NSW Resources
Resources Regulator

Quarterly safety report

April to June 2025

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NSW GOVERNMENT

About this report

This quarterly health and safety performance report has been prepared by the Resources Regulator for mine and petroleum site operators in NSW. It contains industry and sector specific information, in addition to information regarding hazards. Wherever possible, trends and patterns have been identified.

The report references sector information about the number of 'active' mines. Active mines have the status: open, intermittent, under care and maintenance, open tourist mines, planned and small-scale titles that are current or pending.

The report also contains information on matters of concern to the Regulator including controls and actions that may be implemented to prevent or reduce the likelihood of future safety incidents.

Operators should use the sector specific information, emerging issues and good practice examples presented in this report to assist them in improving safety management systems and undertaking risk assessments at their sites. This report refers to the date the incident was notified rather than the date the incident took place.

All data is subject to continuous improvement due to changes to reporting requirements, internal audit and validation processes and updates from external sources. Incorrectly classified information from past reporting periods is sometimes found and reclassified in source databases. The Regulator's reporting employs the best available data at the time of data extraction, which may differ from previously published figures.

Document control

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Contents

Executive summary

This report is prepared to assist mine and petroleum site operators meet their obligations under relevant work health and safety legislation, including the *Work Health and Safety (Mines and Petroleum Sites) Act 2013*. It is also a way in which the NSW Resources Regulator monitors progress in implementing our risk-based compliance and enforcement strategy.

As a high-hazard regulator, we focus on compliance with legislative requirements associated with principal and other high-risk hazards, including mechanical and electrical energy and explosives. This report highlights dangerous and high potential incidents, in addition to incidents where a serious injury occurred. 'Roads or other vehicle operating areas' and 'fire or explosion' are principal mining hazard classifications that feature regularly in incident notifications to the Regulator.

As well as providing an overview of incidents across the mining industry, this report looks at the safety performance and regulatory activities of 6 sectors: coal mines, metalliferous mines, extractives mines, opal mines, petroleum and geothermal sites, and exploration sites.

This report provides information on significant mining events in Australia and globally, and summarises safety incident notifications, compliance activities and outcomes for Quarter 4 (April to June) of financial year (FY) 2025. For selected measures, data is analysed over a 15-month period from April 2024 to June 2025.

In this reporting quarter, there were a total of 502 incident notifications received — a 7% decrease from the previous quarter and a 3% decrease from the equivalent period one year earlier.

There were no fatalities during the quarter.

Incident notifications decreased for coal mines (-10%) and extractives mines (-20%) compared to the previous quarter. Conversely, the metalliferous mines sector saw a 14% increase of notified incidents.

Assessments increased by 16% overall this quarter from 791 to 916. The increase was primarily led by non-mine locations which saw 334 assessments commencing this quarter compared to 217 in FY 2025 Q3.

Safety notices increased slightly this quarter from 696 to 711 (+2%), with s191 improvement notices accounting for over two-thirds (500) of all notices issued.

Quarterly snapshot

0 Deaths

22 Serious injuries or illnesses

86 Dangerous incidents

82 Potentially dangerous incidents

164 Other high potential incidents

502
Incident notifications received*

30 Medical treatment injuries or illnesses

112 Lost time/restricted duty injuries or illnesses

6 Explosives Reg incidents

0 Events at a mine rescue station

* By requirement to report as notified by mines. The actual number of incidents, injuries and illnesses recorded may differ from original incident notifications following assessment of the notified event.

Incident notifications received by sector and operation type

Coal mines
372
down from 412

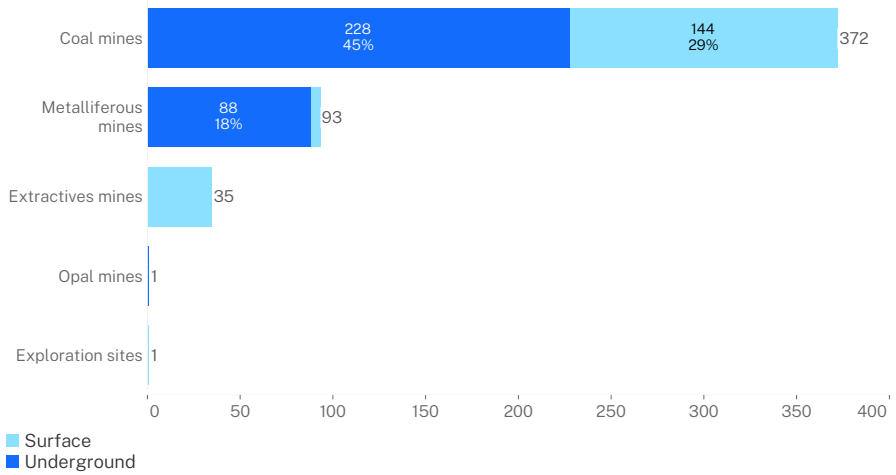
Metalliferous mines
93
up from 85

Extractives mines
35
down from 44

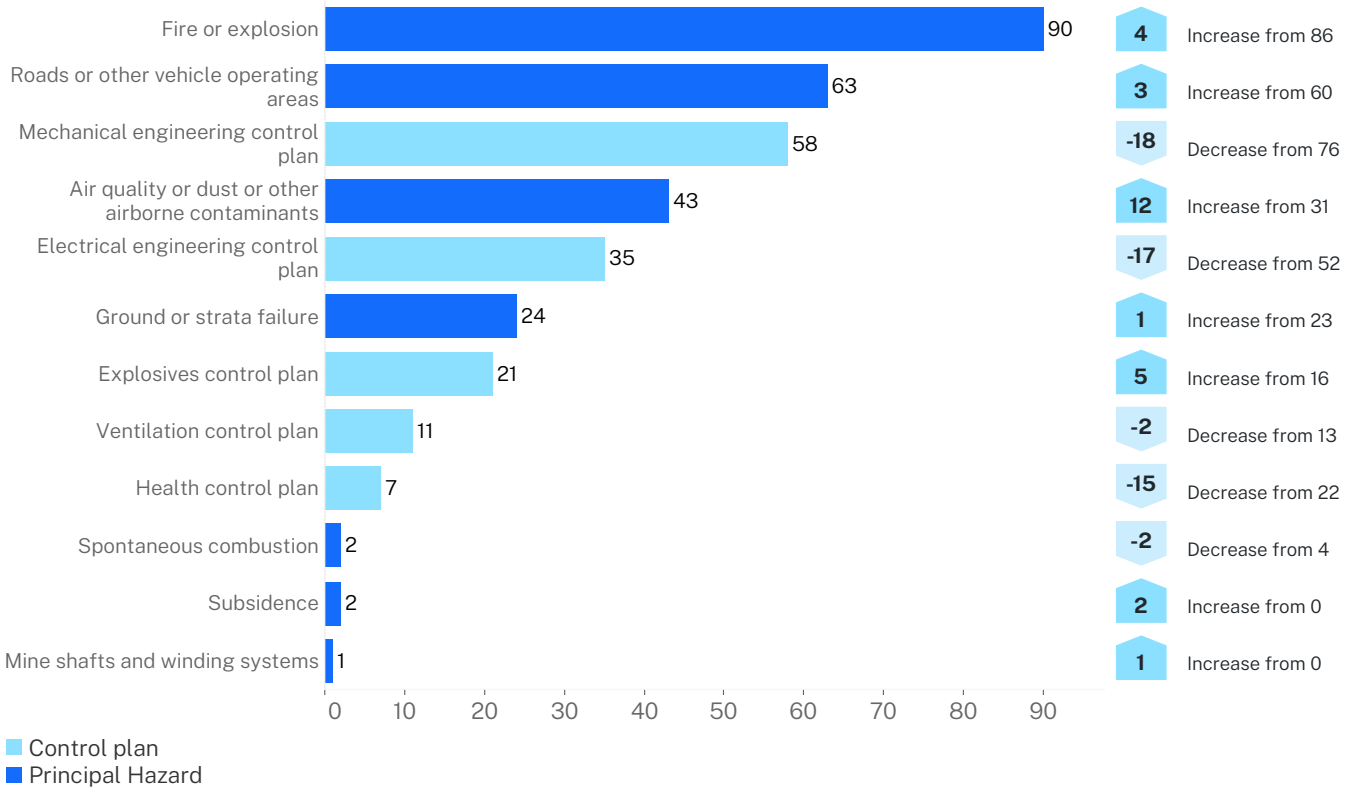
Opal mines
1
up from 0

Other mines
0
down from 1

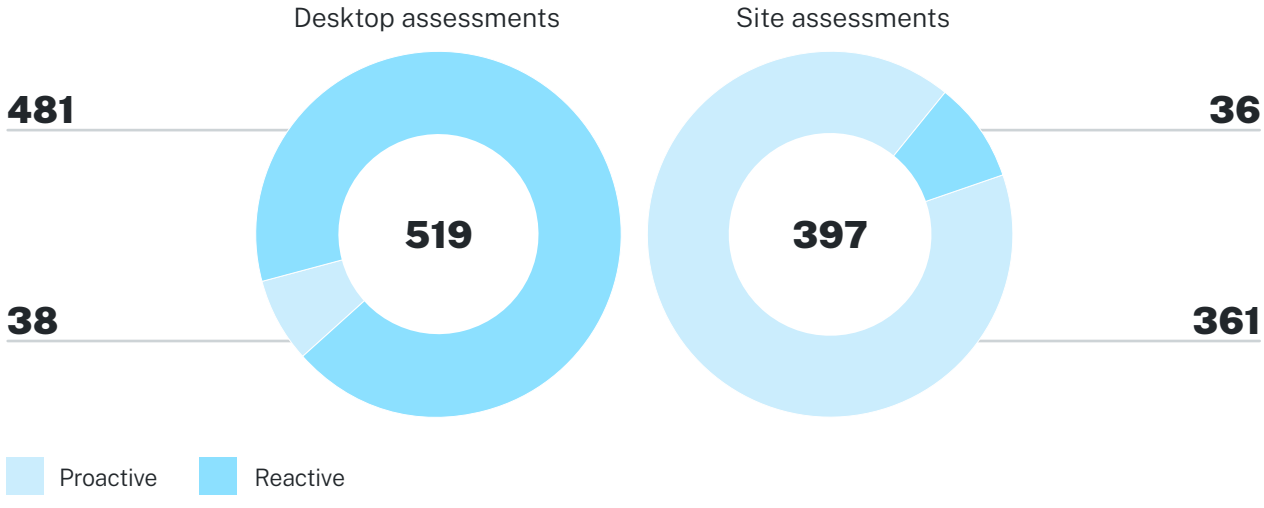
Exploration sites
1
up from 0



Incident notifications classified by principal mining hazard or principal control plan

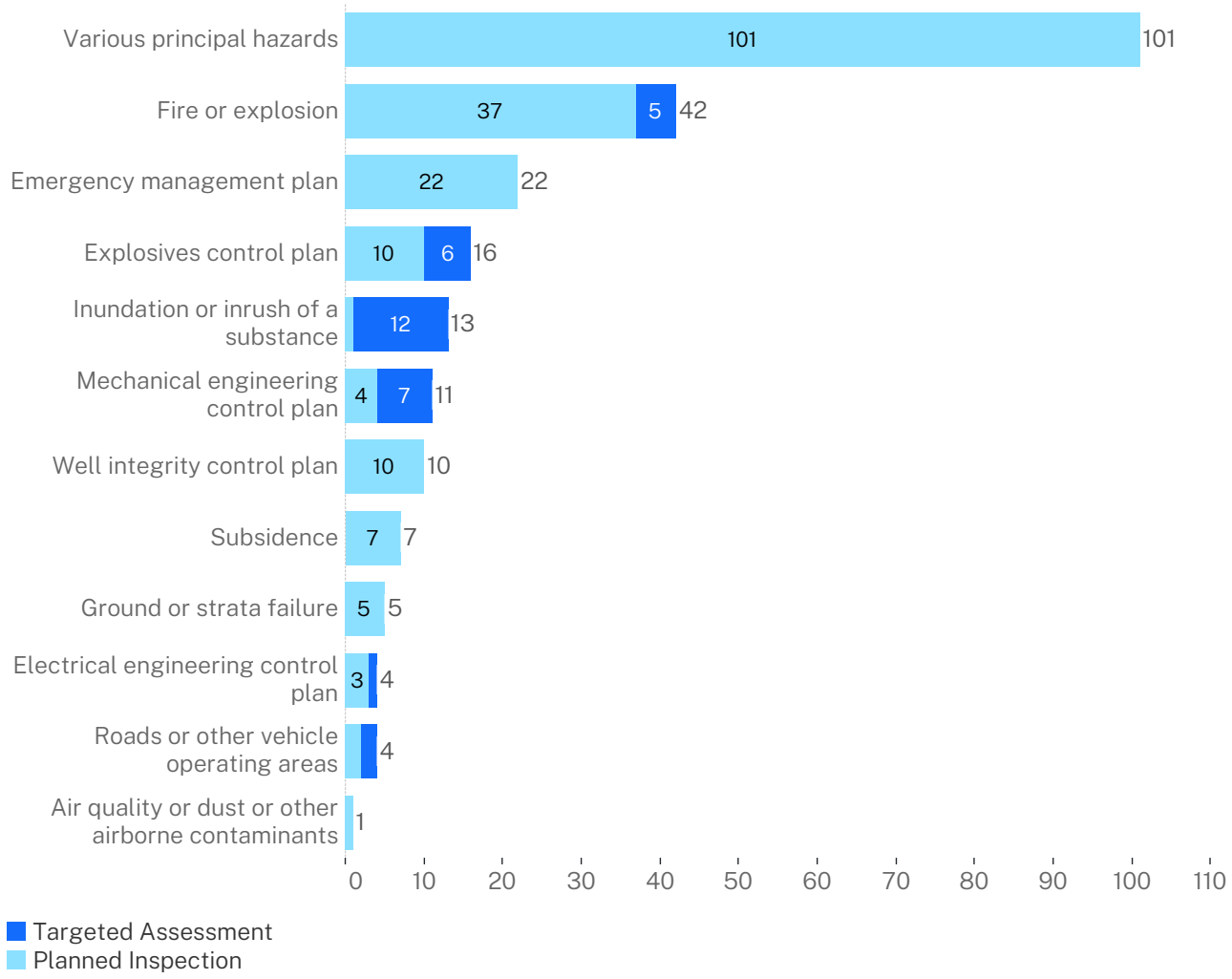


916 Assessments commenced



Coal mines	Metalliferous mines	Extractives mines	Petroleum & geothermal sites	Opal mines	Other mines	Exploration sites	Non-mine locations
322 up from 297	81 down from 92	161 (no change)	13 down from 17	1 down from 2	1 (no change)	3 down from 4	334 up from 217

Programmed site assessments conducted by principal mining hazard and principal control plan



711 Notices issued

1
WHSA s198
non-disturbance notices

68
WHSA s195
prohibition notices

500
WHSA s191
improvement notices

142
WHS(MPS)A s23
notices of concern

National and international significant events

The Regulator is committed to sharing safety information about significant mining-related events and fatalities to increase industry awareness.

The following list includes safety alerts (including fatalities) and bulletins that occurred and were published between 1 April and 30 June 2025.

The incidents selected were based on their relevance to equipment and processes commonly used across the NSW mining industry.

Fatal injuries

Australia

Victoria

On 13 May 2025, a quarry operator died after being crushed under the back wheels of a prime mover at Mitiamo, north of Bendigo. It is believed the sole trader was working under the truck which was attached to a trailer when it rolled backwards, crushing him and dragging him about 40 metres before he was found. Refer to WorkSafe Victoria news report dated 14 May 2025.

On 29 April 2025, an employee died in an incident involving an elevated work platform (EWP). The employee was trying to load the scissor-lift EWP onto a tilt-tray truck in West Melbourne. The EWP fell from the rear of the vehicle and the force ejected the employee from the EWP. The employee received serious head injuries and died in hospital. Refer to WorkSafe Victoria safety alert dated 16 May.

International

United States of America

On 1 May 2025, an excavator operator died after material from a tailings cell engulfed the excavator he was operating. At the time of the accident, the excavator operator was loading dry material into two haul trucks. Refer to MSHA fatality alert dated 1 May 2025.

On 19 May 2025, a miner died when the haul truck he was operating travelled through a berm and over an approximately forty-foot highwall to the bench below. Refer to MSHA fatality alert dated 19 May 2025.

On 15 June 2025, a miner died after the telehandler that he had been operating overturned onto him while he was outside the equipment moving a water pump suction line. Refer to MSHA fatality alert dated 15 June 2025.

Alerts, bulletins, fact sheets and incident information releases

New South Wales

Safety alerts and bulletins

- **Safety Alert: Near miss between light vehicle and front-end loader**

  A front-end loader was travelling up a ramp approaching an intersection at about 10 km/h. The operator failed to identify a light vehicle with 2 occupants waiting to turn right at the intersection ahead of the loader. As the loader approached the light vehicle from behind, the light vehicle operator became aware that the loader was about 10–15 metres away and still travelling forwards. The light vehicle operator took evasive action, moving forward and left onto the haul road. This narrowly avoided the light vehicle being crushed by the loader, which could have resulted in serious injury or fatality to the light vehicle occupants. The loader operator was unaware that the light vehicle was in its travel path and failed to stop, continuing through the intersection. It was not until the loader operator was contacted via the two-way that they became aware of the near miss event. Refer to SA25-01 Near miss between light vehicle and front-end loader dated 13 May 2025.

- **Safety Alert: Rock falls from an unsupported face, hitting worker**

  At 3:40 pm on 5 May 2025, 2 workers were charging an underground development face when a large rock (about 2-3 tonne) dislodged from a wedge failure at the face at a height of about 2.5 metres. The drill face was being charged up from a Normet charge-up rig when the rock fell from the upper left face out of a wedge made by an intersection of 2 clay-lined joints. The heading was meshed and bolted up to the face and had been scaled 3 times in the development cycle. The rock hit one of the workers, grazing his head and hitting him on the shoulder. An emergency was called, and the worker was transported to hospital. Refer to SA25-02 Rock falls from an unsupported face, hitting worker dated 13 June 2025.

- **Safety Bulletin: Recent increase in heavy vehicle rollovers**

  The Resources Regulator has noticed, with some considerable concern, an increasing trend in truck rollovers in the past 12 months throughout all sections of the mining industry in New South Wales, as evidenced by 40 notified incidents. A review of details on these incidents indicated that the predominant causes were:

  - Poor ground conditions at tip heads and dump areas.
  - Hang up and carry back in trays causing poor centres of balance and trucks tipping.
  - Running out dirt while moving.

  Mine operators must have a structured, risk-assessed approach to address adverse vehicle interactions and should review and consider all relevant resources available, including Resources Regulator guidance material. Refer to SB25-03 Recent increase in heavy vehicle rollovers dated 26 May 2025.

- **Safety Bulletin: Electric shocks in the mining industry**

  Since January, there have been 15 electric shock incidents notified to the Resources Regulator in a five-month period. This is a substantial increase on the previous 12 months, and the trend has also seen an increase in apprentices suffering electric shocks. Mine operators and other persons conducting a business or undertaking (PCBUs) should assess their electrical engineering control plans to confirm the existing safeguards against electric shock are suitable for the specific tasks being carried out. This assessment should include an evaluation of how well these risk controls are being applied. Guidance on these matters can be found in the Code of practice: Electrical engineering control plan.

