Weekly incident summary

Week ending 11 July 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	37
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0049420 Underground metals mine Roads or other vehicle operating areas 	Two haul trucks collided on a narrow section of haul road that had recently begun to be used. One operator heard noise that they assumed was a rock falling from the other truck, and continued along the road. The operator only discovered damage to the offside mirror after stopping at an intersection. The road was identified as too narrow for a dual lane haul road for the truck size.	Mine operators must ensure that the standard for haul road widths is adhered to. Roads should be verified as built-to-standard before use. Where a road is below the width for safe operation as a dual lane road, traffic management controls should be implemented to ensure the road is used as a single lane road only.

Weekly incident summary week ending 11 July 2025

Incident type	Summary	Comments to industry
	 	
Dangerous incident IncNot0049434 Underground coal mine Ground or strata failure 	While shotfiring a stone face, a large sandstone/gas outburst occurred. The gas release was estimated at 2400 m3 with about 80% methane and 20% carbon dioxide. The ejected stone was estimated to be about 600 tonnes. During the event, a gas monitor in a panel return recorded a methane exceedance, with a maximum recorded gas reading of 5.07% occurring for 27 seconds before decaying. There were no injuries with all workers withdrawn to outbye the firing location before the shot was detonated. Witnesses reported a large windblast at their location – over 200 metres from the outburst site and on the intake side. The mine had identified this area as high risk following a previous outburst.	This incident is under investigation and further information may be published later.

Weekly incident summary week ending 11 July 2025

Incident type	Summary	Comments to industry
	 	
Dangerous incident IncNot0049435 Open cut coal mine Roads or other vehicle operating areas 	Two haul trucks collided in a loading area when one truck drove forward into the tailgate of a stationery truck. The handrail and fire extinguisher on the off-side of the moving truck were damaged. The incident occurred at night and neither truck driver was aware of the presence of the other, nor had clear vision of the other while manoeuvring. 	Vehicle operators need to remain situationally aware and ensure that other operators in their vicinity know of their presence. Operators should visually check their surroundings before moving, rather than assuming the way is clear. Lighting plants must be positioned to avoid glare and shadowing work areas. When workers identify hazards with lighting in their work area, they should immediately report this to their supervisors. Mine operators should consider applying engineering controls such as proximity detection and collision avoidance systems to assist in managing the risks associated with mobile plant interactions.

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	Daniel Holle, a 51-year-old front-end loader operator with 28 years of mining experience, died when sand from the highwall engulfed the front-end loader he was operating on March 28, 2025, between 4 pm and 4:30 pm. At the time of the accident, Mr Holle was removing sand from an area at the base of the highwall. The highwall was severely undercut. Mr Holle had been digging at the base of the highwall at a downward trajectory on about 5% grade. He stockpiled the sand on the outer corner of the highwall. The mine operator did not have any written procedures for either of these mining methods. Investigators determined that neither mining method was safe for the type of material and height of the highwall at this mine. The removal of sand from the base of the highwall created hazardous ground conditions. The mine operator did not use mining methods that maintained highwall stability, which contributed to the incident. The incident occurred because the mine operator did not: 1) examine ground conditions as warranted during the work shift 2) use mining methods that maintained highwall stability. Details
MSHA	Juan Maciel, a 57-year-old welder with over 7 years of mining experience, died when he became entangled in a belt conveyor tail roller on March 5, 2025, at 10.55 am. The incident occurred because the mine operator did not de-energise and block the No. 12 belt conveyor against hazardous motion. During maintenance, and after repairing the belt skirt rubber on the No. 14 belt conveyor, Mr Maciel attempted to remove a strip of belt material wrapped around the tail roller for the No. 12 belt conveyor. He removed a piece of guarding from the side of the No. 12 belt conveyor to gain access to the self-cleaning tail roller, where the strip of belt material was located. He entered the enclosed belt conveyor structure and made his way to the tail roller. While he was in the belt conveyor structure, the incoming power was restored to the water pumps, and the Control Tower Operator Robert Cafaro went through the plant start-up procedures. Mr Cafaro sounded the manual alarm and started the belt conveyors, including the No. 12 belt conveyor. Mr Maciel did not have time to exit the confined space of the belt structure and became entangled between the belt and the self-cleaning tail roller of the No. 12 belt conveyor. 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 11 July 2025

Document control	
ISSN:	2982-1010 (online)
CM10 reference	D25/61249
Mine safety reference	ISR25-28
Date published	18 July 2025
Authorised by	Deputy Chief Inspector Office of the Chief Inspector