

Weekly incident summary

Week ending 29 August 2025

This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the Resources Regulator: phone 1300 814 609 24 hours a day, 7 days a week.

At a glance

High level summary of emerging trends and our recommendations to operators.

Туре	Number
Reportable incident total	35
Summarised incident total	3

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident IncNot0049712 Underground coal mine	A fourth-year apprentice was removing an inter-chock manifold plug on a powered roof support on a longwall install face. The plug ejected under pressure and the apprentice was hit on his helmet by the plug and sprayed with emulsion and air.	This incident highlights the need for safe work procedures to be developed and implemented. Workers must be trained in relevant safe work procedures for tasks they are conducting.
	 The single point isolation valve (SPIV) was seized in the closed position and could not be operated. 	
	• The isolation process was not stopped when the SPIV could not be operated.	
	 The fitter incorrectly assumed that using the back flush filter would remove residual pressure from the return circuit when the SPIV was in the closed position. 	

Incident type

Summary

Recommendations to industry

 The pressure gauge does not give any indication of the pressure in the circuit of concern – the return circuit.





Dangerous incident IncNot0049740 Underground metals mine

Ground or strata failure



A rockfall occurred from an identified geotechnical hazard with material from the rockfall filling the catch benches below and some debris landing on the haul road.

The haul road was operational during the time of the incident, however there were no workers or machinery in close proximity.

All mines with highwalls should complete geotechnical assessments to determine the design of the highwall. All geological and geotechnical issues need to be considered and highwalls designed accordingly.

Mine operators are reminded that when developing the control measures to manage the risks of ground or strata failure, consideration must be given to:

- the means by which water may enter the mine
- the procedures for removing water from the mine
- how those procedures influence rock stability over time
- the geotechnical characteristics of the rocks and soil, including the effects of water on rock support and stability.

Refer to the safety bulletin:

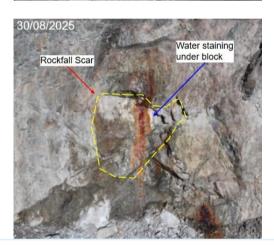
Incident type

Summary



Recommendations to industry

SB20-01 Failure of highwalls, low walls and dumps.



Dangerous incident IncNot0049745 Open cut coal mine Fire or explosion



A fire occurred underneath a dozer while weld repairs on the transmission piping within the bevel gear housing were being undertaken.

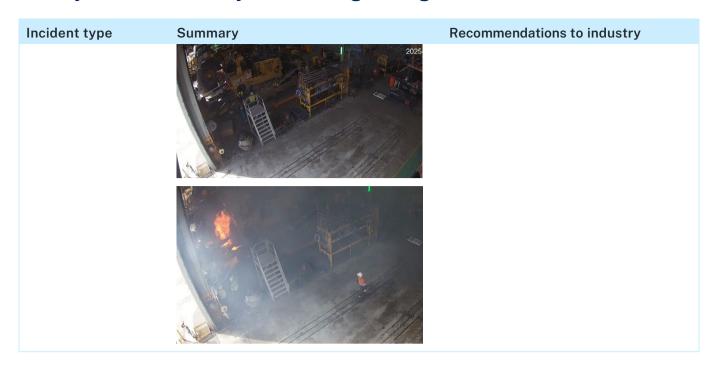
Hot material caused hydrocarbons beneath the dozer to catch fire. A boilermaker went under the dozer to try to pull oil trays out but was forced to retreat because of the flames.

The fire was extinguished using fire water hoses and extinguishers.

When water was applied to the fire the flames increased.

Mine operators must have processes in place to ensure that the controls identified within site procedures and permits are implemented. Work procedures should not allow for flammable materials to be in the vicinity of hot work.

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 response training.



Other publications of interest

The incidents are included for your review. The Resources Regulator does not endorse the findings or recommendations of these incidents. It is your legal duty to exercise due diligence to ensure the business complies with its work health and safety obligations.

Publication	Issue/topic
	International (fatal)
MSHA	USA - Final fatality report: 22 February 2025, fatal powered haulage accident The mine operator drills and blasts limestone in an open pit and transports the material by truck to the processing facilities, where the material is crushed and mixed with other materials, fed into a rotary kiln, and processed into cement. On February 22, 2025, at 2:00 am, Angel Gustavo Perez-Perez, a 28-year-old contract miner for Elite Refractory, with about 17 weeks of mining experience, was fatally injured when the bridge providing access into the kiln shifted, causing the skid steer loader he was operating to fall backward into the cooler chute. The incident occurred because: 1) the mine operator and contractor did not provide safe access to the inside of the kiln 2) the mine operator did not properly train miners to assemble and secure the ramp/bridge assembly for kiln access Details

Note: While the majority of incidents are reported and recorded within a week of the event, some are notified outside this time period. The incidents in this report therefore have not necessarily occurred in a one-week period. All newly recorded incidents, whatever the incident date, are reviewed by the Chief Inspector and senior staff each week. For more comprehensive statistical data refer to our annual performance measures reports.

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Document control	
ISSN:	2982-1010 (online)
CM10 reference	D25/93288
Mine safety reference	ISR25-35
Date published	5 September 2025
Authorised by	Deputy Chief Inspector Office of the Chief Inspector