  Refer to SB25-04 Electric shocks in the mining industry dated 23 June 2025.

Fact sheets

- **Control plan – mechanical engineering control plan – unplanned movement of person in workbox or MEWP or integrated tool carrier or crane**

  The Resources Regulator has developed a broad-brush risk assessment and a program of bowties to review principal hazard and control plan topics. The bowtie program identified the material unwanted events (MUE) and critical controls to prevent serious injury or death of mine workers. The bowtie for the mechanical engineering control plan (MECP) identified 6 MUEs and the critical controls for assessment programs. This fact sheet provides information about the assessment program focussing on the MUE – unplanned movement of person in workbox or mobile elevated work platform (MEWP) or integrated tool carrier (IT) or crane box.

  The Regulator's assessment program will focus on the following critical controls to prevent serious injury or death caused by unplanned movement of person in workbox or MEWP or IT or crane box.

  - Equipment design, construction and operation within limits
  - Fall prevention with secure point of attachment
  - Stabilisation devices (where applicable)
  - Maintain sufficient distance between fixed structures and platform/worker

  Refer to Fact sheet – Control plan – mechanical engineering control plan – unplanned movement of person in workbox or MEWP or integrated tool carrier or crane box dated 23 April 2025.

- **Control plan – mechanical engineering control plan – object falling**

  This fact sheet provides information related to the assessment program focusing on the MUE – object falling. The Regulator's assessment program will focus on the following critical controls to prevent serious injury or death caused by objects falling:

  - Engineered lifting equipment operated within limits
  - Correct lifting practices
  - Dropped object containment devices
  - Dropped object arrest systems
  - Dropped object retention systems
  - Falling object protection/deflection
  - People removed from high-risk areas (exclusion zones)
  - Provision of effective isolation, energy dissipation and verification

  Refer to Fact sheet – Control plan – mechanical engineering control plan – object falling dated 23 April 2025.

- **Quarry manager practising certificate – 3-tier approach**

  The NSW Resources Regulator, in consultation with the Mining and Petroleum Competence Board, has adopted a 3-tiered approach to the administration of the quarry manager practising certificate scheme. The previous system of production manager permits was replaced by practising certificates issued for specific quarries, which has been transitioned into the new 3-tier approach. We recognise that many small and medium-sized quarrying operations have lower inherent hazard profiles than larger, more complex quarries. As such, the changes introduced provide a more efficient and less burdensome approach regarding standards and experience requirements for individuals who carry out the quarry manager statutory function.

  NSW quarries under the jurisdiction of the Resources Regulator are divided into 3 categories with the following requirements for exercising the quarry manager statutory function:

  - Tier-1: quarry manager practising certificate attained on basis of holding certificate of competence.
  - Tier-2: quarry manager practising certificate.
  - Tier-3: competent person (no practising certificate required).

  We will determine which category a quarry falls into by assessing the hazards at the site using the risk profiling tool.

  Refer to Fact sheet – Quarry manager practicing certificate – 3-tier approach dated 2 May 2025.

- **Guidance on enforceable undertaking applications – industry and community strategies**

  This purpose of this fact sheet is to provide guidance to proponents of enforceable undertakings under the Mining Act 1992 or WHS undertakings under the Work Health and Safety Act 2011 (collectively referred to hereafter as 'enforceable undertakings' unless specifically referring to WHS undertakings). It is a requirement that enforceable undertaking proposals include:

  - projects, initiatives or strategies (collectively referred hereafter as 'projects') that deliver benefits to workers, industry and the community
  - details of the projects
  - timeframes for implementation of the projects
  - estimated costs of the projects

  Proponents of enforceable undertakings may choose to involve third parties to assist in the delivery of projects. The Resources Regulator recognises that third parties may specialise in research and delivery of projects to enhance work health and safety (WHS) or the environment across the mining industry and the community.

  Refer to Fact sheet – Guidance on enforceable undertaking applications – industry and community strategies dated 20 May 2025.

- **Control plan – explosives control plan – unintended detonation of explosives**

  The bowtie for the explosives control plan identified one MUE and the critical controls for assessment programs. This fact sheet provides information about the assessment program focusing on the MUE – unintended detonation of explosives. The Regulator's assessment program focuses on the following critical controls to prevent serious injury or death caused by unintended detonation of explosives:

  - Blast design (including blast-product sequencing) considers conditions and design
  - Initiation equipment fit for application
  - Restricted access (including bench activities, storage and during transport)
  - Explosives transport/handling (including a mobile processing unit) equipment designed for products and conditions
  - Traffic management around loaded shots, magazines, reload facilities, shared haul roads
  - Heat sources separated from explosives and precursors
  - Lightning protection/earthing on manufacturing plant and magazines
  - Equipment has operator protection (excavation for unintended initiation of misfires)
  - On-site emergency response

  Refer to Fact sheet – Control plan – explosives control plan – unintended detonation of explosives dated 21 May 2025.

- **Control plan – mechanical engineering control plan – unintended interaction with rotating or moving equipment**

  The bowtie for the mechanical engineering control plan (MECP) identified 6 MUEs and the critical controls for assessment programs. This fact sheet provides information about the assessment program focussing on the MUE – unintended interaction with rotating or moving equipment. The Regulator's assessment program will focus on the following critical controls to prevent serious injury or death caused by unintended interaction with rotating or moving equipment:

  - Removable guarding (removed using tooling)
  - Two handed control limiter (reduces pressure and speed when operating with one hand, safe mode)
  - Maintenance of a separation distance from unguarded entanglement hazards (safe standing zone, exclusion zone, no-go zone, drop zone)
  - Equipment is prevented from operation while people are working near hazards (isolation process)
  - Hazardous energy treatment (identified and controlled - hazardous energy treatment blocking or chocking)

  Refer to Fact sheet – Control plan – mechanical engineering control plan – unintended interaction with rotating or moving equipment dated 27 May 2025.

- **Control plan – mechanical engineering control plan – uncontrolled release of energy including spring energy or fluid under pressure**

  The bowtie for the mechanical engineering control plan (MECP) identified 6 MUEs and the critical controls for assessment programs. This fact sheet provides information about the assessment program focussing on the MUE – uncontrolled release of energy including spring energy or fluid under pressure. The Regulator's assessment program focuses on the following critical controls to prevent serious injury or death:

  - Mechanical shielding/separation
  - Equipment can withstand operating pressures/forces introduced (including surge, intensification, tension, loads and relief devices)
  - People removed from high-risk areas
  - Restraining device
  - Retention device
  - Provision of effective isolation, energy dissipation and verification
  - Fit for purpose lateral load shifting system
  - Fit-for-purpose tooling

  Refer to Fact sheet – Control plan – mechanical engineering control plan – uncontrolled release of energy including spring energy or fluid under pressure dated 27 May 2025.

- **Principal hazard – ROVOA – collision of remote controlled equipment**

  The bowtie for the principal hazard topic of roads or other vehicle operating areas (ROVOA) identified 3 MUEs and the critical controls for assessment programs. This fact sheet provides information related to the assessment program focussing on the MUE – collision of (autonomous and manned) equipment in autonomous function. The Regulator's assessment program focuses on the following critical controls to prevent a collision:

  - Separation/segregation (people to vehicles or equipment)
  - Fit-for-purpose remote-controlled systems (visual and audible systems i.e. line of site) to machine
  - Software management
  - Fit-for-purpose remote controlled operating system – tele-remote facility/location
  - Provision of effective isolation, energy dissipation and verification

  Refer to Fact sheet – ROVOA – collision of remote controlled equipment dated 30 May 2025.

- **Principal hazard – ROVOA – collision of equipment in autonomous function**

  The bowtie for the principal hazard topic of roads or other vehicle operating areas (ROVOA) identified 3 MUEs and the critical controls for assessment programs. This fact sheet provides information related to the assessment program focussing on the MUE – collision of (autonomous and manned) equipment in autonomous function. The Regulator's assessment program focuses on the following critical controls to prevent a collision:

  - Mine (vehicle operating areas) design (layout and construction)
  - Separation/segregation (people to the vehicles or equipment)
  - Proximity detection and collision avoidance
  - Fit-for-purpose autonomous systems
  - Provision of effective isolation, energy dissipation and verification.

  Refer to Fact sheet – ROVOA – collision of equipment in autonomous function dated 30 May 2025.

- **Schedule 11 – manifest quantity hazardous chemical notifications**

  All hazardous chemicals (or groups of hazardous chemicals) used, handled or stored at a workplace in excess of the quantities listed in Schedule 11 of the Work Health and Safety Regulation 2017 (WHS Regulation) are notifiable to the Resources Regulator.

  At a mine or petroleum site to which the *Work Health and Safety (Mines and Petroleum Sites) Act 2013* applies, if the Schedule 11 manifest quantities are going to be exceeded, the person conducting a business or undertaking (PCBU) is required to notify the Regulator.

  Refer to Fact sheet – Schedule 11 manifest quantity hazardous chemical notifications dated 11 June 2025.

Reports

- **Investigation Information Release – IIR25-04 Workers injured by suspected gas and rock burst at underground coal mine**

  Four mine workers were operating a continuous miner about 133 metres inbye of 11 cut-through at B heading in the Razorback Mains development panel on 6 April 2025. The heading runs parallel to a known geological structure. Earlier, sections of the heading were developed using a grunching mining method, which is an outburst mining control method that removes persons from the face in identified high-risk areas, by progressively advancing the mining face using shotfiring. At the time of the incident the development of the heading had returned to normal mining methods using a continuous miner under the approved authority to mine. At 2:15 am workers were positioned on the platforms of a 12CM30 continuous miner. They had completed mining the cut-out sequence and were preparing to position mesh and bolt up to the mining face. The roof and ribs in the vicinity of the workers was supported by installed bolts and mesh. An estimated 100 tonnes of sandstone roof material and gas has then abruptly ejected from above the coal seam in the heading roof, hitting and partially burying the continuous miner and 3 of the 4 workers. The fourth worker, on the left side platform of the continuous miner was hit with ejected rock material. First responders attended the area, manually removed the ejected rock material to free the workers and provided first aid. The workers suffered various injuries including cuts, abrasions and injuries to joints. One worker suffered rib, pelvis and vertebrae fractures. All 4 workers were transported by ambulance for hospital treatment.

  Refer to IIR25-04 – Workers injured by suspected gas and rock burst at underground coal mine dated 29 April 2025

- **Investigation Information Release – IIR25-05 Worker struck by conveyance in winder shaft**

  A worker on stage level 4 of the vent shaft 8 winder was struck by a personnel conveyance travelling down the kibble well of the shaft sinking stage about 9.30 pm on 8 May 2025. At the time of the incident, the worker was attempting to provide verbal instructions to a mucker operator at a lower level. To communicate with the mucker operator, the worker extended his head and upper body through a hatch in modified guarding on the stage kibble well. The hatch was not interlocked with the winder control system. The worker suffered minor injuries to the neck and head.

  Refer to IIR25-05 Worker struck by conveyance in winder shaft dated 30 May 2025

- **Investigation Report – Forklift attachment injures worker**

  A worker was injured when a forklift's jib attachment hit him in the mechanical workshop at Cedar Point quarry on 2 March 2024. The jib, and the forklift's tynes and load guard, detached from the forklift which was being used to recover a damaged truck cabin. The worker was standing in front of the forklift at the time of the incident.

  Refer to Investigation Report – Forklift attachment injures worker dated 22 April 2025

- **Investigation Report – Serious injury to a worker conducting maintenance work on a mobile screen**

  At Mt Magometon Quarry, 3 Lynch Contractors workers were conducting general maintenance on company-owned mobile plant at the quarry, which included 2 mobile crushers and 2 mobile screens on 28 August 2023. As part of their maintenance activities, the contract workers commenced cleaning mud and debris from the inside of a Terex Finlay 694+ mobile screen by opening various fixed guards before using an air cleaning gun to blow dirt out of the machine which had built up around the conveyors. Worker one noticed the belt feeder conveyor was tracking to one side and decided to track the belt to recentre it on the idler drum and rollers. Guards previously opened for cleaning the machine were left open during this process. By 3:30 pm, Worker one had been tracking the belt for about 30 minutes but was having problems centring it. He increased the belt speed to track it more quickly. As Worker one continued working at the rear of the machine, Worker 2 stood to the right-rear of the mobile screen, talking with Worker one, but not engaged in any specific task. Worker one walked away to his light vehicle parked about 5 metres to the rear of the mobile screen. At this time, Worker 2 accessed the belt feeder conveyor through the open right-hand side guard door for an unknown reason. His right arm became entangled in the idler drum that was turning at speed. Worker 2's arm was pulled under the rotating drum up to his shoulder by the moving conveyor. Worker one then became aware of Worker 2's entanglement and shut down the mobile screen using the key at the control panel.

  Refer to Investigation report - Serious injury to a worker conducting maintenance work on a mobile screen dated 19 May 2025

- **Investigation report – Serious injury to a jumbo offsider during drilling work**

  A nipper offsider and a jumbo operator were developing an underground drive in the mine at 4670 decline, 301 east heading at 8:55 pm on 19 June, 2023. A jumbo drill rig was being used to conduct drilling, bolting and meshing to install ground support in the heading. One of the offsider's tasks was changing various components on the booms of the jumbo as the ground support work progressed. The offsider normally worked as an Agitator Operator. He had limited experience in the role of a nipper offsider and on the date of the incident, he was working only his third shift as a nipper offsider for the mine operator. Shortly before the incident, the operator exited the jumbo while a lever in the operator's cabin of the jumbo remained engaged, which caused the right-hand boom to continuously rotate. Immobiliser switches (used to stop movement of the booms) were positioned on the front left and right sides of the jumbo. Without engaging the switch, the offsider approached the front of the jumbo to change a component on the right-hand boom, which was angled back towards the left side of the jumbo. The offsider inserted a 3.7 metre drill steel into the coupling of the right-hand boom as the coupling rotated. His left arm became entangled on the rotating drill steel resulting in traumatic amputation to his left arm below the elbow. An emergency response was activated resulting in the offsider being transported to the surface and airlifted to hospital. The offsider remained in hospital for over 5 weeks.

  Refer to Investigation report – Serious injury to a jumbo offsider during drilling work dated 27 May 2025

- **Investigation Report – Worker suffers serious burns while using an angle grinder to cut an intermediate bulk container (IBC)**

  Work was being undertaken to reline a grinding mill in the ore processing plant at the mine on 4 April 2023. A practice had developed at the mine in which the tops of used IBCs were removed to enable them to store and transport waste. A reciprocating saw was usually used to cut the IBCs but an angle grinder was sometimes used. Using an angle grinder created more heat and presented a greater likelihood of sparking than a reciprocating saw. A forklift operator retrieved an IBC from a used IBC storage area and transported it to an open area of the processing plant. The IBC had not been washed. It contained a residual amount of a liquid substance (Fischerchem Collector C503) that was stored inside it. The forklift operator asked the injured worker to take an angle grinder to the location of the IBC so that he could cut the top off it. The forklift operator left the area temporarily and, during this time, the worker made the decision to remove the top of the IBC using an angle grinder. The worker used the angle grinder to cut a strip along the top of the IBC as well as the 2 metal straps at the top of the IBC. He removed one of the straps and left one of the straps attached to the frame at one end. Vapours from inside the IBC reacted violently with heat or sparks produced by the angle grinder. The force and heat of the reaction caused the worker to move a short distance back from the IBC. He felt a burning sensation through his shirt in the region of his chest. He did not see a flame or smoke and did not hear any sounds created by the ignition.

  Refer to Investigation Report – Worker suffers serious burns while using an angle grinder to cut an intermediate bulk container (IBC) dated 30 June 2025

- **Investigation Report – Worker seriously injured while refuelling pressure cleaner**

  A worker suffered burns to his hands, face and body when unleaded petrol came into contact with the hot engine components of a hot water pressure cleaner he was refuelling at the Rix's Creek mine on 22 June 2023. During refuelling, unleaded petrol was released in an uncontrolled manner from a 10-litre plastic fuel container equipped with a plastic spout attachment. The worker was refuelling a pressure cleaner powered by a Honda petrol engine, which was housed within a purpose-built trailer. The worker was positioned inside the trailer, adjacent to the pressure cleaner, and was leaning over the equipment to direct the flow of fuel from the fuel container. After the transfer of fuel had started, the worker opened the breather/airlock of the container, resulting in the uncontrolled release of petrol. The discharged fuel contacted hot engine components, causing ignition and a fire. The worker was exposed to the risk of suffering more serious burns or even death, if he had not quickly exited the trailer, discarded the fuel container and removed his jacket which had caught fire.

  Refer to Investigation Report – Worker seriously injured while refuelling pressure cleaner dated 30 June 2025

- **Consolidated Report – Slope stability – stage 2 - surface METEX mines (July 2023 to December 2024)**

  A planned inspection program at surface METEX mines for the principal hazard management plan – ground or strata failure was conducted between April 2023 and January 2025. The 33 METEX mines assessed consisted of 24 extractive mines (21 construction material mines and 3 industrial mineral mines), 6 metalliferous metal mines (1 surface mine, 1 processing site and 4 surface areas at underground metal mine sites) and 3 mineral sands mines (2 dredging operations and 1 surface mine). The Regulator identified 11 threats and 5 consequences for the stage 2 assessment program. Four critical control criteria for assessment of the material unwanted event (MUE) of unplanned ground or strata failure were also identified. As part of the planned assessment activities, Regulator inspectors attended 33 surface METEX mines with a focus on assessing the identified critical control criteria and control supports. This planned inspection program was part of an ongoing effort by the Regulator to reduce the potential risks associated with human exposure to unplanned ground or strata failure. This report provides information on assessment findings and recommendations for surface METEX mine operators. Of the 33 surface METEX mines assessed, a total of 71 compliance notices were issued to the 33 mine sites assessed. Fifty compliance notices of the 71 notices issued related specifically to the topic of human exposure to unplanned ground or strata failure.

  Refer to Consolidated Report – Slope stability – stage 2 - surface METEX mines (April 2023 to January 2025) dated 14 May 2025

- **Consolidated Report – Air quality, dust or other airborne contaminants – stage 1 surface coal mines (February 2024 to January 2025)**

  A planned inspection program at surface coal mines for the principal hazard management plan – air quality or dust or other airborne contaminants was conducted between February 2024 and January 2025. The Regulator's bowtie identified 4 threats for the stage 1 assessment program, which were low oxygen environments, dust raised into suspension, hazardous chemicals in the atmosphere and carcinogens in the atmosphere. The bowtie identified 3 critical control criteria for assessment of the material unwanted event (MUE) of unplanned exposure to hazardous atmospheres. As part of the planned assessment activities, Regulator inspectors attended 25 surface coal mines and coal handling and preparation plant (CHPP) with a focus on assessing the identified critical control criteria and control supports. This planned inspection program was part of an ongoing effort by the Regulator to reduce the potential risks associated with human exposure to hazardous atmospheres at surface coal mines. This report provides information on assessment findings and recommendations for surface coal mine operators. Of the 25 surface coal mines assessed, 25 compliance notices were issued to 15 of coal mines. 21 compliance notices were issued that related specifically to assessing human exposure to hazardous atmospheres at surface coal mines.

