Weekly incident summary

Week ending 8 August 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	35
Summarised incident total	3

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident IncNot0049587 Underground coal mine Roads or other vehicle operating areas 	A load haul dump (LHD) machine was exiting a drift with a fully loaded pipe trailer when the machine lost traction. The operator applied the service brake, but the LHD and pipe trailer slid backwards 18 metres and jack-knifed into the rib line. The operator was not injured. The surface was moist and slippery. 	Principal hazard management plans for roads or other vehicle operating areas (ROVOA) should consider the impact of road design and characteristics, including grade, camber, surface, radius of curves and intersections for the vehicles using the roadway. When developing control measures to manage the risks of ROVOA, consideration must be given to the potential for interaction between mobile plant and fixed structures. Mine operators should conduct frequent physical inspections of mine roadways to ensure they are

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Incident type	Summary	Recommendations to industry
		safe and compliant with site procedures.
Dangerous incident IncNot0049593 Underground metals mine Roads or other vehicle operating areas 	A fully loaded water truck lost control while travelling down a ramp. The brakes failed to slow the vehicle, and the operator steered the truck along the wall and into a pile of dirt at the base of the ramp to bring it to a halt. The operator suffered minor whiplash.  	Mine operators are reminded that they must develop and adhere to strict inspection and maintenance standards and practices to ensure plant is fit-for-purpose. Safety critical systems such as braking should be inspected, maintained and tested in accordance with the manufacturer's recommendations. Vehicle operators must be trained and competent to respond appropriately to safety critical system failures. 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. For further information refer to TRG: Roads or other vehicle operating areas – principal hazard management plan for surface mining operations
Dangerous incident IncNot0049609 Underground metals mine	A surface drill rig was demobilising and travelling toward a main road on site when the mast made contact with, and broke an 11 KV overhead line. The jib arm on the mast was in the upwards position and had not been completely	Wherever power lines cross a road, consideration should be given to installing signs on each side of the power lines on both sides of the road identifying the voltage of the power line and the clearance.

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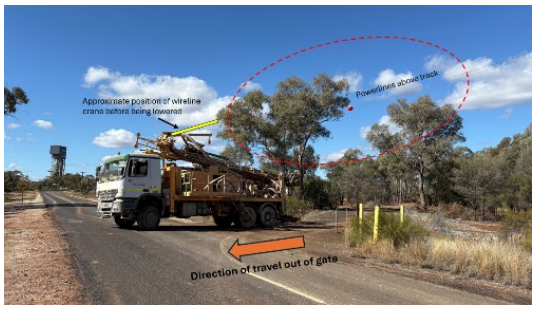
Incident type	Summary	Recommendations to industry
Roads or other vehicle operating areas 	lowered. Contact was made with one of the 3 overhead powerlines. 	An elevated, clearly visible boom should be positioned where each pair of signs is located. The height of the boom should be set at the safe clearance below the power lines. Consider controls such as visual or audible warning devices that will automatically stop or inhibit the movement of a truck while the boom is in the raised position.

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 - 25 March 2025: Fatal explosives and breaking agents accident, final report** Anthony Sievers, a 67-year-old owner/vice president with over 50 years of mining experience, died on 25 March 2025 when a piece of fly rock from a blast hit him. The incident occurred because the mine operator did not: 1) ensure miners were in a blast shelter while initiating a shot in the blast area 2) test the blasting circuit prior to detonating the shot, and 3) maintain the blasting lines in good repair. Details
	National (other, non-fatal)
LGIRS WA (The Department of Local Government, Industry Regulation and Safety- Western Australia)	**Vehicles working in close proximity to underground voids** An educational video that provides recommended mitigations for one of the risky activity's leading hazards – vehicles operating near open voids or stopes. Mobile plants falling into perilous areas have contributed to multiple preventable deaths on Western Australia mine sites. Typically, these fatal incidents occurred when procedures weren't followed, barriers weren't installed, and supervisors weren't focused. Details
Business Queensland	**QLD - Report - MMQ quarterly report April to June 2025** The latest Qld Mineral Mines and Quarries Inspectorate quarterly report has been released with updates on regulator activity, statistics, serious accidents, high potential incidents and more. 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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