

Weekly incident summary

Week ending 19 September 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	48
Summarised incident total	3


Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident IncNot0049837 Surface operations	A second-year apprentice fitter mistakenly removed a brake accumulator without first releasing the pressure, causing the accumulator to eject and land 2-3 metres away from him, spraying oil across the area. Two qualified fitters were present during the service. The machine was isolated for servicing at the time. The apprentice was covered in oil after the incident. It appears that the main cause was the apprentice's failure to release the pre-charge pressure before removing the accumulator, which led to the exposure to risk.	Information regarding this incident is provided to industry to remind all operators that when working with pressurised systems you must isolate, depressurise and test for dead. This incident also highlights risks associated with inexperienced workers who may not fully appreciate or understand the hazards they are exposed to. Active supervision of these workers is critical to ensure appropriate isolation procedures are followed at all times.

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Incident type	Summary	Recommendations to industry
Dangerous incident IncNot0049843 Surface quarry		
		<p>Where there is a risk of objects falling from height, such as skyline conveyor systems, mine operators must ensure those areas are barricaded appropriately to prevent workers from accessing areas where they may be exposed to the risk of falling objects.</p> <p>Where workers are required to work within object fall zones, appropriate systems (housekeeping, guarding,</p>

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	<p>He immediately notified the control room of the incident.</p> <p>At the time, the conveyor belt was confirmed to be empty. The source of the rock was unclear and may have resulted from rollback on the belt or may have dislodged from the structure above.</p>	<p>isolation) must be in place to ensure the risk of falling material is eliminated or minimised as far as reasonably practicable.</p>
		
<p>Dangerous incident IncNot0049848 Surface coal mine</p>	<p>An electrician suffered an electric shock while attempting to disconnect tails from a circuit breaker. The electrician was removing terminals from the out-of-service drive cell in the distribution board to be used at another drive cell, while also disconnecting the tails to prevent accidental re-energisation. After testing for dead and removing the terminals, the workers proceeded to remove the tails from inside the drive cell but mistakenly accessed the wrong side of the drive circuit breaker, where live conductors were present. This lapse in concentration led to the electric shock. The incident is under investigation to reinforce proper isolation and safety measure during such tasks.</p>	<p>Electrical engineering control plans must set out control measures for the risk of injury to people caused by direct or indirect contact with electricity.</p> <p>Procedures should be developed to include the safe systems of work for people dealing with electrical plant and electrical installations including the isolation, dissipation and control of all electrical energy sources from the electrical plant or electrical installation.</p>

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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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