  Refer to Consolidated Report – Air quality, dust or other airborne contaminants – stage 1 surface coal mines (February 2024 to January 2025) dated 17 April 2025

Northern Territory

- **9-inch angle grinder kick-back lacerates worker's face and throat**

  A 71-year-old worker was seriously injured earlier this year, while using a 9-inch angle grinder during renovation work at an industrial shed in Winnellie. The worker was standing on a ladder and cutting steel wall frames above his head when the incident occurred. The worker had been using a 5-inch angle grinder to make the initial cuts but switched to the larger grinder to finish the job quicker. The grinder kicked-back causing a laceration that ran from the worker's face, along this throat and into his chest.

  Refer to NT WorkSafe Safety Alert - 9-inch angle grinder kick-back lacerates worker's face and throat dated 14 May 2025

Queensland

- **Fall or release from height of polish rod clamp blast inspections**

  A worker was almost struck by a lifting device that unexpectedly released during the maintenance operation on a well. Early investigations indicated that during the change-out operation of a polish rod the polish rod clamp used to lift the polish rod out of the well unexpectedly released (slipped off the end of the broken polish rod). Polish rod replacement operations can be affected by a range of hazards and conditions including but not limited to: worn or deteriorated polish rod or rod components that may reduce effectiveness of lifting devices; fatigued polish rod or rod components that may fail under load; stuck polish rod or rod components within the wellbore requiring excessive force to free. There are significant consequences associated with the hazards identified above resulting in: fatality to workers struck by lifting equipment that unexpectedly releases from the polish rod under load, or the unsecured polish rod falling on the worker in the immediate vicinity of the lift; impalement of workers if the polish rod is released and a worker is within the immediate vicinity of the lifting zone; fractures sustained due to being hit by falling polish rod or lifting equipment.

  Refer to RSHQ Petroleum & Gas Inspectorate Alert No.120 V 1 Fall or release from height of polish rod clamp dated 2 May 2025

- **Uncontrolled movement of coal stacker boom**

  A raw coal stacker boom was in the process of lowering into position when it rapidly and unexpectedly luffed-up fully. Although a coal mine worker (CMW) was on board at the time, he was not injured. Initial investigations indicate the hydraulic luffing cylinder (HLC) had detached at the bottom, allowing the mass of the counterweight to drive the boom into the air. The bottom end of the hydraulic cylinder that luffs the boom up or down was attached with two clevises and bolts. When the bolts failed, the clevises and the bottom end of the hydraulic cylinder detached. There was subsequently no down force to counteract the motion of the large counterweight on the opposite end of the boom. The weight moved downwards, rotating the boom end upwards. From preliminary observations, it appears that the western clevis bolts had failed prior to the event. The incident occurred later when the eastern bolts failed. The failed bolts were worn thinner than original. The thread on some nuts was stripped off.

  Refer to RSHQ Coal Inspectorate Alert No.456 V 1 Uncontrolled movement of coal stacker boom dated 12 May 2025

Victoria

- **Operating mobile plant in or near to water bodies**

  A recent incident near a water body resulted in the complete submerging of a 75-ton excavator in a flooded quarry pit. At the time of the incident, the excavator operator was positioning the powered mobile plant on a bench in the flooded extraction area. While entering the water body to position the excavator on the bench, the excavator became submerged. The operator needed to escape and swim away from the excavator. The operator received first aid at the site before he was transported to nearby medical facilities for further treatment.

  Refer to Worksafe Victoria Safety Alert – Operating mobile plant in or near to water bodies dated 17 June 2025

- **Operator ejected from cabin was not wearing seatbelt**

  A quarry employee was operating an articulated dump truck (ADT) on a haul road. The ADT's front right wheel hit a windrow, causing the vehicle's cabin to rock violently. The force of the rocking ejected the operator from the cabin. The ADT continued along the haul road under its own power until it travelled over an edge and overturned. The ADT operator, who was admitted to hospital with serious injuries, was not wearing a seatbelt at the time of the incident.

  Refer to Worksafe Victoria Safety Alert – Operator ejected from cabin was not wearing seatbelt dated 30 April 2025

Notifiable incidents relating to hazards

The Work Health and Safety (Mine and Petroleum Sites) Regulation 2022 (the Regulation) identifies principal mining hazards and principal control plans for special consideration.

Principal mining hazards have a reasonable potential to result in multiple deaths in a single incident or a series of recurring incidents.

Principal control plans cover risks to health and safety from hazards, work processes and plant that may result in incidents that are high potential, frequently occurring or of a certain complexity.

Note that Principal hazards/control plans fields have changed due to system alterations, and they may change again in the future because of ongoing reclassifications.

Summary of incident notifications received

The table below shows the number of incident notifications received for the past 5 quarters as classified against a principal mining hazard or principal control plan.

Overall, there were 539 incident notifications. Of these, 37% (200) related to principal mining hazards, 32% (174) related to principal control plans, with the remainder (31%) related to other incident types.

Table 1. Incident notifications received by principal mining hazard and principal control plan – April 2024 to June 2025

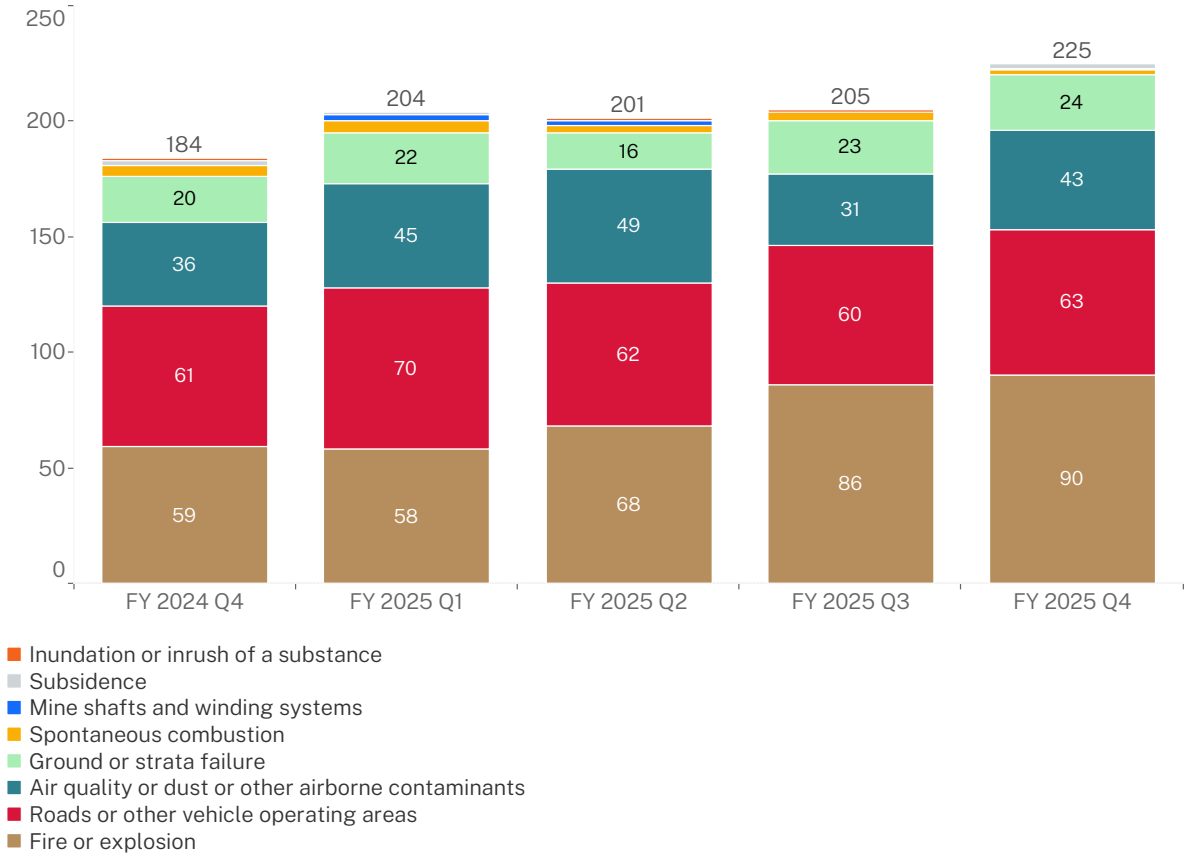
Principl hazard or Control plan	Principal hazard/Control plan	FY 2024 Q4	FY 2025 Q1	FY 2025 Q2	FY 2025 Q3	FY 2025 Q4	Grand total
Hazard	Fire or explosion	59	58	68	86	90	361
	Roads or other vehicle operating areas	61	70	62	60	63	316
	Air quality or dust or other airborne contaminants	36	45	49	31	43	204
	Ground or strata failure	20	22	16	23	24	105
	Spontaneous combustion	5	5	3	4	2	19
	Mine shafts and winding systems	0	3	2	0	1	6
	Subsidence	2	1	0	0	2	5
	Inundation or inrush of a substance	1	0	1	1	0	3
	Total	**184**	**204**	**201**	**205**	**225**	**1019**
Control plan	Mechanical engineering control plan	95	94	68	76	58	391
	Electrical engineering control plan	25	58	76	52	35	246
	Explosives control plan	24	25	17	16	21	103
	Health control plan	9	13	32	22	7	83
	Ventilation control plan	6	3	8	13	11	41
	Total	**159**	**193**	**201**	**179**	**132**	**864**
Other	No related principal mining hazard or principal control plan	173	192	149	158	145	817
Grand total		**516**	**589**	**551**	**542**	**502**	**2700**

Principal mining hazards

Note: while only one hazard/control plan per incident appears in the report, it is possible for more than one hazard or control plan to be applicable to the incident. The classification of incident notifications related to principal hazards is also subject to change once investigations have been finalised.

The chart below presents a further breakdown of numbers of incident notifications received by quarter related to principal mining hazards as defined in section 4 of the Regulation.

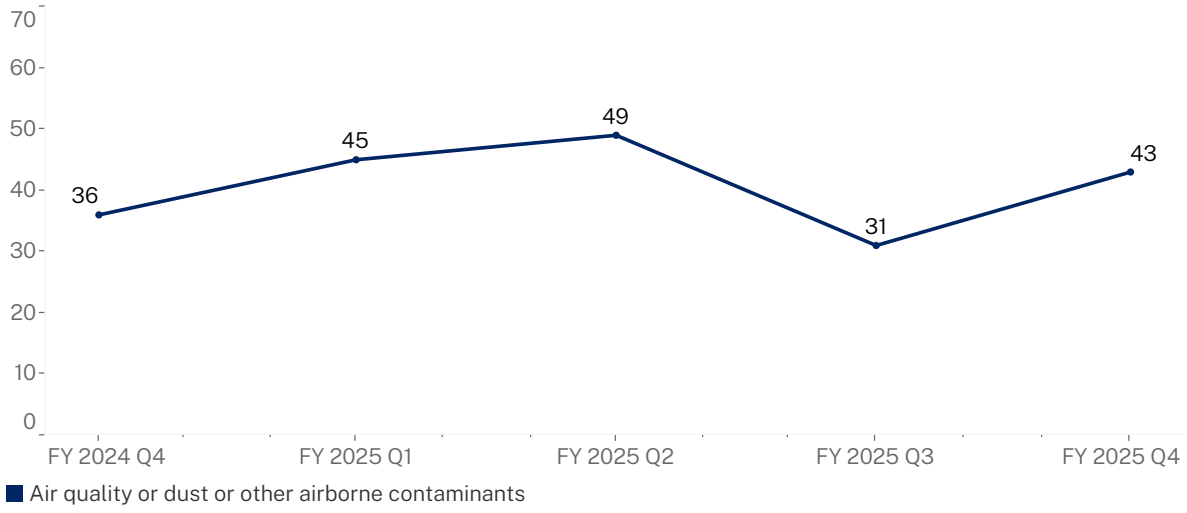
Figure 1. Incident notifications received by principal mining hazards – April 2024 to June 2025



Air quality, dust or other airborne contaminants

Airborne contaminants comprise a large and varied range of substances and forms. Coal and silica particles, along with methane and carbon monoxide, are regularly present in mining as dusts, fumes and vapours. These contaminants have exposure standards and can affect workers rapidly (CO or CO_2) or over several years (coal/silica dust).

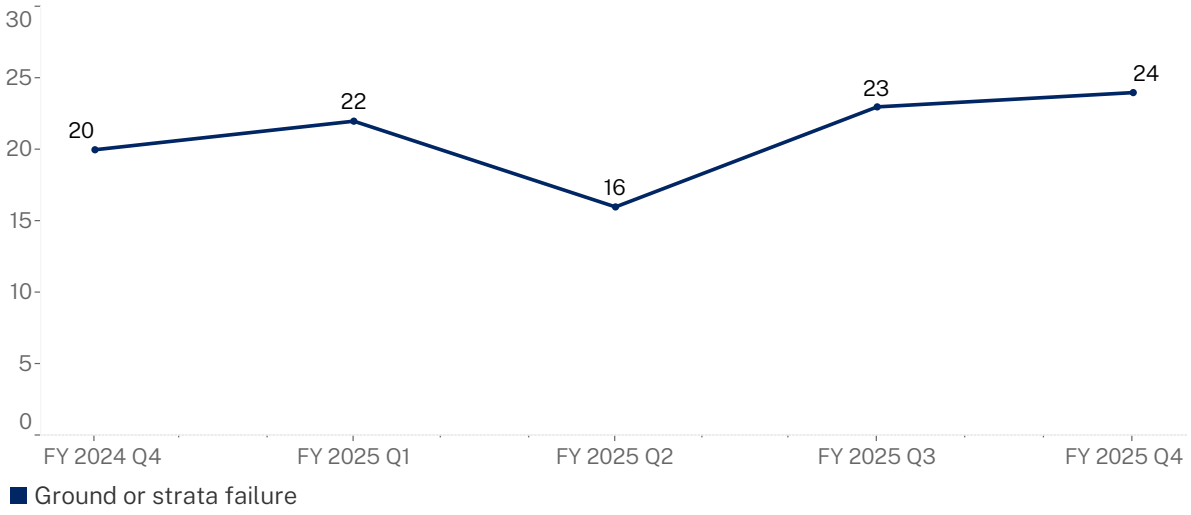
Figure 2. Incident notifications received related to the principal mining hazard air quality, dust or other airborne contaminants – April 2024 to June 2025



Ground or strata failure

Ground or strata failure is an ever-present hazard in both surface and underground mining, with a significant risk posed to workers from unplanned movement of ground.

Figure 3. Incident notifications received related to the principal mining hazard ground or strata failure – April 2024 to June 2025



Dangerous incident | IncNot0048887 – Workers engulfed after energy release

Summary: Four workers were engulfed in pulverised material following an unexpected dynamic energy release from stone in a mine roof. The workers were standing on a continuous miner work platform at the time and were pushed off the platform by a pressure wave. Three of the workers were partially buried and material had to be moved to free them. The workers were all taken to hospital for treatment.

Picture 1.
Pulverised material after incident

Dangerous incident | IncNot0049042 – Large rock fell from 2.5 metres

Summary: Two workers were charging a face when a large rock around 2 to 3 tonnes dislodged from a height of about 2.5 metres, grazing one worker's head, and striking him on the shoulder. The face was scaled prior to work commencing.

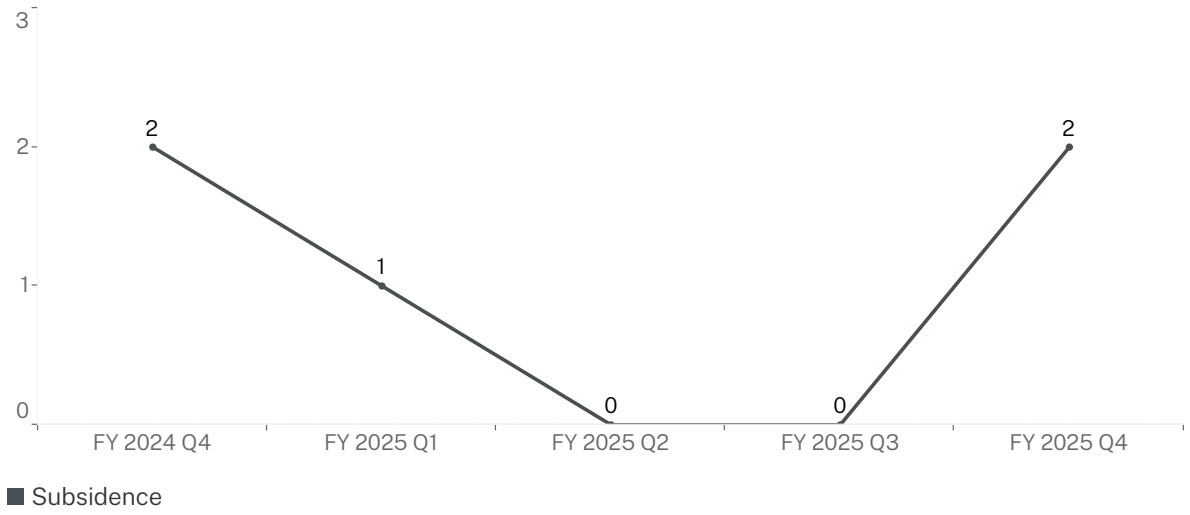
Picture 2.
Fallen rock

Comments to industry: Mine operators must assess the risk associated with ground and strata to identify all foreseeable hazards. Identified hazards must be managed in accordance with the hierarchy of controls. Face inspections should identify intersections of geological structures at risk of forming wedge failures and appropriate controls should be implemented to minimise the risk to workers.

Subsidence

Surface subsidence hazards may exist where there has been underground mining. The potential to cause significant damage (from deformation or sinkholes) to infrastructure (roads, dwellings etc.) and injure persons nearby, makes this a principal mining hazard in NSW.

