Weekly incident summary

Week ending 30 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	28
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0049184 Underground coal mine	During the installation of conveyor belting onto a newly installed drift conveyor system, a winching system was configured to wind belting through a transportable conveyor drive and loop take-up assembly. As the belt was winched into the loop take-up, the synthetic sling (used to rig the winch rope to the belt pulling tongue) failed. This resulted in a loss of friction to the drive drum, which allowed the belt to slip back through the drive and loop take-up and begin travelling inbye along the carry side. The belting gradually accelerated down the drift until the inbye end made contact with a roll of belt hung just inbye of the bootend. The belting continued to travel and concertina inbye of the bootend.	Mechanical engineering control plans must set out the control measures for risks associated with the unintended release of mechanical energy by considering safe work systems for people dealing with plant or structures. Mine operators should review how workers and supervisors are trained to recognise the potential hazards associated with all energy sources, including the load introduced by winching equipment. This is especially important when there is the potential for stored energy to be released without warning. When using slings, operators must ensure that they are appropriately

Incident type	Summary	Comments to industry
	The inertia of the remaining belt mass on the drift caused another section to concertina about 150 metres outbye of the bootend. The cause appeared to be the failure of the synthetic sling connecting the winch rope to the belt-pulling tongue. The work team set out specific control of access to all areas inbye of the winch before the commencement of the task. This was physically verified by the undermanager before the start of the task, and additional sentries were positioned in adjacent roadways to further prevent access to the drift where the winching activities were to be conducted. Nobody was exposed to the uncontrolled belting or the failure of the rigging equipment. 	rated for the job, fit-for-purpose and free of any wear and tear.

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	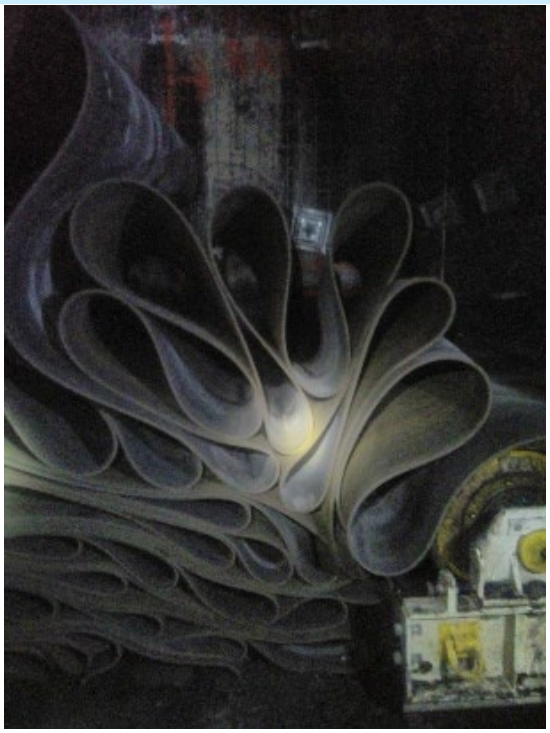	
Dangerous incident IncNot0049200 Open cut coal mine Roads or other vehicle operating areas 	As a loaded haul truck attempted to move forward out of a loading bay, the ground under the position 5/6 tyre slumped, causing the load to shift in the tray. The truck slid backwards into a hole, resulting in the position one tyre lifting off the ground. The excavator operator quickly used the bucket to secure the truck and prevented it from overturning. Weak, weathered material slumped underneath position 5/6 tyre and, in combination with the uneven floor at the rear of the loading bay, resulted in position 5/6 slumping back into a hole and shifting the load of the truck, unbalancing it and lifting position one tyre.	Mine operators should identify all work activities on mine sites where trucks are used. Consideration should be given to the following risk controls to ensure ground stability and suitability for vehicle operations and to prevent a truck rollover. • Loading areas should be level without cross grades. • The ground should be stable and capable of withstanding the truck wheel pressures and not prone to subsidence. • Work areas should have suitable inspection regimes in place. • Changes in conditions, such as wet weather, should trigger a change in inspection frequency.

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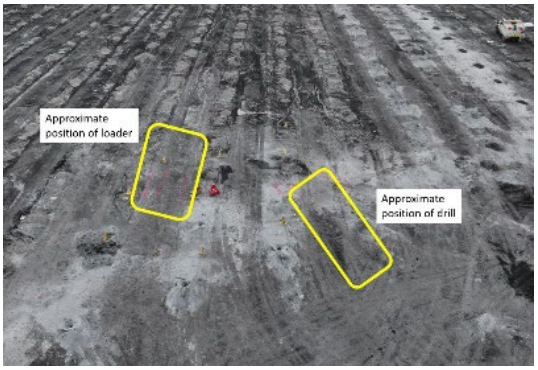
Dangerous incident IncNot0049193 Open cut coal mine Fire or explosion 	A loader inadvertently ran over and damaged 2 boosters that were on the ground while exiting a shot pattern. 	The traffic management plan for the shot floor should clearly identify travel routes so that trucks do not inadvertently drive along the incorrect path. Drivers should know the travel routes before entering the shot floor. To aid the drivers, demarcation of usable tracks should be clearly identified by using visible cues such as cones or signs. Mine operators should ensure effective supervision and auditing of compliance with documented traffic management plans. Mine operators should also have a spotting process that includes using hand-held two-way radios to maintain effective communication with all people on the bench. Mine operators should establish spotting protocols to ensure only spotting activities are being performed during the task, and a process that ensures that non-explosives loading activities are managed to ensure that explosives

Incident type	Summary	Comments to industry
		will not be in the vicinity during these tasks.
		

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	**USA – 12 February 2025: Fatal machinery accident, final report** Edward Blomquist, a 73-year-old highwall drill operator with over 46 years of mining experience, died when the ground beneath the drill he was positioning failed, causing the drill to fall off the highwall on 12 February 2025. The accident occurred because the mine operator did not: • have a policy or procedure in place to ensure safe drilling and work practices near the edge of the highwall

Publication	Issue/topic
	• correct or barricade the loose and unconsolidated material along the edge of the highwall. 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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