Weekly incident summary

Week ending 4 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 IncNot0049392 Open cut coal mine Roads or other vehicle operating areas 	A loader and grader collided when both reversed directly towards each other. Tyre position 4 of the loader made contact with the front right-hand drive tyre and mudguard on the grader causing the tyre to burst. The bump stop on the rear right-hand corner of the loader made contact with the emergency stop and access platform on the grader, bending the support and shattering the right-hand side cabin window. In the process of turning behind the loader, the grader operator tried to call the loader using the two-way radio. The loader operator did not acknowledge the call but the grader operator continued to complete the turn regardless. At the same time, the loader operator, unaware of the grader in the immediate work	Lack of positive communication (pos comms) has been the root cause of many incidents at mine sites and mine operators must consider higher-order controls including proximity detection over administrative controls (such as pos comms). Mine operators should consider periodic refreshers in pos comms protocols for operators using mobile equipment. 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 communications

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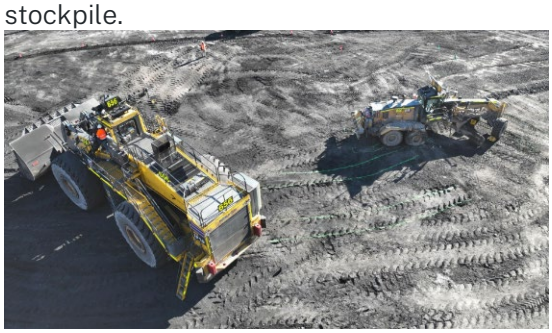
	area began reversing out of the coal stockpile.   	compliance during every radio call on their shift. Transport management plans should take into consideration road repairs being undertaken in production areas.
Dangerous incident IncNot0049399 Underground coal mine Fire or explosion 	An ignition occurred on a longwall while mining through a fault. The crew observed a flame and immediately stopped the longwall. A fire extinguisher was used to put out the flame. Gas monitoring indicated readings within expected tolerances. The cause appeared to be frictional ignition because of picks striking hard sandstone material. 	This incident is under investigation and further information may be published later.

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High potential incident IncNot0049373 Open cut coal mine	A service truck was parked in a maintenance workshop when the inside wall of the right-hand rear tyre failed, rapidly deflating. Maintenance personnel were walking in the vicinity just before the tyre burst. At the time of the burst, the maintenance personnel were not in direct line-of-fire but were behind other equipment in the workshop. Rock damage to the inside wall of the right-hand rear tyre caused the separation and failure of the shoulder. The tyre failed at this point. 	An exploding tyre can have catastrophic consequences. Tyres should be inspected as part of pre-use inspections to include checking for rocks stuck between dual tyres. Operators should receive training to assist them to identify tyre defects.

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Incident type	Summary	Comments to industry
		

Other Resources Regulator publications

Investigation launched into arcing flash incident

The Resources Regulator in NSW has begun an investigation into an incident in which an electrician suffered burns from an arcing flash.

The incident occurred at Appin Mine North (Westcliff Colliery) in Appin, NSW on 7 June 2025.

Two electrical tradespersons had completed an internal inspection on a workshop 415V distribution board (DSBW202) at 1.15 pm on 7 June 2025. They were at the isolation point, trying to close the circuit breaker (ACB1) in distribution board (DSBW201).

The circuit breaker would not close, so the workers began fault-finding tasks.

While investigating the function of closing the circuit breaker ACB2, which is adjacent to ACB1, the circuit breaker racking handle was used as a levering tool. During the process, the racking handle inadvertently made contact with a live phase and the enclosure frame (i.e. earthed) causing a phase-to-earth fault and a subsequent arc blast. As a result, one of the workers suffered arc flash burns to his left hand.

Read the full investigation information release. (PDF, 334.62 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.

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Publication	Issue/topic
	International (fatal)
MSHA	**Fatal falling, rolling or sliding rock accident, final report** Segundo Bosquez, a 44-year-old haul truck operator with 4 months and 4 days of mining experience, died when he was engulfed by material in a trench on 3 January 2025. The incident occurred because the mine operator did not: 1. conduct a ground condition examination before managers and miners worked in the trench 2. correct hazardous ground conditions. 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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