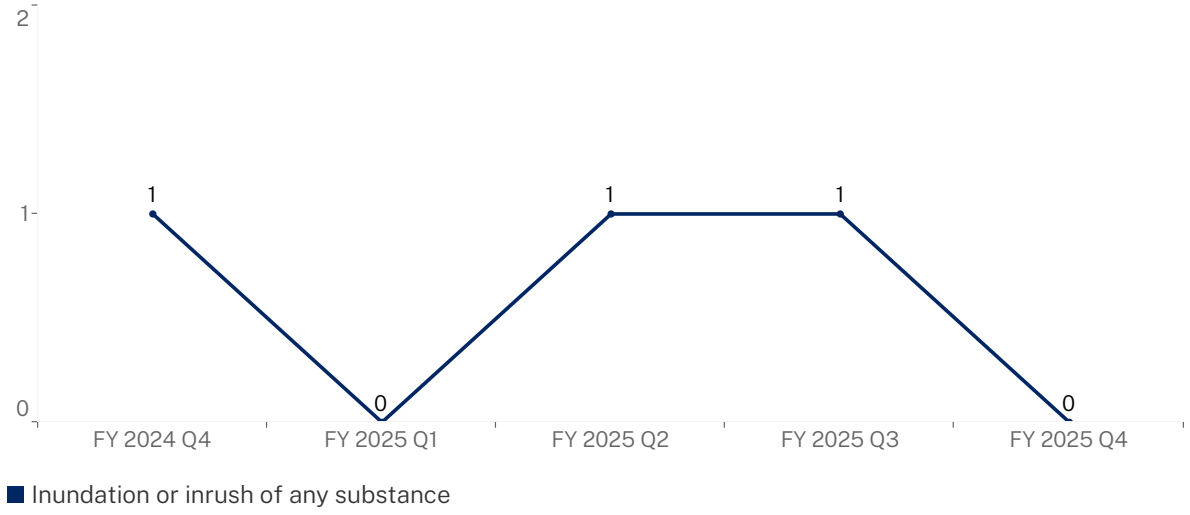
Figure 4. Incident notifications received related to the principal mining hazard subsidence – April 2024 to June 2025



Inundation or inrush of any substance

Inundation or inrush is a low frequency, high consequence hazard, particularly in underground mining. Incidents often involve inrushes of water or inundation by denser materials (sand or rock). The potential to cause multiple fatalities in a single event like at Gretley Colliery in 1996 make this a principal mining hazard in NSW.

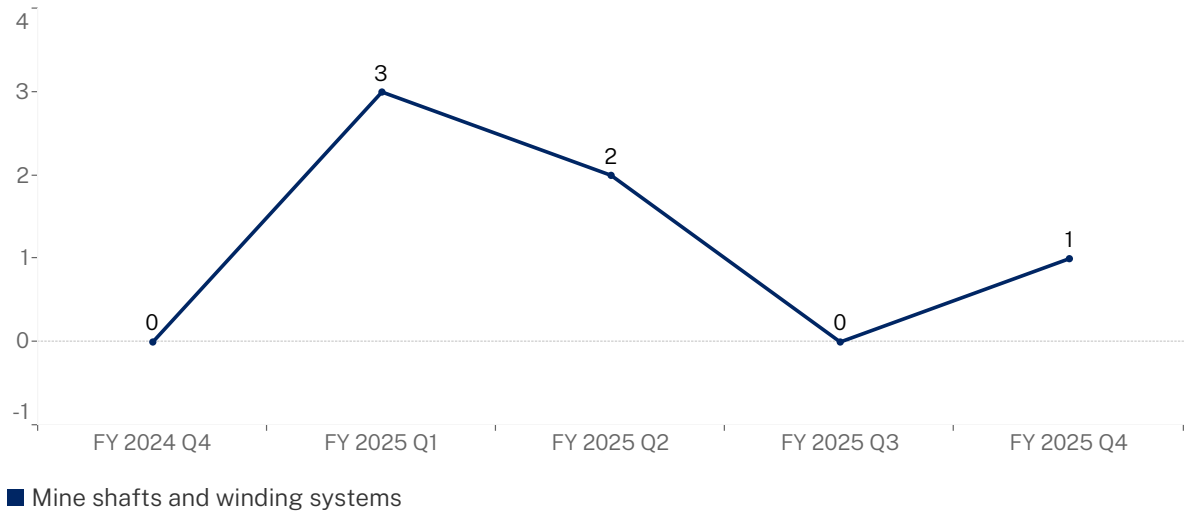
Figure 5. Incident notifications received related to the principal mining hazard inundation or inrush – April 2024 to June 2025



Mine shafts and winding systems

Mine shaft integrity and the operation of winding systems require specific focus. The safe movement of material and workers up and down mine shafts can be hazardous and has the potential to impact on the safety of multiple workers at a mine.

Figure 6. Incident notifications received related to the principal mining hazard mine shafts and winding systems – April 2024 to June 2025



Severe incident | IncNot0049070 – Worker struck by man cage

Summary: A worker was struck on the head by a man cage as it travelled through the work stage in the shaft. The worker placed his head and shoulders through a hatch into the kibble well to communicate with the mucker operator below him. The worker was struck when the man cage was being lowered through the stage, with the chamfered edge of its base colliding with the worker's hard hat. The worker rapidly pulled his head back scraping his neck on the hatch sill causing a small abrasion, and neck soreness.

Picture 3.
The cage involved in incident

Gas outbursts

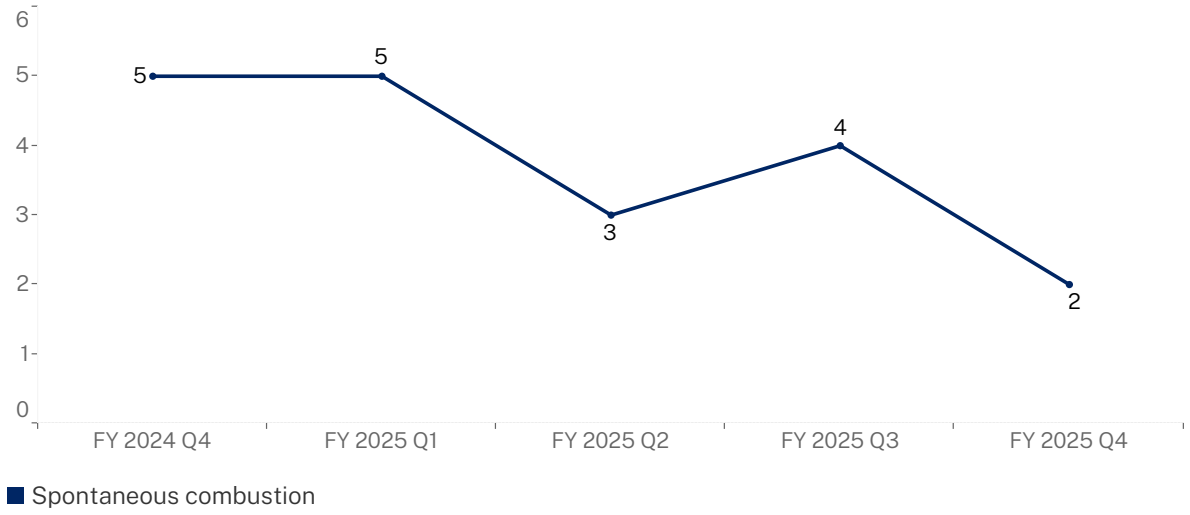
The implementation of appropriate risk controls ensure gas outbursts are not a high frequency hazard event, however their often sudden and violent nature has the potential to cause fatalities to workers. This hazard also includes the liberation of gases that can asphyxiate, lead to explosions or cause a fire. These circumstances make this a principal mining hazard in NSW.

There have been no notified incidents of gas outbursts in the NSW mining sector since November 2022.

Spontaneous combustion

While spontaneous combustion (of coal) is a hazard exclusive to the coal sector, in the underground parts of the mine the consequences have the potential to cause multiple fatalities. The chart below includes spontaneous combustion incidents underground and on the surface of coal mines.

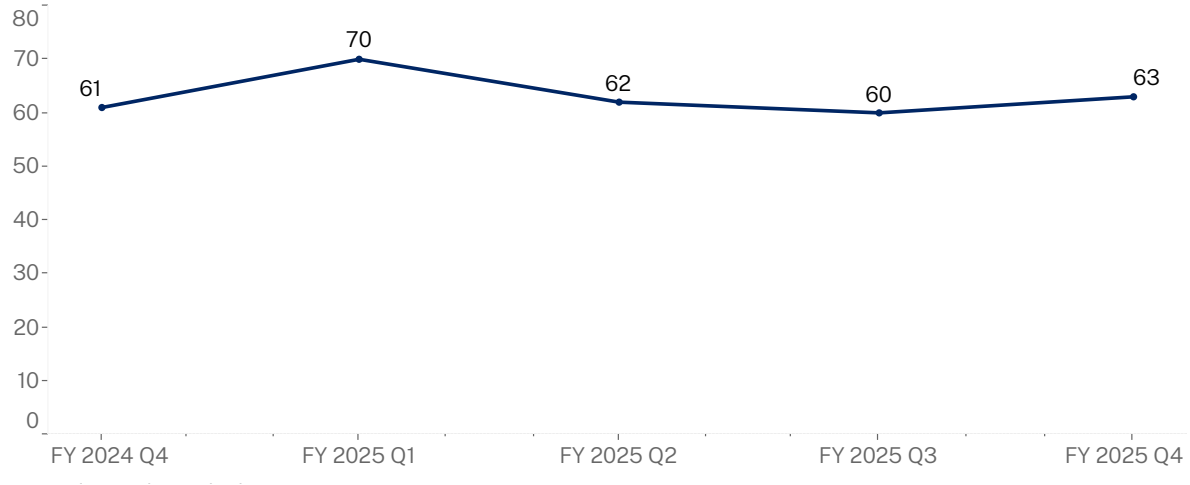
Figure 7. Incident notifications received related to the principal mining hazard spontaneous combustion – April 2024 to June 2025



Roads or other vehicle operating areas

Vehicle movements in and around mine sites require specific design considerations and controls to ensure that collisions and other vehicular accidents do not occur, and place workers lives at risk. The high volume of vehicular interactions on mine sites and the size of the mobile plant utilised classifies this as a principal mining hazard in NSW.

Figure 8. Incident notifications received related to principal mining hazard roads or other vehicle operating areas – April 2024 to June 2025



Dangerous incident | IncNot0048820 – Haul truck rolled backwards after losing power

Summary: A haul truck lost power on a ramp and rolled 30 metres backwards before coming to rest on a bench. The operator had stopped on the ramp with the motor running, waiting for another task to be completed. When the task was completed, the operator put the truck in gear, released the handbrake and took his foot off the footbrake to accelerate. The engine cut out and the truck began rolling backward. The operator pumped the footbrake and pulled the retarder up and down multiple times with no result. He couldn't use the secondary retarder as he was trying to steer the truck. He managed to steer the truck over a water diversion bund and bring it to a halt. The cause of the failure is being investigated.

Picture 4.
Haul truck on bench

Comments to industry: Mine operators must have systems in place to ensure the regular review and effectiveness of fit-for-purpose safety critical components over their lifecycle. This includes driving, braking, steering and emergency systems. Further information may be published later.

Dangerous incident | IncNot0048853 – Dozer rolled after mounting large rock

Summary: A dozer rolled onto its side when travelling over wet material on one track and mounted a large rock with the other track. The operator was able to exit the dozer and was unharmed.

Picture 5.
Dozer on side after incident

Comments to industry: Pre-task inspections of work areas should be undertaken to identify and manage hazards. This includes confirming lighting is adequate for the tasks being conducted. Dozer operators must remain situationally aware while the dozer is in motion and continually assess the work area for hazards.

Refer to safety bulletins:

- SB19-01 Rise in dozer incidents putting operators at risk
- SB19-10 Dozer incidents increase despite warnings

Dangerous incident | IncNot0048854 – Truck sinks after ground gives way

Summary: While dumping a load at a tip head, the ground gave way beneath a Load Haul Dump (LHD) truck, causing the back of the truck to sink up to the axle.

Picture 6.
Sunk truck at tip head

Comments to industry: Changes in conditions, such as wet weather, should trigger an increase in inspection frequency. Design of dumps and catch bunds should consider areas where water can accumulate.

Refer to Safety Bulletin: SB20-01 Failure of highwalls, low walls and dumps

Dangerous incident | IncNot0048912 – Collision causes truck tyre blow out

Summary: A dozer collided with the position 6 tyre of a loaded haul truck on an active dump causing the tyre to blow out. The dozer operator expected the truck operator to dump on the left-hand side of the tip face. The truck operator went to the right-hand side of the tip face following a previous truck dump position. There was no communication between the operators on the correct dump position for the truck. The dozer operator was aware the truck was on the dump.

Picture 7.
Damaged tyre following collision

Comments to industry: The consequences of vehicle operators not establishing positive communications with other vehicle operators can, and has been, fatal. Despite the prevalence of site procedures, operator training and the introduction of driver assistance systems, many operators continue to ignore the importance of following basic procedures. Operators have a responsibility to establish positive communications every time they interact with another vehicle. Other plant operating nearby should be sighted and visual contact should be maintained where possible while manoeuvring at the tip face. Visual aids and segregation should be implemented before relying on procedural controls.

Dangerous incident | IncNot0048918 – Loader bucket hit dump truck body and handrail

Summary: A wheeled loader was loading a rear dump truck with coal when the bucket hit the truck body and a handrail. Coal material tipped from the bucket and broke the cab window. The operator was uninjured. The incident occurred on night shift and there was no lighting plant in operation at the time of the incident.

Picture 8.
Damaged truck handrail and window

Comments to industry: Pre-task inspections of work areas should be undertaken to identify and manage the hazards present. This should include confirming that lighting is adequate for the tasks being conducted in the area. Mine operators should require workers to set up lighting plant before commencing loading activities outside daylight hours.

Dangerous incident | IncNot0049004 – Haul truck lost traction and span 180 degrees

Summary: While travelling on a wet section of road, an empty haul truck lost traction as a mobile manufacturing unit (MMU) was passing on the opposite side. The haul truck slid along the road and crossed the centre line before ending up at 180 degrees from the intended direction of travel. The haul truck missed colliding with the MMU by about 8 - 9 m.

Picture 9.
Spun truck on haul road

Comments to industry: Workers must operate vehicles at a speed that is appropriate to the prevailing conditions. Mine operators should ensure that, after rain events and when operating in wet weather conditions, adequate systems are in place (including statutory inspections) to check road conditions and communicate these conditions to the workforce. When developing control measures to manage the risks of operating vehicles, mine operators must consider mobile plant operating characteristics including stopping distances, manoeuvrability, and speeds for both loaded and unloaded vehicles.

Dangerous incident | IncNot0049152 – Dozer reversed into haul truck

Summary: A dozer was doing a clean-up for an excavator while the excavator was loading a dump truck. A second dump truck entered the area and went into the queue about 30 metres from where the truck was being loaded. The dozer operator reversed to turn and leave the work area and collided with position 6 tyre of the queued truck. The dozer operator had not identified that the second truck had entered the work area.

Picture 10.
Contact between dozer and dump truck

Comments to industry: Situational awareness is a key control when operating mobile equipment. Workers should be trained in the importance of this control and include it in their pre-task risk assessments. Mine operators should continually review the suitability of collision avoidance technology as it evolves, and new products become available. Operators should prioritise segregation between dozers and haul trucks over lower order controls such as positive communication and work procedures.

Refer to: Safety bulletin SB24-01 Bulldozer incident increase

Dangerous incident | IncNot0049141 – Load shifted resulting in truck rollover

Summary: An old shearer body (with no counterweight or ranging arms) was loaded onto a heavy haulage truck using a forklift. The left and right shearer haulage sprockets and trapping shoes were positioned on the gate end/transition pans that have a larger clevis arrangement on the back of the pan set. Once the load was dogged down and cleared for transport, the truck was driven about 300 metres and rolled, while driving at slow speed on flat ground around a left-hand corner. The driver was uninjured. Two gate/transition pans were used instead of run-of-face (ROF) pans for the sprockets to sit on. This shifted the load towards one side, shifting the centre of balance.

Picture 11.
Rolled truck

Comments to industry: Operators must identify the risk of loads shifting due to an imbalance, especially when there is steel-on-steel contact. Mine operators should have a procedure for transporting shearers that specifies the appropriate pans to use for transport purposes. Secure loading should not be the sole responsibility of the transport driver who may not be familiar with the equipment. In this instance, the load was well secured but the centre of balance was off.

Dangerous incident | IncNot0049157 – Haul truck and drill rig collision

Summary: A haul truck was passing a drill rig that was tramming along a haul road when the position 2 tyre and the mast of the drill rig collided. The truck operator saw an indicator light flash on the drill rig and assumed that it was a signal to pass.

Picture 12.
Scene of truck and drill rig collision

Comments to industry: 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 communication compliance during every radio call on their shift. Work Health and Safety Regulation 2017 section 35 and 36 require higher order risk controls to be implemented and administrative controls such as positive communication, only to be used when no higher order controls can be implemented. Controls such as equipment segregation and proximity awareness systems should be implemented before positive communication are considered.

Dangerous incident | IncNot0049200 – Material slumped underneath loaded haul truck

Summary: As a loaded haul truck attempted to move forward out of a loading bay, the ground under the position 5/6 tyre slumped, causing the load to shift in the tray. The truck slid backwards into a hole, resulting in the position one tyre lifting off the ground. The excavator operator quickly used the bucket to secure the truck and prevented it from overturning. Weak, weathered material slumped underneath position 5/6 tyre and, in combination with the uneven floor at the rear of the loading bay, resulted in position 5/6 slumping back into a hole and shifting the load of the truck, unbalancing it and lifting position one tyre.

Picture 13.
Stricken truck with lifted tyre

Comments to industry: Mine operators should identify all work activities on mine sites where trucks are used. Consideration should be given to the following risk controls to ensure ground stability and suitability for vehicle operations and to prevent a truck rollover.

- Loading areas should be level without cross grades.
- The ground should be stable and capable of withstanding the truck wheel pressures and not prone to subsidence.
- Work areas should have suitable inspection regimes in place.
- Changes in conditions, such as wet weather, should trigger a change in inspection frequency.

Dangerous incident | IncNot0049222 – Load haul dump collided with Brain tank trailer

Summary: A stationary load haul dump machine (LHD), with a Brain tank trailer attached, was hit by a travelling LHD that caused the stationary LHD to be pushed backwards. A worker was hit on the shoulder by the Brain tank as the stationary LHD was pushed back.

Picture 14.
Scene of incident

Comments to industry: When operating an LHD, the implement should be positioned to maximise the operator's vision. Plant parked in roadways should be visually delineated to minimise the risk of collision with other plant.

Dangerous incident | IncNot0049290 – Personnel transporter collided with roof support

Summary: A personnel transporter (SMV) was exiting a mine portal when it collided with a roof support that was stored near the portal. When exiting the portal, the SMV operator saw a second SMV stopped on the roadway near a washdown pad. The operator believed there was adequate room to pass the stationary SMV but collided with the roof support in the process. The SMV operator failed to see the stored roof support.

Picture 15.
Transporter at scene of incident

Comments to industry: Principal hazard management plans for roads or other vehicle operating areas should consider factors that may affect an operator's ability to safely navigate a vehicle. Roof supports should have a designated storage location. They should not be stored on a travel road. Further, a standard form of delineation must be in place around stored roof supports on the surface.

Dangerous incident | IncNot0049308 – Excavator became bogged before sliding

Summary: An excavator operating in a weathered zone became bogged and the machine slid about 3 metres. The operator was working on saturated overburden when the machine bogged. The operator slewed the excavator, and the counterweight went over the downward slope causing the track to sink further.

