to help protect workers from injury or illness. Where a procedure exists for a particular task, workers should follow the procedure. Any deviation from a procedure should first be discussed with a supervisor and appropriate risk control measures put in place. In this particular incident, the method chosen to retract the bucket cylinder introduced a risk that was not identified or controlled. Workers should ensure that loads attached by slings to a crane are adequately supported and secured to prevent unplanned movement.

Weekly incident summary week ending 20 June 2025

Incident type	Summary	Comments to industry
	  	
Dangerous incident IncNot0049290 Underground coal mine Roads or other vehicle operating areas	A personnel transporter (SMV) was exiting a mine portal when it collided with a roof support that was stored near the portal. When exiting the portal, the SMV operator saw a second SMV stopped on the roadway near a washdown pad. The operator believed there was adequate room to pass the stationary SMV but collided with the roof support in the process.	Principal hazard management plans for roads or other vehicle operating areas should consider factors that may affect an operator's ability to safely navigate a vehicle. Roof supports should have a designated storage location. They should not be stored on a travel road. Further, a standard form of delineation must be in place around stored roof supports on the surface.

Weekly incident summary week ending 20 June 2025

Incident type	Summary	Comments to industry
	The SMV operator failed to see the stored roof support.  	
Dangerous incident IncNot0049308 Construction materials Roads or other vehicle operating areas 	An excavator operating in a weathered zone became bogged and the machine slid about 3 metres. The operator was working on saturated overburden when the machine bogged. The operator slewed the excavator, and the counterweight went over the downward slope causing the track to sink further. 	Ground stability should be a primary consideration when working on overburden. Material consistency, wet conditions and dipping ground should be considered. Inspections should verify ground integrity and areas that do not meet the standard should be demarcated, communicated and remediated to meet the standard. When operating machinery, workers' primary focus must remain on the operation and control of the plant or vehicle. Mine operators should review the triggers for competency assessment and the minimum level of competence required before workers are authorised for solo operations.

Weekly incident summary week ending 20 June 2025

Incident type	Summary	Comments to industry
		

Other Resources Regulator publications

Electric shocks in the mining industry

The Resources Regulator in NSW has published a safety bulletin, reporting that since January, there were 15 electric shock incidents notified to the Regulator in a five-month period. This is a substantial increase on the previous 12 months, and the trend has also seen an increase in apprentices suffering electric shocks.

The Regulator has made a number of recommendations including that mine operators and other persons conducting a business or undertaking (PCBUs) should assess their electrical engineering control plans to confirm the existing safeguards against electric shock are suitable for the specific tasks being carried out. This assessment should include an evaluation of how well these risk controls are being applied. Guidance on these matters can be found in the Code of practice: Electrical engineering control plan.

Read the full safety bulletin (PDF, 1.03 MB) and watch the supporting video.

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
	International (fatal)
MSHA	**Fatality – final report** Billy Stalker, a 46-year-old seal construction worker/crew leader for Wright Concrete Underground LLC with 28 years of mining experience, died when a portion of rib rock fell on him on 28 February 2025. About 2:30 pm, Mr Stalker was jackhammering an area in the mine floor for the second water trap when fellow worker Bradley Stiltner relieved Mr Stalker. Mr Stalker sat against the rib to rest. Mr Stiltner heard something and glanced to see a rib rock laying on Mr Stalker. The incident occurred because the mine operator did not: 1) support or otherwise control the rib to protect miners 2) conduct adequate pre-shift examinations. Details
	National (other, non-fatal)
Worksafe Victoria	**Operating mobile plant in or near water bodies** A recent incident near a water body resulted in the complete submerging of a 75 tonne excavator in a flooded quarry pit. At the time of the incident, the excavator operator was positioning the powered mobile plant on a bench in the flooded extraction area. While entering the water body to position the excavator on the bench, the excavator became submerged. The operator needed to escape and swim away from the excavator. The operator received first aid at the site before he was transported to nearby medical facilities for further treatment. 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.

Weekly incident summary week ending 20 June 2025

Document control	
ISSN:	2982-1010 (online)
CM10 reference	D25/51969
Mine safety reference	ISR25-25
Date published	27 June 2025
Authorised by	Deputy Chief Inspector Office of the Chief Inspector