Weekly incident summary

Week ending 1 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	31
Summarised incident total	3

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident IncNot0049555 Open cut coal mine	A worker suffered an electric shock while handling a damaged lead from a portal hydraulic pump. He was connecting the damaged lead to an energised extension lead. While holding the plug, an arcing fault occurred, resulting in an electric shock and burns to his right hand. The cable gland was damaged allowing ingress of moisture. 	Mine operators should seek every opportunity to apply the hierarchy of controls while managing electrical equipment in harsh environments. Using extra low voltage electrical equipment and field devices considerably reduces the risks associated with electric shock. Where this control cannot be applied, the maintenance of the ingress protection (IP) rating for the electrical equipment should be paramount. Refer to safety bulletin: SB20-03 Electric shocks in the mining industry

Weekly incident summary week ending 1 August 2025

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Dangerous incident IncNot0049548 Open cut coal mine	A maintenance worker narrowly avoided being crushed by the ladder of a haul truck when the ladder began to retract, unknown to the worker. The electrician was repairing defects on the battery/starter motor isolator box at the time. This work was outside the scope of the live testing process. Three workers were in the maintenance party – the live test coordinator (seated inside the truck cabin), a mechanical worker and an electrician. During testing, the live test coordinator released the park brake causing the retractable access ladder to move up automatically. The electrician was unaware that the ladder was moving. The mechanical worker saw the situation and called out to alert the electrician who quickly moved to avoid being crushed by the ladder handrail.  	Where a powered retractable ladder system is fitted, it should meet the following requirements: • Ladder movement shall stop when the control is released. • The ladder is to be visible from the control location. • The ladder should have a control station fitted at both the top of the system and ground level. • It should be interlocked with the machine to inhibit movement when not in the stored position. • It should be able to be lowered without power where no other means of egress exists. If live testing is being performed a detailed scope of work should be developed and implemented. Any changes to the scope should require the team to cease the process, review and update scope where applicable.

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Dangerous incident IncNot0049574 Open cut coal mine Roads or other vehicle operating areas 	Two light vehicles were travelling in the same direction along a haul road at night in muddy conditions. Mud splashed onto the windscreen of the lead vehicle, slowing it down. The driver used the wipers to clear the windscreen. The trailing vehicle operator was trying to clean its windscreen but there was no water in the wiper's reservoir. The trailing vehicle failed to notice that the lead vehicle had slowed and collided with the front vehicle at speed. A passenger in the rear vehicle suffered a laceration and was treated for whiplash.	Mine operators should use the layered defence approach to help achieve safe operating states for mobile plant. Although all layers of the approach are relevant in this incident particular attention to: Layer 3: Operating procedures (standard operating procedures, maintenance, road rules, quality control, lockout): • Speed limits by equipment type, location and conditions. • Procedures for passing mobile and stationary equipment. • Parking in operational areas including the means of isolating equipment and activity from danger of collision during breakdowns, emergencies, infield servicing, refuelling and maintenance. • Shift roster design that includes defined hours of work and rest requirements, including travel time and a process to manage additional hours of work. Advice and support for supervisors including fatigue call-ups during shift and how to

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	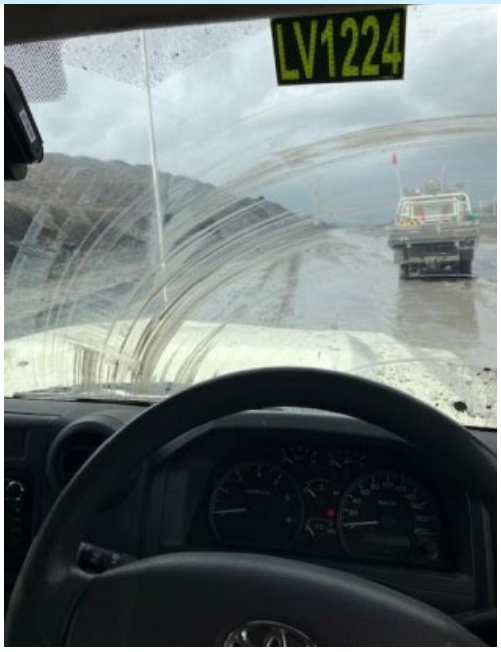 	manage fatigued people from the workplace – a baseline assessment. Mine operators should verify where they are on the vehicle interaction journey, and how to progress to a safer workplace. There are 4 steps to follow: 1. Conduct a baseline assessment using the maturity framework. 2. Review existing operational control measures using the layered defence approach. 3. Identify and implement additional operational controls to achieve safe operating requirements. 4. Consider implementing reactive technology controls. Further reading: Technical reference guide Roads or other vehicle operating areas – principal hazard management plan for surface mining operations

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
	National (other, non-fatal)
Resources Safety & Health Queensland	**Safety alert – Detachment of overhead crane rope** A worker was lowering the hook of a gantry crane to allow for a load to be connected on 19 June 2025. As the hook block neared the ground, the rope detached from the drum, resulting in the rope and hook block falling to the ground. The investigation revealed poor maintenance, and poor inspections were the cause. The investigation identified that the hook height limit switch was damaged and inoperable. The absence of an operational limit switch allowed the crane hook to lower further than it should have, resulting in all of the rope winding off the drum. The full load was then held only by the rope fasteners on the drum. The rope fasteners failed, releasing the rope, allowing it to fall to the ground.

Publication	Issue/topic
	The investigation revealed poor maintenance, and poor inspections were the cause. A routine maintenance and inspection program should be implemented with the guidance of a suitably qualified, competent person to ensure the crane is within the condition and performance limits of its specifications, and that it is capable of performing its intended function. 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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