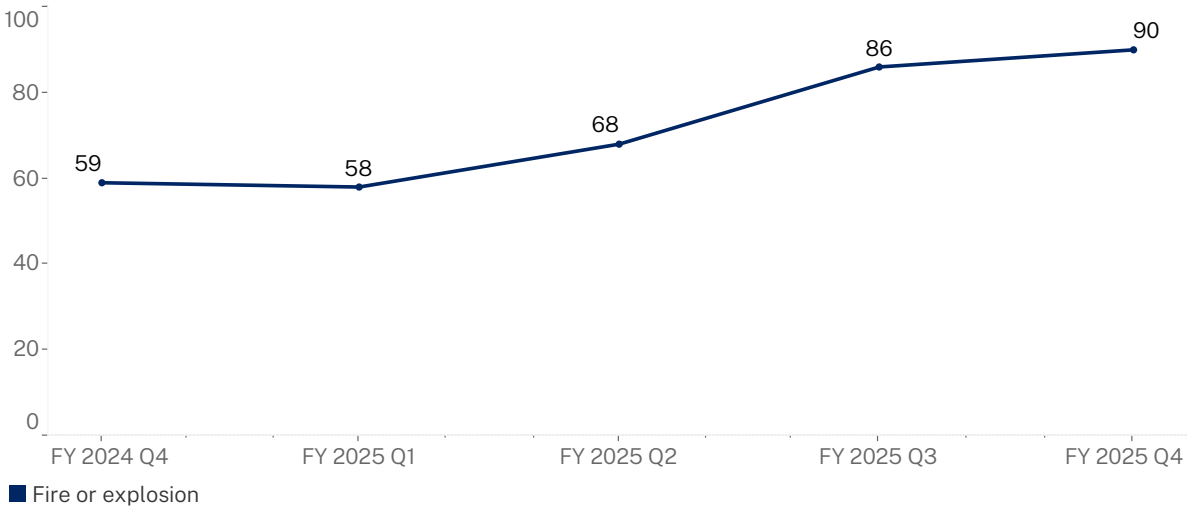
Picture 16.
Bogged truck

Comments to industry: Ground stability should be a primary consideration when working on overburden. Material consistency, wet conditions and dipping ground should be considered. Inspections should verify ground integrity and areas that do not meet the standard should be demarcated, communicated and remediated to meet the standard. When operating machinery, workers' primary focus must remain on the operation and control of the plant or vehicle. Mine operators should review the triggers for competency assessment and the minimum level of competence required before workers are authorised for solo operations.

Fire or explosion

This principal mining hazard includes risk associated with all sources of flammable, combustible and explosive substances and materials in the working environment. A common source of these incidents are fires on mobile plant. This principal mining hazard is distinct from the hazards covered in the explosives control plan.

Figure 9. Incident notifications received related to principal mining hazard fire or explosion – April 2024 to June 2025



Dangerous incident | IncNot0048960 – Sparks, embers and smoke from LHD exhaust

Summary: A dry scrubber load haul dump machine (LHD) was tramming underground in a coal mine when the operator noticed sparks, embers and thick smoke coming from the exhaust. The LHD was shut down. The incident was notified as a failure of explosion-protected characteristics on explosion-protected plant, and the scene was not held. While an investigation is underway, the cause seems to be either the ignition of the glycol coolant that may have leaked into the exhaust, or the combustion of the exhaust particulate filter from excessive exhaust back pressure. The photograph below shows a burnt exhaust filter. The original equipment manufacturer (OEM) had communicated design improvements, but these had not been made to this LHD at the time of the incident.

Picture 17.
Damaged exhaust after incident

Comments to industry: Mine operators are reminded of statutory reporting requirements and the need to preserve incident sites in line with legislation. Explosion-protected diesel engines must be used in accordance with their registration requirements and conditions. There are safety risks associated with using exhaust filters on diesel engines beyond the use/pressures recommended by the OEM. Mine operators should consider using non-flammable (non-glycol) coolants where the risk of glycol ignition is present. OEM upgrades should be completed where the upgrades improve safety.

Dangerous incident | IncNot0049044 – Rubbing conveyor belt generated significant heat

Summary: While undertaking a conveyor and thermography inspection, a deputy noticed haze and smoke coming from the ground. There was a glow from the ground and the thermography camera measured 264 degrees at that point. It was discovered that the return conveyor belting was rubbing on the return structure frame. The conveyor was shut down and the area was doused with water.

Picture 18.
Heat location underneath conveyor belt

Comments to industry: This incident illustrates the importance of conveyor inspections following work where changes have been made to the conveyor. Mine operators must plan to monitor and inspect conveyors after events such as bulk roller change out or conveyor belt replacement.

Dangerous incident | IncNot0049082 – Grinder sparks ignited brake-cleaning fluid

Summary: A boilermaker was using a grinder while working on the chassis rails of a dump truck. The sparks from the grinder ignited a trolley-mounted tray containing brake-cleaning fluid that was beneath the truck. One worker moved the trolley clear of the truck and 2 workers attempted to smother the fire with cloths. Unfortunately, this only added fuel to the fire. The trolley was wheeled outside the workshop and tipped over, allowing the burning liquid to spread across the ground. Another worker used a dry chemical powder extinguisher to put out the fire. Nobody was injured during the incident, although workers were exposed to smoke, extinguishing medium and the fire.

Picture 19.
Trolley mounted tray on fire

Comments to industry: Workers are reminded that they have duty under the Work Health and Safety Act to comply with all reasonable instructions, policies and procedures that mines have in place. Mine operators must have processes in place to ensure that the controls identified within site procedures and permits are implemented. Workers must be trained regularly about how to respond in an emergency such as a fire. Workers should be aware of the location of emergency equipment and mine operators should conduct regular emergency management training. Work procedures should not allow for flammable liquids to be in the vicinity of hot work.

Dangerous incident | IncNot0049193 – Loader ran over boosters

Summary: A loader inadvertently ran over and damaged 2 boosters that were on the ground while exiting a shot pattern.

Picture 20.
Damaged boosters

Comments to industry: The traffic management plan for the shot floor should clearly identify travel routes so that trucks do not inadvertently drive along the incorrect path. Drivers should know the travel routes before entering the shot floor. To aid the drivers, demarcation of usable tracks should be clearly identified by using visible cues such as cones or signs. Mine operators should ensure effective supervision and auditing of compliance with documented traffic management plans. Mine operators should also have a spotting process that includes using hand-held two-way radios to maintain effective communication with all people on the bench. Mine operators should establish spotting protocols to ensure only spotting activities are being performed during the task, and a process that ensures that non-explosives loading activities are managed to ensure explosives will not be in the vicinity during these tasks.

Principal control plans

The Work Health and Safety (Mines and Petroleum Sites) Regulation 2022 specifies principal control plans for managing certain risks associated with hazards at mine and petroleum sites.

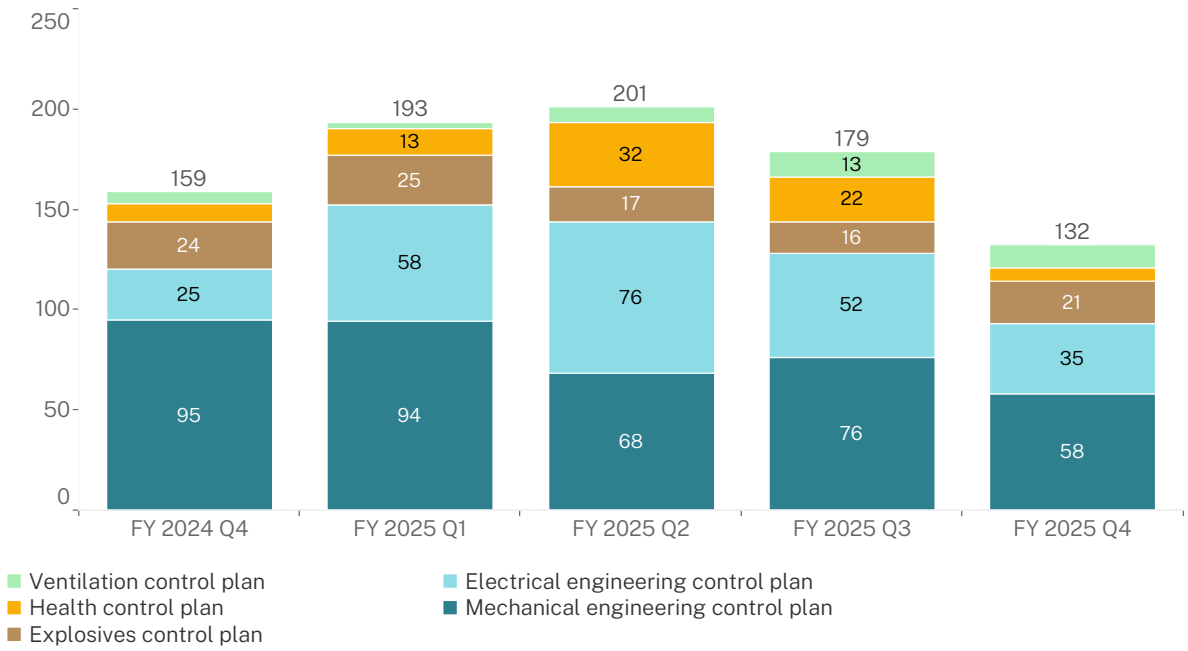
There are 5 principal control plans specified in the Regulation.

Note – while the legislation references 5 principal control plans – Health control plan, Mechanical Engineering control plan, Electrical Engineering control plan, Explosives control plan and Well Integrity control plan, there is also the Ventilation control plan and Emergency Management control plan (although no incidents yet relating to emergency management control plan).

From FY 25 Q1, the classification 'Electrical and/or mechanical engineering control plan' was discontinued and existing data was mapped to 'Mechanical engineering control plan'. The number of electrical engineering control plan and mechanical engineering control plan incident notifications across each of the quarters may be influenced by these changes.

The figure below presents a further breakdown of numbers of incident notifications received related to principal control plans as defined in section 19 and Schedule 2 of the Regulation.

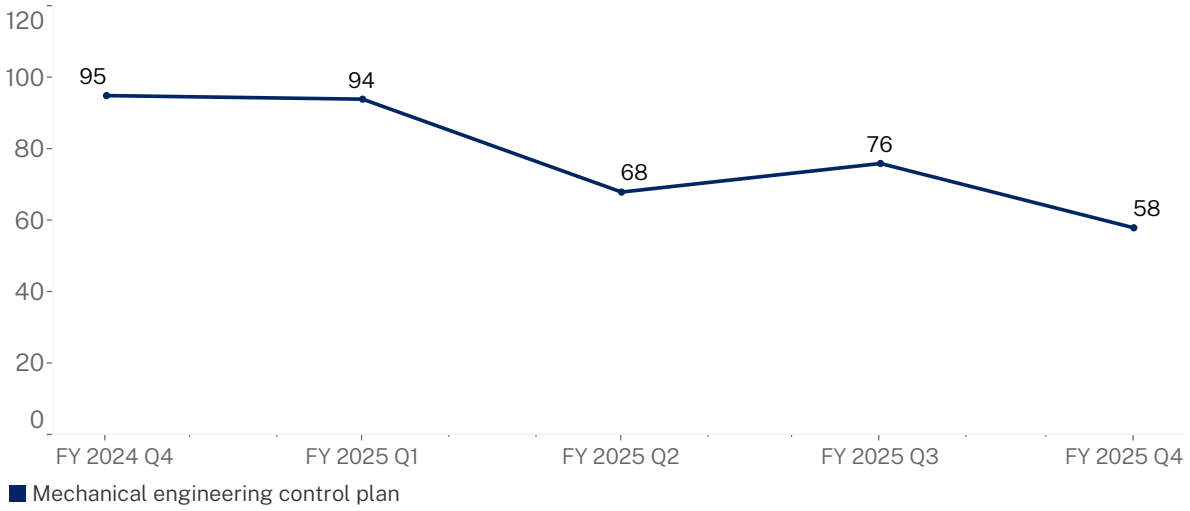
Figure 10. Incident notifications received by principal control plans – April 2024 to June 2025



Mechanical engineering control plans

The mechanical engineering control plan covers ‘lifecycle’ risks associated with mechanical hazards (vehicles, plant and mechanical systems and structures) that workers may be exposed to. This includes risks associated with pressurised fluids.

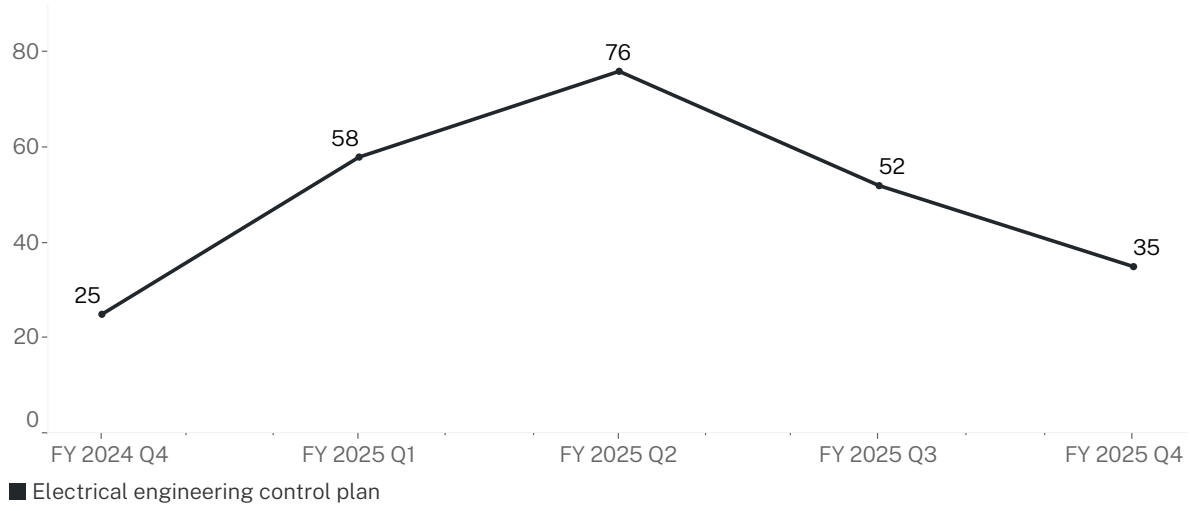
Figure 11. Incident notifications received related to mechanical engineering control plans – April 2024 to June 2025



Electrical engineering control plans

The electrical engineering control plan covers ‘lifecycle’ risks associated with electrical hazards (supply, vehicles, plant or infrastructure) that workers may be exposed to.

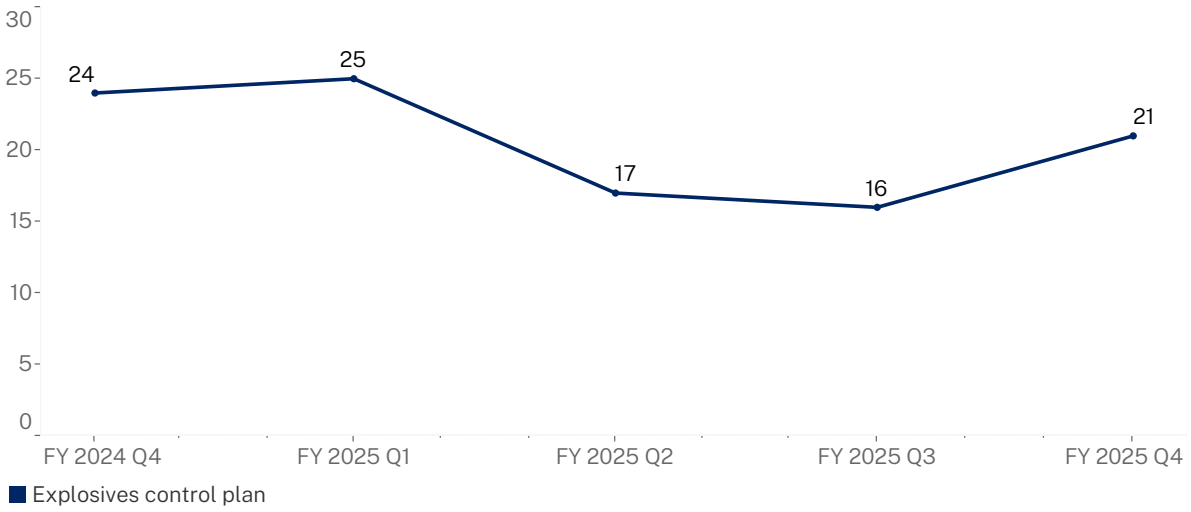
Figure 12. Incident notifications received related to electrical engineering control plans – April 2024 to June 2025



Explosives control plans

The explosives control plan covers risks associated with the use and management of explosives hazards workers may be exposed to. This includes incidents involving ‘flyrock’ and misfire events.

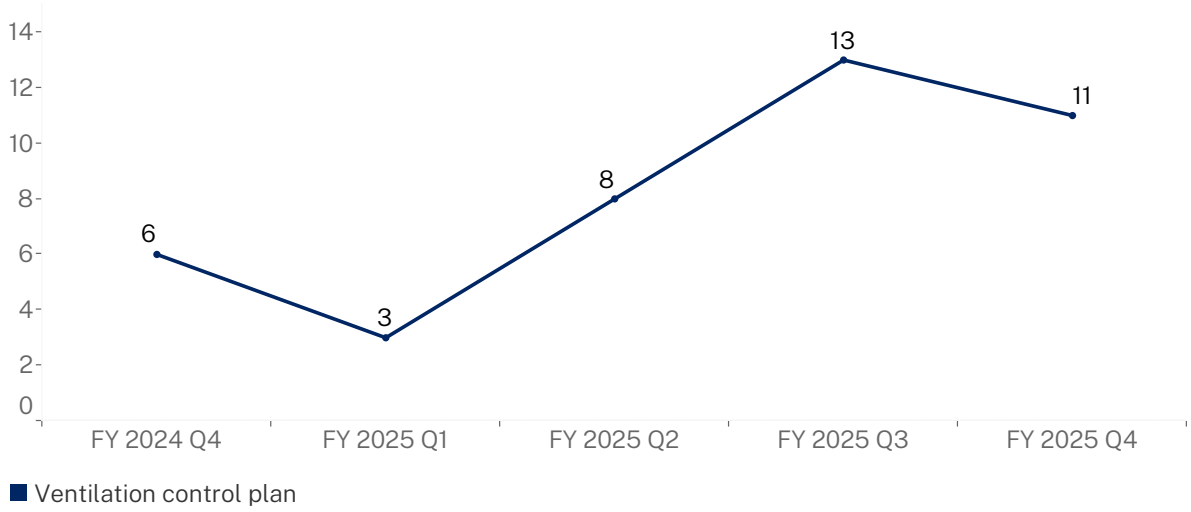
Figure 13. Incident notifications received related to explosives control plans – April 2024 to June 2025



Ventilation control plans

A ventilation control plan covers risks associated with ventilation in underground mines. This includes incidents involving failed atmospheric conditions and where trigger action response plans may have been activated.

