

Weekly incident summary

Week ending 15 August 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	36
Summarised incident total	3



Summarised incidents

Incident type	Summary	Comm to industry
Dangerous Incident IncNot0049647 Open cut coal mine	A scraper was in the process of filling up with gravel when the material at the rear wheels of the scraper slumped causing the scraper to slide down the stockpile. The scraper slid approximately 3m and rolled onto its roof.	Before starting work, supervisors and equipment operators should inspect and assess the work area to determine hazards, such as the potential for material collapse.
Roads or other vehicle operating areas	The driver exited through the front windscreen using the emergency exit. The driver sustained a minor injury. The operator was wearing a seatbelt at the time of the incident.	<p>The operating environment should be examined to ensure:</p> <ul style="list-style-type: none">the ground beneath the working area is stable and free from faults, fractures and soft areasthere is no moisture or water present in the earth or rock below the equipmentwork is not carried out close to the edge or in a zone of influence of an excavation or any previously disturbed ground.

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Incident type	Summary	Comm to industry
	 	<p>The circumstances of this incident underpin the importance of wearing seatbelts as a mitigating control.</p>
<p>Dangerous Incident IncNot0049652 Underground coal mine Fire or explosion</p>	<p>An operator walking the longwall conveyor belt observed a 300mm flame and a glowing hot return roller.</p> <p>The operator stopped the belt and doused the roller with water.</p> <p>The long flat return roller was positioned directly behind the jib pulley for the purpose of flattening the belt line to improve scraper contact.</p> 	<p>Mine operators must have systems to identify and change-out defective conveyor rollers.</p> <p>The installation of return rollers used for flattening belt lines should take into consideration high belt tensions, high belt speeds and deflections distances to prevent premature failures.</p> <p>Workers conducting conveyor inspections must be aware of the increased risk of roller failure at high tension areas of conveyors.</p> <p>Workers must diligently inspect for fire risks such as accumulation of material, failing or collapsed idlers and contact between conveyor belts and fixed structures.</p> <p>Further reading:</p> <p><u>Code of practice Mechanical engineering control plan</u></p>

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Dangerous Incident IncNot0049655 Open cut coal mine Roads or other vehicle operating areas	<p>A haul truck lost traction on an active haul road and slid into the centre bund.</p> <p>The operator was attempting to assist graders by rolling mud into the haul road.</p> 	<p>This incident highlights the importance of having appropriately designed and maintained roadways.</p> <p>Engineering controls that minimise the risk of loss of control should be considered, including the use of speed-limiting devices, speed monitoring and alarms.</p> <p>The Resources Regulator has published a technical reference guide (TRG) to assist mine operators with developing their principal hazard management plan for roads or other vehicle operating areas.</p> <p>For further information refer to TRG: <u>Roads or other vehicle operating areas – principal hazard management plan for surface mining operations</u></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
	International (other, non-fatal)
MSHA	<p>Fatal Machinery Accident, Final Report</p> <p>On January 30, 2025, at approximately 11:25 a.m., Reynaldo Barrientos, a 47-year-old leadman and plant operator with nine years of mining experience, died after he became entangled in a log washer. Investigators learned the two paddle shaft bearings had completely failed, allowing the shafts to rotate inside of the bearing housing. This condition caused misalignment, allowing the paddle shafts to bind against one another, preventing them from rotating. Additionally, the keyway on the drive pulley for the unit was stripped out and would turn on the drive shaft when started. The mine operator made several failed attempts to weld a makeshift collar</p>

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Publication	Issue/topic
	<p>onto the shaft to stop the shaft from slipping in the drive pulley. The mine operator was aware of the mechanical defects and the unsafe work practices used to start the log washer. The mine operator did not take the log washer out of service, tag, or use another effective method of marking the defective items to prohibit further use until the defects were corrected. Investigators determined that this contributed to the accident.</p> <p>The accident occurred because the mine operator did not:</p> <ol style="list-style-type: none">1. remove the log washer from service when defects affecting safety were known2. de-energize or block the log washer against hazardous motion while work was being performed on the log washer <p>Details</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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