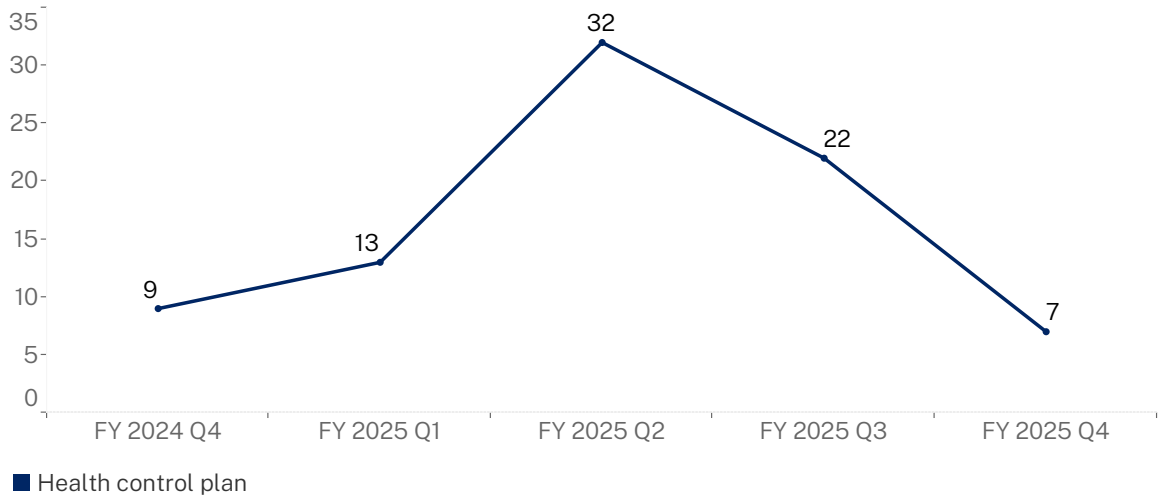
Figure 14. Incident notification received related to ventilation control plans – April 2024 to June 2025



Health control plans

A health control plan (HCP) sets out how the operator will manage the risks to health associated with their mining or petroleum operations. The HCP forms part of the safety management system (SMS). An HCP identifies the hazards which present a risk to health of workers and measures to control them.

Figure 15. Incident notification received related to health control plans – April 2024 to June 2025



Sector profiles

Resources Regulator
Sector reporting

Coal mines

Includes open cut, underground and processing plants, and excludes exploration

Metalliferous mines

Includes metals and mineral sands, and excludes exploration

Extractives mines

Includes construction materials and industrial materials, and excludes exploration

Petroleum and geothermal

Includes onshore petroleum and geothermal, and includes exploration

Opal mines

Includes small scale titles, opal claims, gemstones or precious stones with operation types of opal mining (all types) and processing, and excludes exploration

Other mines

Gemstones or precious stones (excluding operation of all types of opal mining), ancillary to mining and treatment plant, and excludes exploration

Exploration sites

Includes exploration for sectors other than petroleum and geothermal sites

Non-mine locations

Includes manufacturers (including OEMs), suppliers, designers, importers, licence holders and registration holders

Coal mines sector

Incident notifications

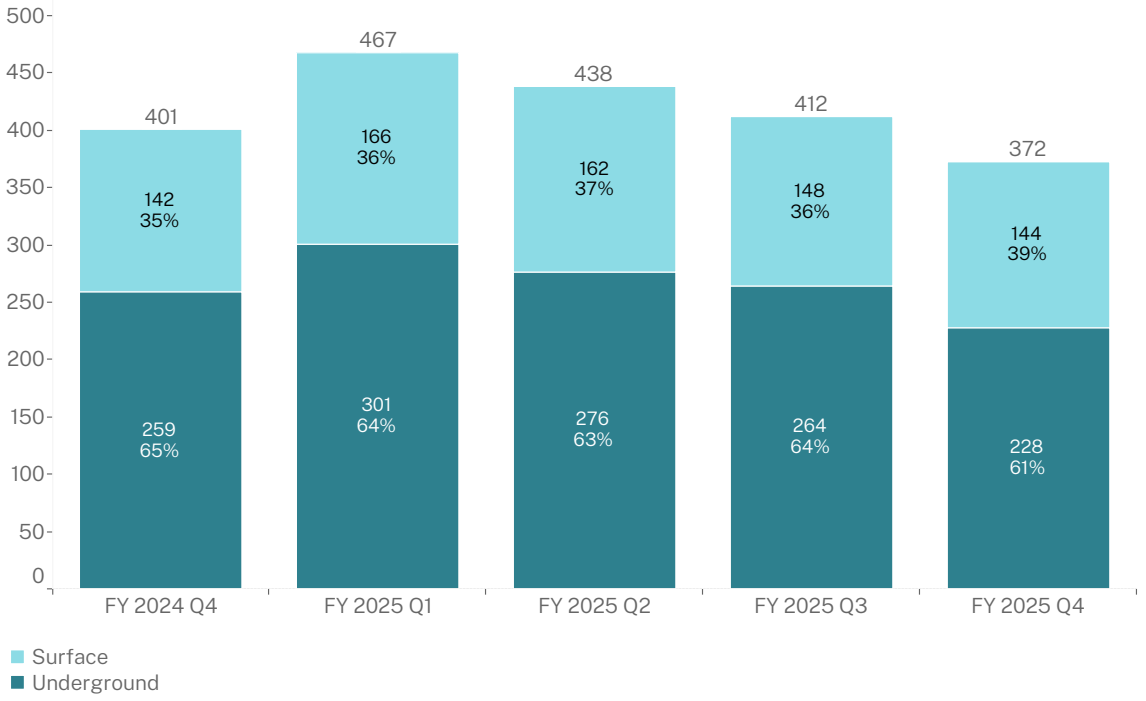
Under work health and safety legislation, mine operators must notify the Regulator about the occurrence of certain types of safety incidents. Incident notification data (by active mine) provides insights into sector-specific reporting trends.

Table 2. Coal mines sector incident notification rates – April 2024 to June 2025

Measure	FY 2024 Q4	FY 2025 Q1	FY 2025 Q2	FY 2025 Q3	FY 2025 Q4
Incidents	401	467	438	412	372
Active mines	102	99	98	98	99
Incident rate per active mine	3.93	4.72	4.47	4.20	3.76
Mines that notified incidents	48	54	51	49	51
% of mines notifying an incident	47%	55%	52%	50%	52%
Incident rate per notifying mine	8.35	8.65	8.59	8.41	7.29

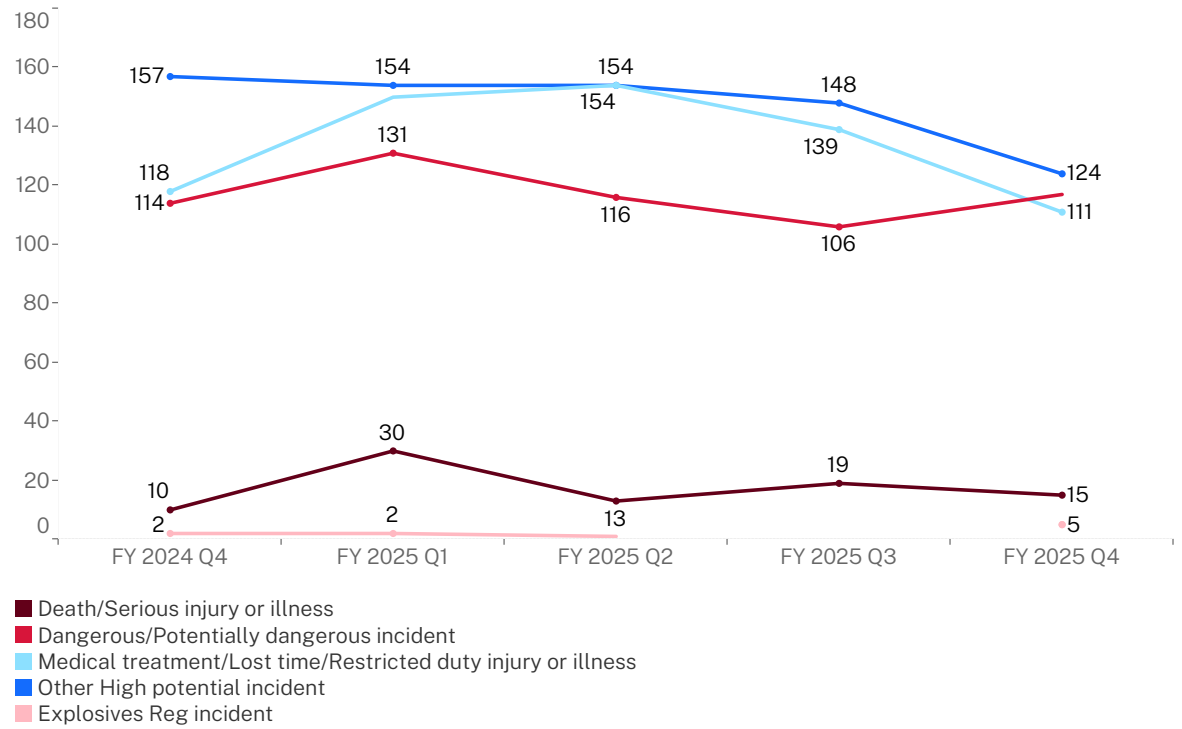
The following graph shows the proportion of safety incident notifications received from surface and underground coal operations.

Figure 16. Coal mines sector incident notifications received by operation type – April 2024 to June 2025



The graph below presents a breakdown of safety incidents notified to the Regulator by the coal mines sector by the requirement to report under safety legislation.

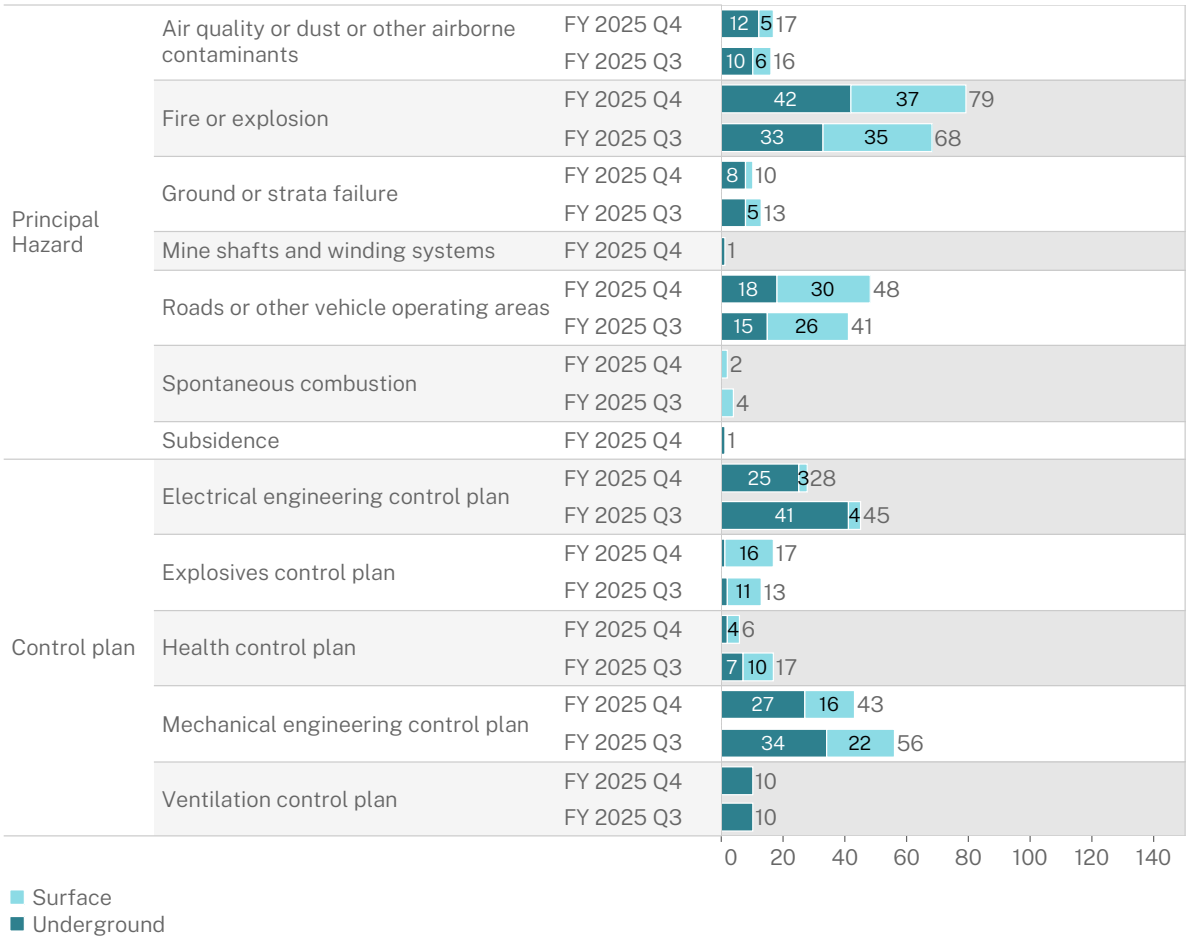
Figure 17. Coal mines sector incident notifications received by requirement to report – April 2024 to June 2025



Incident notifications received by principal mining hazard or principal control plan

The figure below shows the number of incident notifications received from the coal mines sector during the past 2 quarters, as classified against related principal mining hazards and principal control plans. The findings highlight hazards where mine operators need to ensure their risk management controls remain fully effective.

Figure 18. Coal mines incident notifications received by principal mining hazard or principal control plan, and by operation type – January to June 2025



Metalliferous mines sector

Incident notifications received

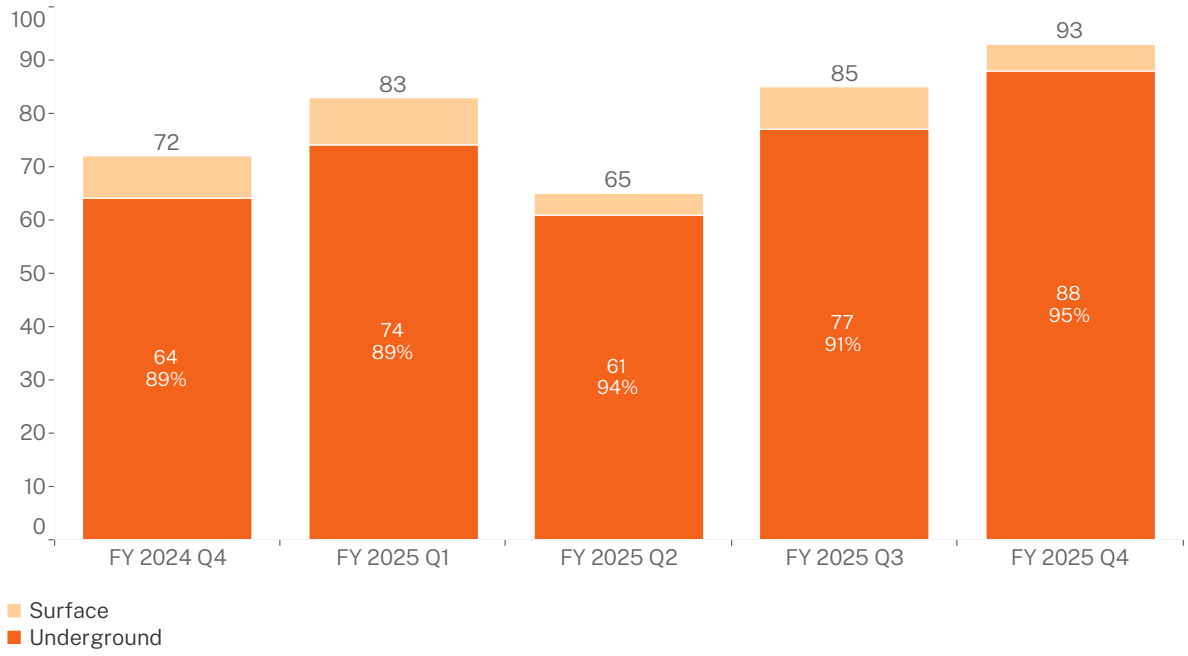
Under work health and safety legislation, mine operators must notify the Regulator about the occurrence of certain types of safety incidents. Incident notification data (by active mine) provides insights into sector specific reporting trends.

Table 3. Metalliferous mines incident notifications received rates – April 2024 to June 2025

Measure	FY 2024 Q4	FY 2025 Q1	FY 2025 Q2	FY 2025 Q3	FY 2025 Q4
Incidents	72	83	65	85	93
Active mines	100	99	97	93	95
Incident rate per active mine	0.72	0.84	0.67	0.91	0.98
Mines that notified incidents	14	17	20	19	19
% of mines notifying an incident	14%	17%	21%	20%	20%
Incident rate per notifying mine	5.14	4.88	3.25	4.47	4.89

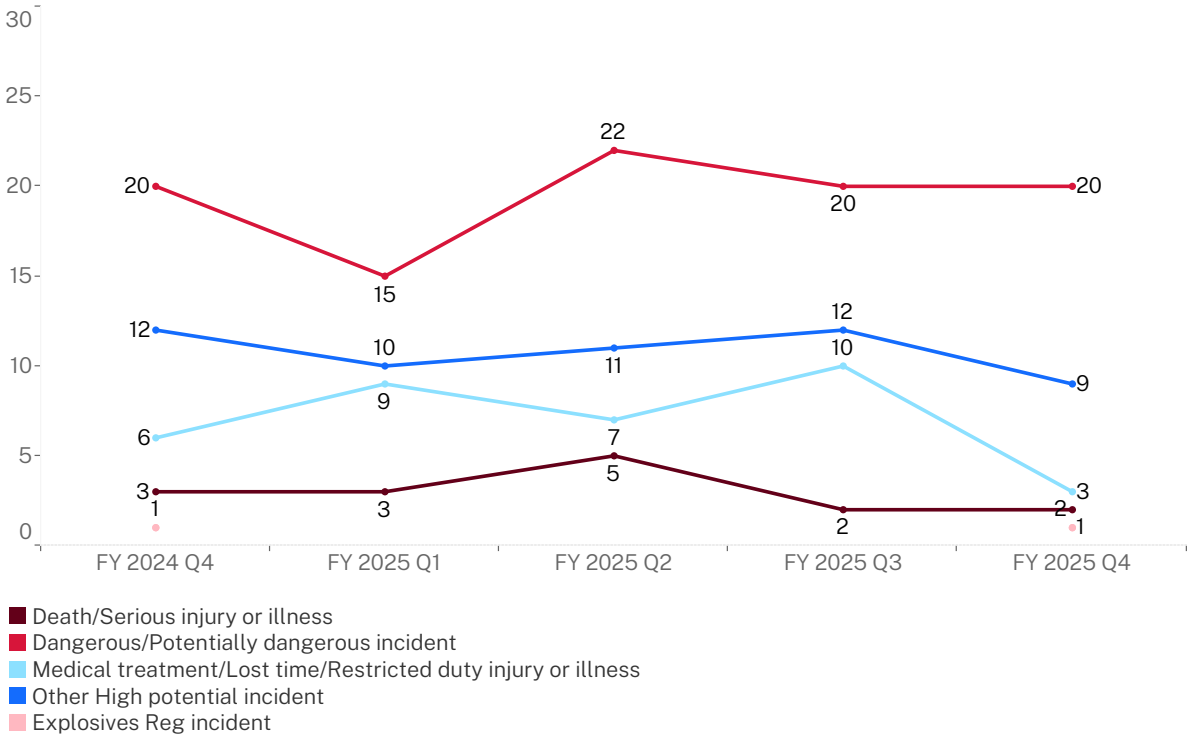
The following graph shows the proportion of safety incident notifications received from metalliferous mines by operation type.

Figure 19. Metalliferous mines incident notifications received by operation type – April 2024 to June 2025



The following graph presents a breakdown of safety incidents notified to the Regulator by the metalliferous mines sector based on the requirement to report under safety legislation.

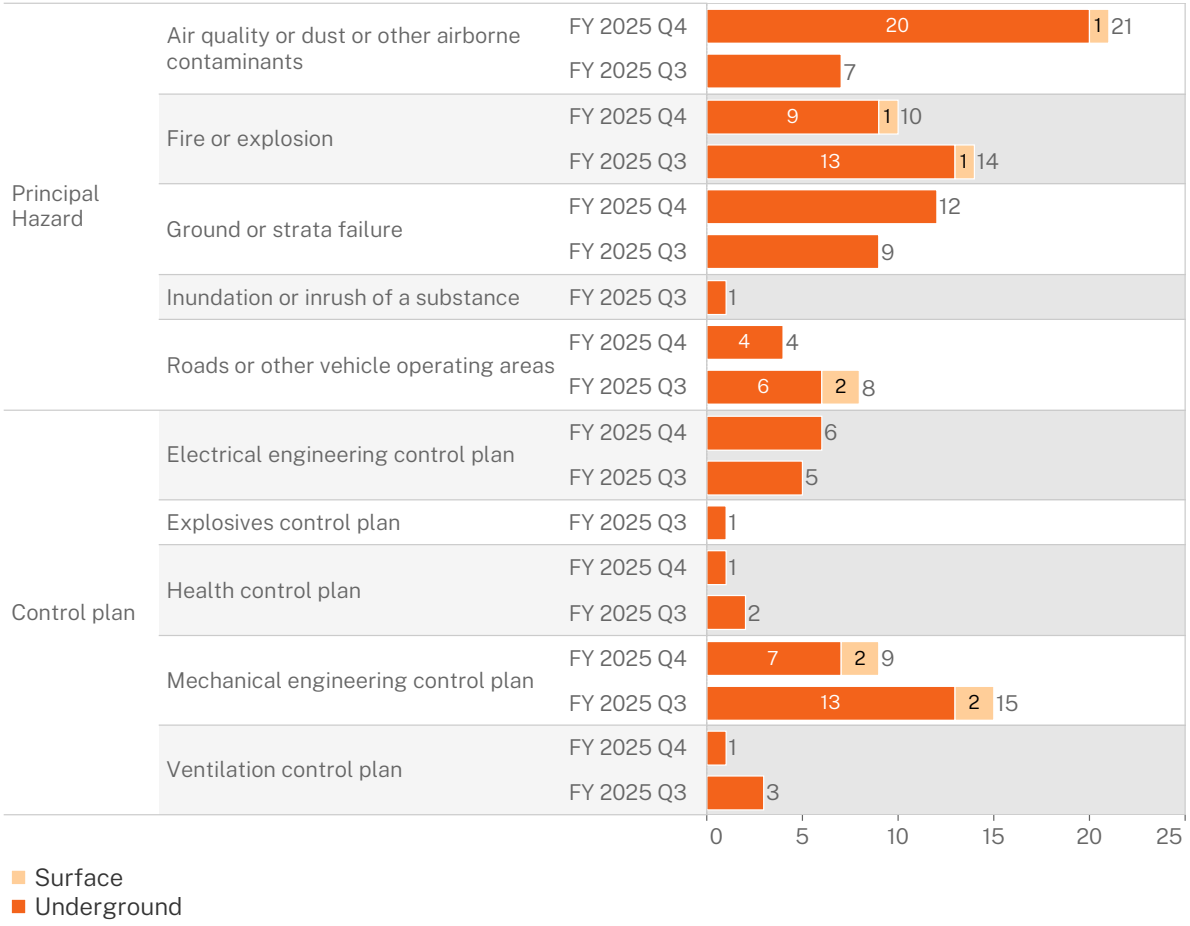
Figure 20. Metalliferous mines incident notifications received by requirement to report – April 2024 to June 2025



Incident notifications received by principal mining hazard or principal control plan

The figure below shows the number of incident notifications received from the metalliferous mines sector during the past 2 quarters as classified against related principal mining hazards and principal control plans. The findings highlight hazards where mine operators need to ensure their risk management controls remain fully effective.

Figure 21. Metalliferous mines incident notifications received by principal mining hazard or principal control plan, and operation type – January to June 2025



Extractives mines sector

Incident notifications received

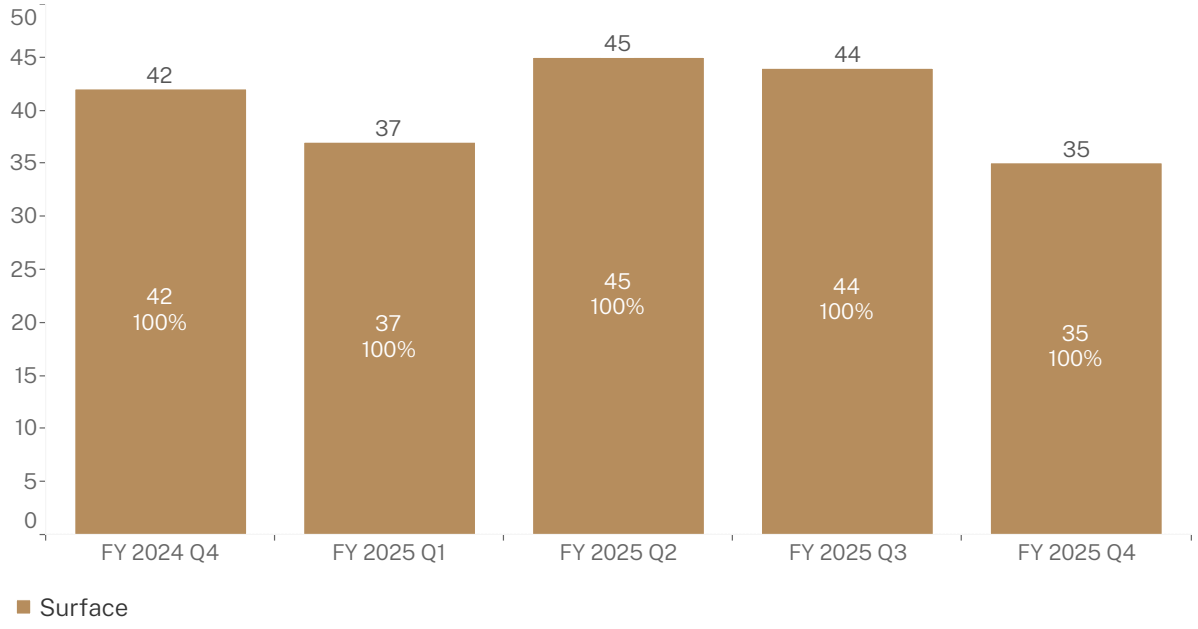
Under work health and safety legislation, mine operators must notify the Regulator about the occurrence of certain types of safety incidents. Incident notification data (by active mine) provides insights into sector specific reporting trends.

Table 4. Extractives mines incident notifications received rates – April 2024 to June 2025

Measure	FY 2024 Q4	FY 2025 Q1	FY 2025 Q2	FY 2025 Q3	FY 2025 Q4
Incidents	42	37	45	44	35
Active mines	2233	2212	2132	2048	2040
Incident rate per active mine	0.02	0.02	0.02	0.02	0.02
Mines that notified incidents	34	30	35	38	27
% of mines notifying an incident	1.52%	1.36%	1.64%	1.86%	1.32%
Incident rate per notifying mine	1.24	1.23	1.29	1.16	1.30

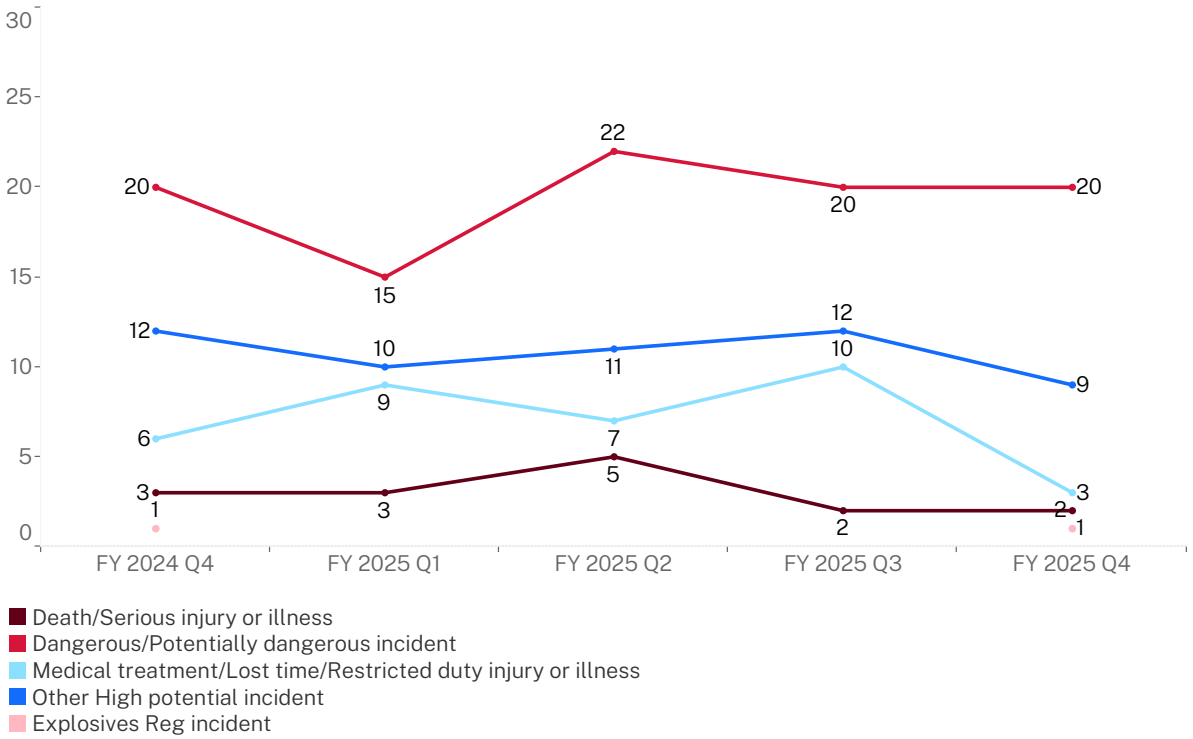
The graph below shows the proportion of safety incident notifications received from extractives mines by operation type.

Figure 22. Extractives mines incident notifications received by operation type – April 2024 to June 2025



The graph below presents a breakdown of safety incidents notified to the Regulator by the extractives mines sector by the requirement to report under safety legislation.

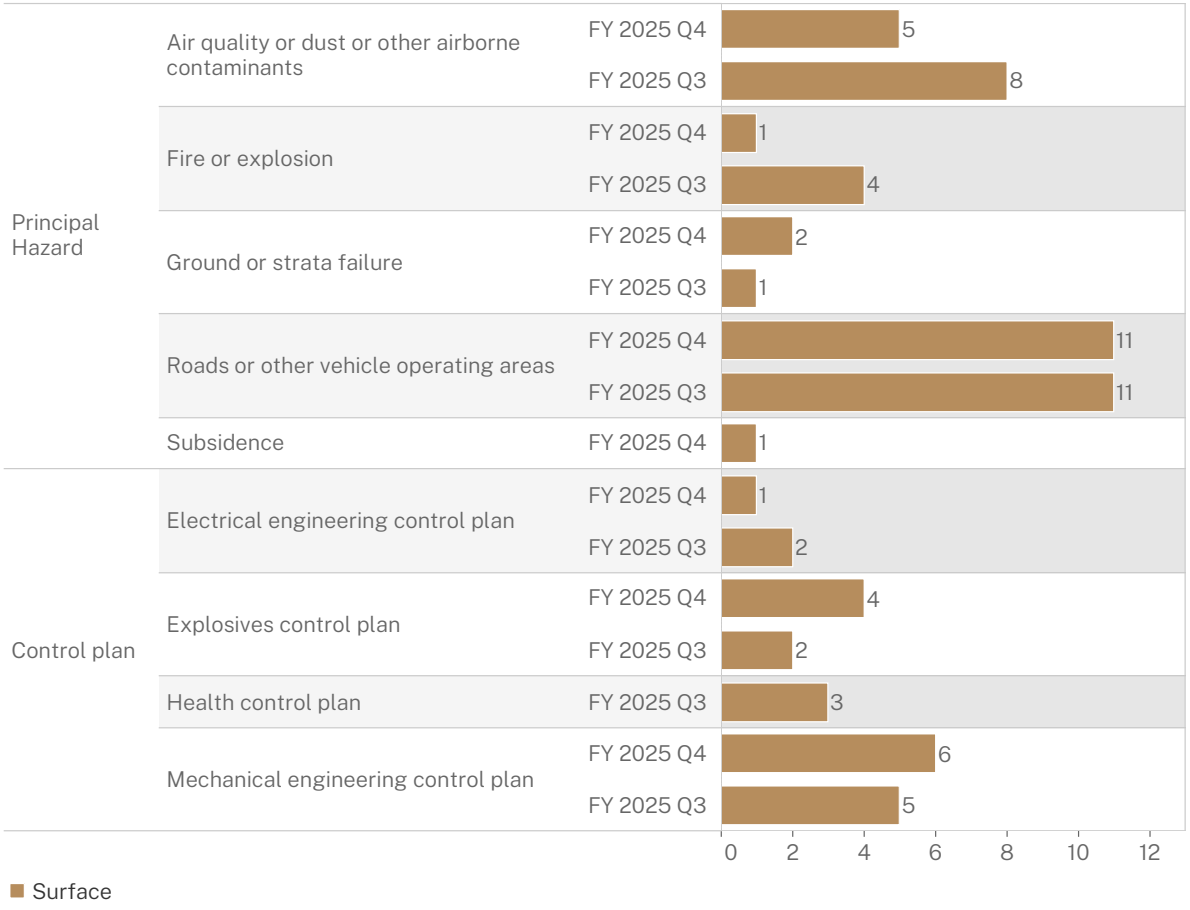
Figure 23. Extractives mines incident notifications received by requirement to report – April 2024 to June 2025



Incident notifications received by principal mining hazard or principal control plan

The figure below shows the number of incident notifications received from the extractives mines sector during the past 2 quarters as classified against related principal mining hazards and principal control plans. The findings highlight hazards where extractives mines operators need to ensure their risk management controls remain fully effective.

Figure 24. Extractives mines incident notifications received by principal mining hazard or principal control plan, and operation type – April 2024 to June 2025



Other sector profiles

Incident notifications received

Under work health and safety legislation, mine operators must notify the Regulator about the occurrence of certain types of safety incidents.

This section relates to petroleum and geothermal sites, opal mines, other mines and exploration sites. The tables below show the number and types of incident notification received by requirement to report under safety legislation and by principal mining hazard.

Table 5. Other sector incident notifications received – April 2024 to June 2025

Sector	Measure	FY 2024 Q4	FY 2025 Q1	FY 2025 Q2	FY 2025 Q3	FY 2025 Q4
Petroleum and geothermal sites	Incidents	0	0	0	0	0
Opal mines	Incidents	0	1	0	0	1
Other mines	Incidents	0	0	0	1	0
Exploration sites	Incidents	1	1	3	0	1

Table 6. Other sector incident notifications received by requirement to report – April 2024 to June 2025

Sector	Requirement to report measure	FY 2024 Q4	FY 2025 Q1	FY 2025 Q2	FY 2025 Q3	FY 2025 Q4
Opal mines	Death/Serious injury or illness	0	1	0	0	0
Other mines	Medical treatment/Lost time/ Restricted duty injury or illness	0	0	0	1	0
Exploration sites	Death/Serious injury or illness	0	0	2	0	0
	Dangerous/Potentially dangerous incident	0	1	1	0	1
	Medical treatment/Lost time/ Restricted duty injury or illness	1	0	0	0	0
	Total	1	1	3	0	1

Table 7. Other sector incident notifications received by principal mining hazard and other hazards – April 2024 to June 2025

Sector	Principal hazard or control plan	FY 2024 Q4	FY 2025 Q1	FY 2025 Q2	FY 2025 Q3	FY 2025 Q4
Opal mines	No related principal mining hazard or principal control plan	0	1	0	0	1
Other mines	No related principal mining hazard or principal control plan	0	0	0	1	0
Exploration sites	Electrical engineering control plan	0	0	1	0	0
	Health control plan	0	0	2	0	0
	Mechanical engineering control plan	0	1	0	0	0
	No related principal mining hazard or principal control plan	1	0	0	0	1
	Total	1	1	3	0	1

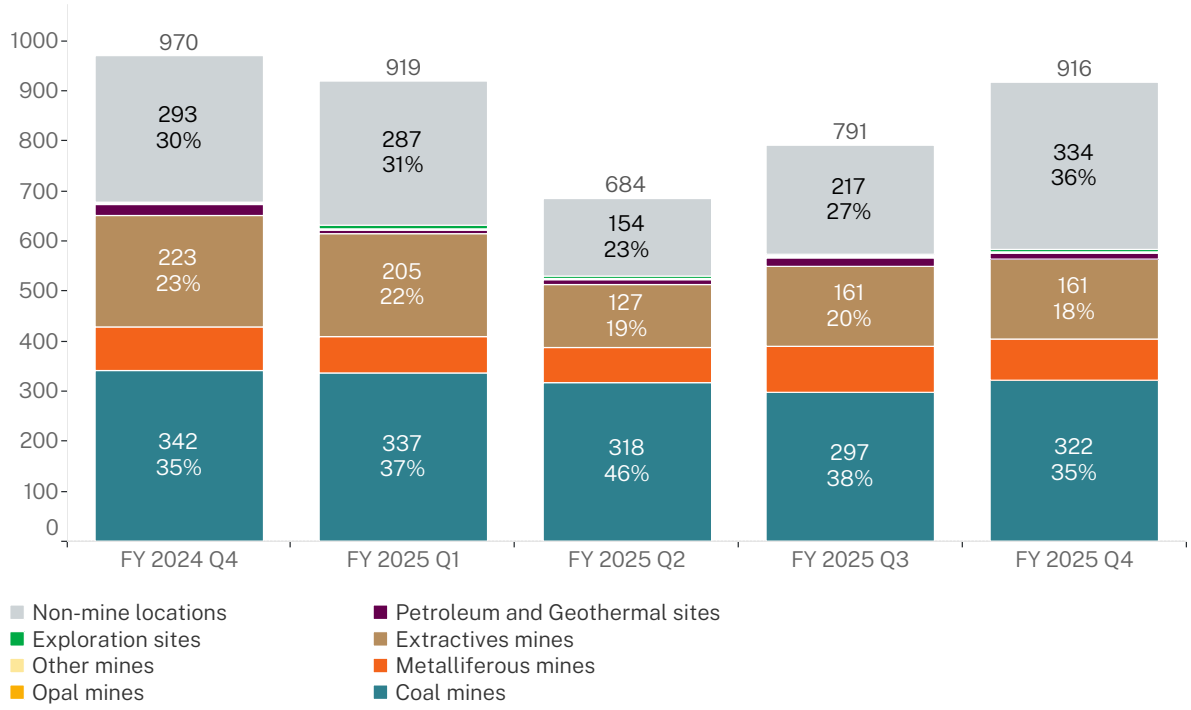
Compliance and enforcement

The Regulator uses a range of tools to promote and secure compliance in mines and petroleum sites in relation to work health and safety legislation. These include desktop assessments, site inspections, investigations and enforcement actions, such as issuing notices and commencing prosecutions.

Detailed information regarding compliance activities, priorities, outcomes and reports are published on our website and in our business activity reports.

Safety assessments by sector

Figure 25. Safety assessments by sector – April 2024 to June 2025

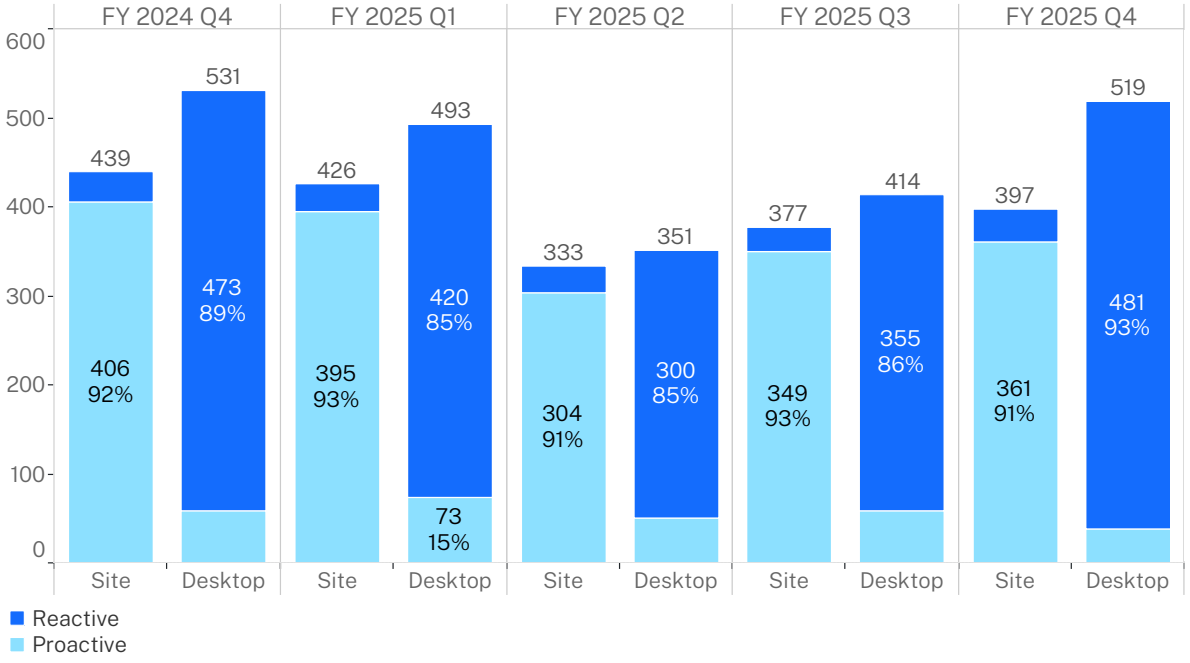


Safety assessments by category and nature

Site-based (visiting mine sites) and desktop activities are both important regulatory tools. While the focus of our on-site compliance activity is on preventing incidents through planned risk-based proactive assessments, our desktop activities are mainly reactive.

Site-based proactive assessments focus on establishing whether critical controls have been effectively implemented. Meanwhile desktop assessment activities include reviews of control measures following an incident, review of personal dust monitoring reports submitted by coal mine operators, assessment of high-risk activity notifications, applications for exemptions from work health and safety laws, subsidence management plans and preparation for site work.

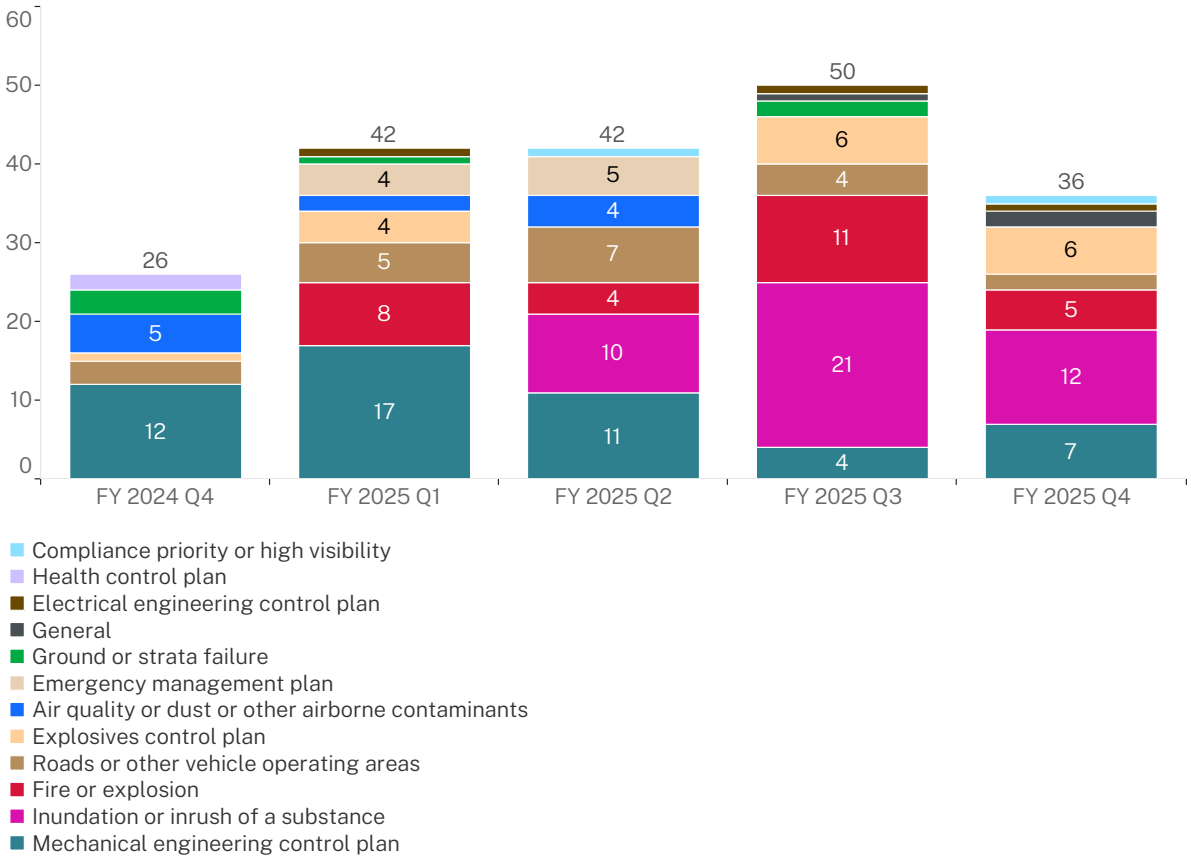
Figure 26. Safety assessments by category and nature – April 2024 to June 2025



Programmed site assessments

Our targeted assessment program establishes a risk-based and proactive approach for assessing the extent to which critical controls for managing principal mining hazards, principal control plans and other programs have been identified, implemented and are being monitored.

Figure 27. Targeted assessments by principal mining hazards, principal control plans and other programs – April 2024 to June 2025

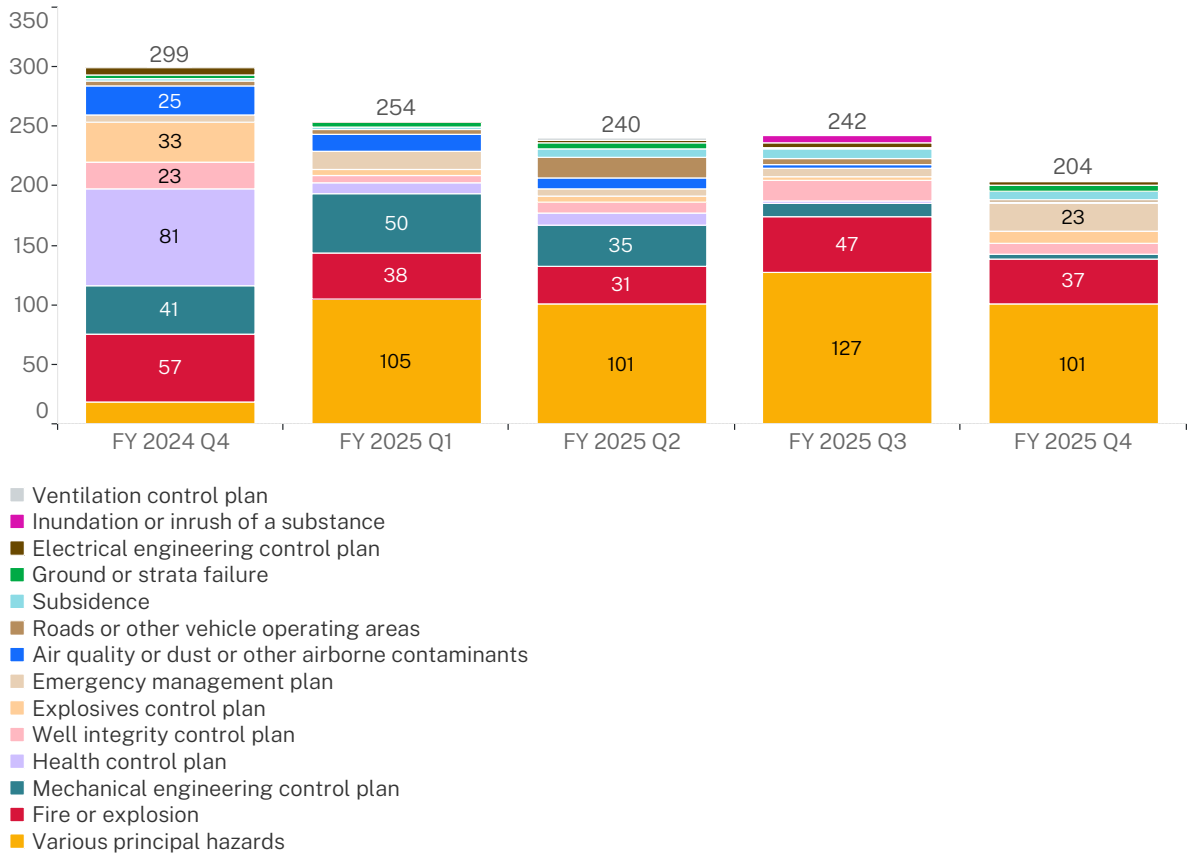


Planned inspections

Planned inspections assist in identifying compliance weaknesses which could lead to an incident or injury. These assessments focus on the physical implementation of critical controls in the operating areas of a mine.

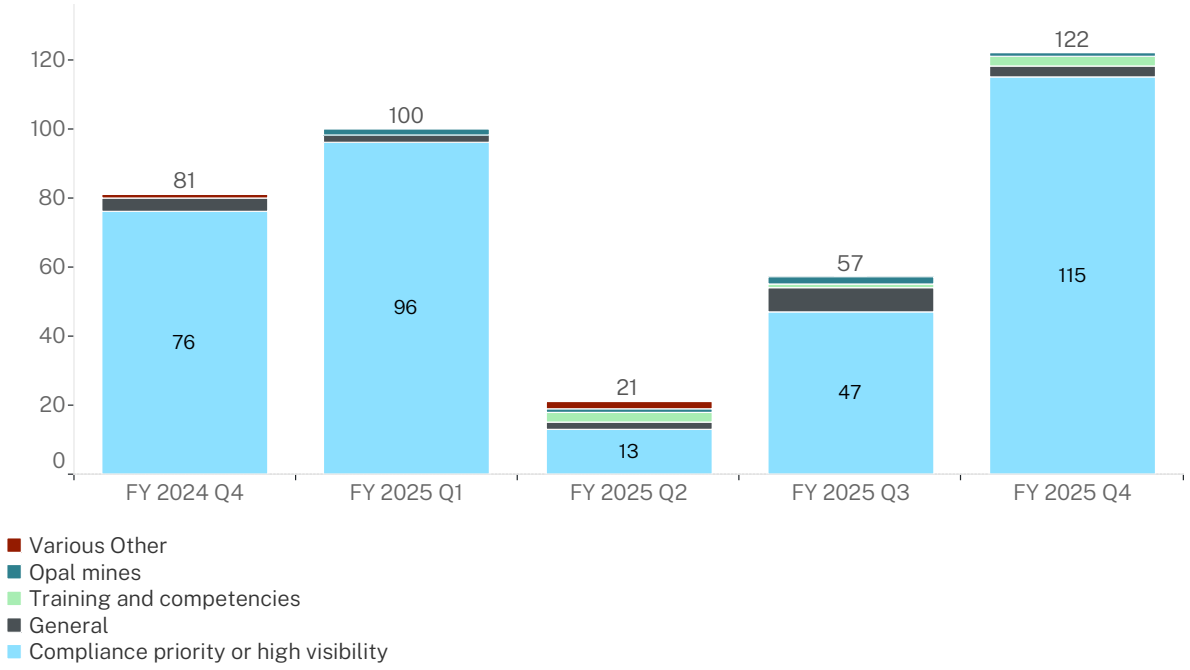
Planned site inspections were commenced on the principal mining hazards and control plans shown in the graph below.

Figure 28. Planned inspections by principal mining hazard and principal control plan – April 2024 to June 2025



The graph below shows planned site inspections commenced for ‘other’ hazards. ‘Other’ hazards are those hazards that are not related to principal mining hazards or principal control plans.

Figure 29. Planned inspections by ‘other’ programs – April 2024 to June 2025



Safety notices issued

We issue risk-based safety notices including prohibition and improvement notices, notices of concern (written notice of matters) and non-disturbance notices.

The graph below shows the number and type of safety notices issued during each of the 5 quarters from April 2024.

Figure 30. Safety notices issued by notice type – April 2024 to June 2025

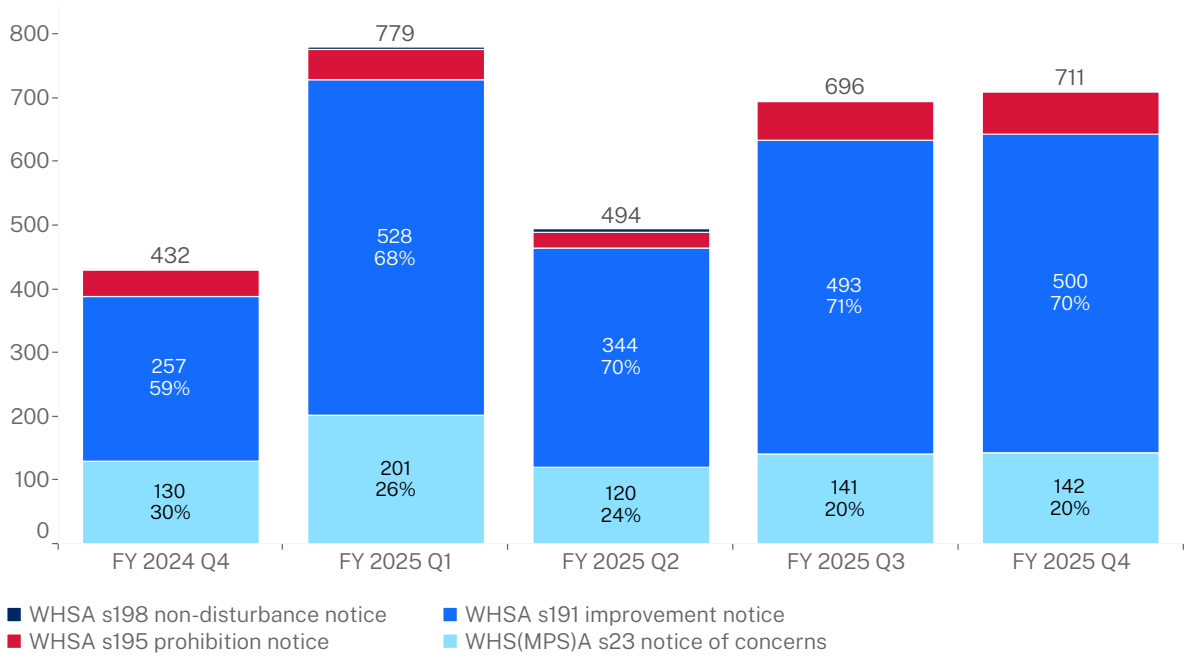
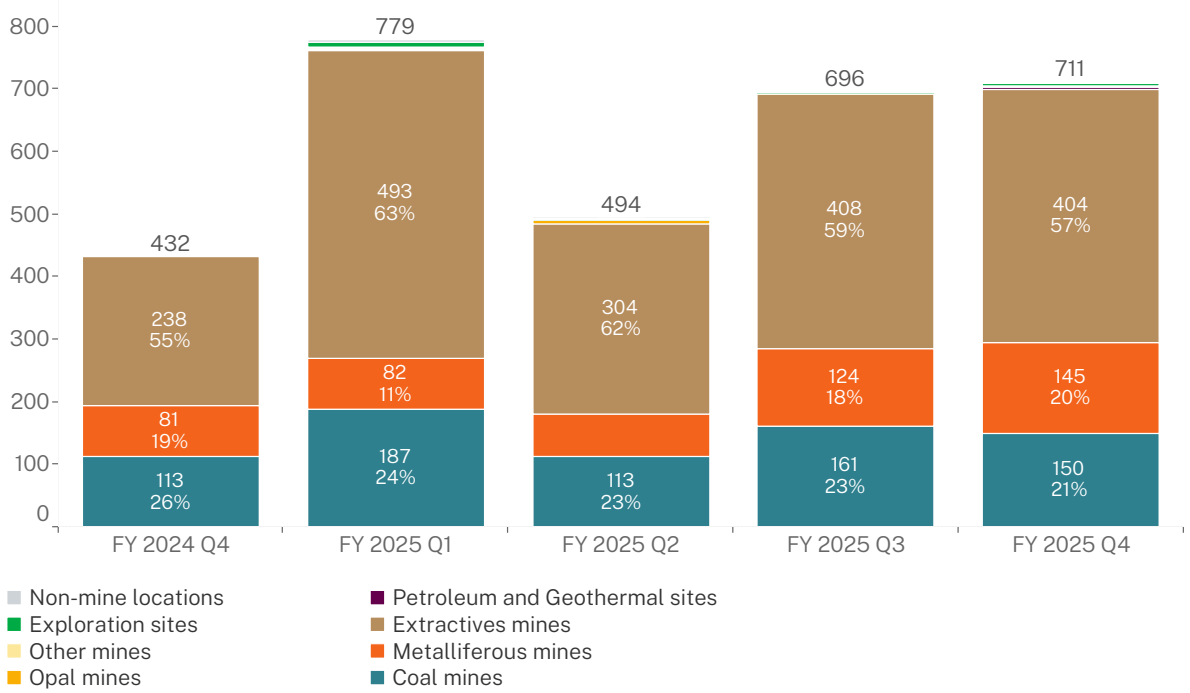


Figure 31. Safety notices issued by sector – April 2024 to June 2025



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