Weekly incident summary

Week ending 26 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	41
Summarised incident total	3

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident IncNot0049952 Open cut coal mine Roads or other vehicle operating areas 	A dump truck crossed a centre bund and rolled onto its side. The operator was rescued using an elevated work platform and did not suffer any injuries.	Vehicle operators are reminded that they must follow procedures related to roads and other vehicle operating areas including speed requirements on ramps and crests. Mine operators should conduct regular audits to determine if there is a need to install crest and ramp speed monitoring and implement it where necessary. Mine operators should also regularly examine information from speed monitors to identify any non-compliance to ramp and crest speeds. This incident highlights the importance of wearing a seatbelt at all times when operating vehicles. The Resources Regulator has published a technical reference guide (TRG) to assist mine operators with developing a

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	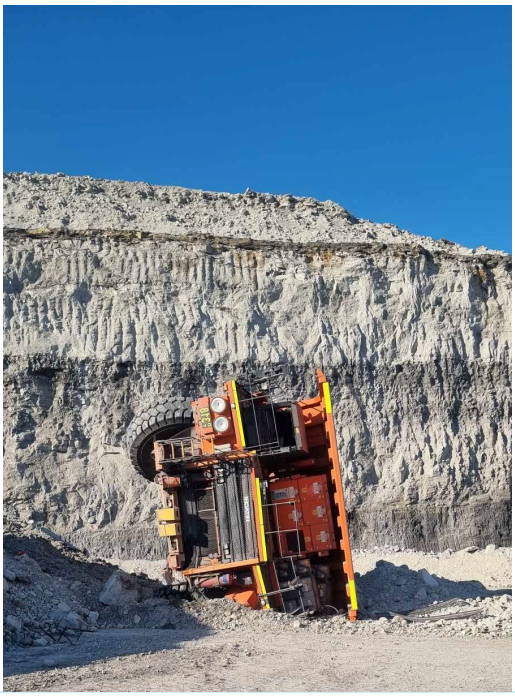	principal hazard management plan for roads or other vehicle operating areas. For further information refer to: TRG: Roads or other vehicle operating areas – principal hazard management plan for surface mining operations.
Dangerous incident IncNot0049874 Underground coal mine Ground or strata failure 	Workers were in the process of advancing mobile roof supports and setting up for production in the last lift of a 15 cut-through, right-hand run-out as part of planned pillar extraction operations. Workers completed the second-last lift of the run-out during the first part of the shift. Workers noted the goaf working and commenced retreating behind the continuous miner when a substantial goaf fall occurred. This goaf fall resulted in an overpressure event (suspected windblast) that knocked 3 workers from their feet. One worker suffered an injury to his left shoulder and was transported to hospital for assessment. Two other workers suffered superficial injuries, including one being hit on the back of the head with a cap lamp.	This incident is under investigation and further information may be published later. All underground mines that complete secondary extraction must consider the risk of windblast as part of the ground or strata failure principal hazard management plan. Operating trigger action response plans (TARPs) should be in place depending on the amount of roof holding up and the potential for windblast especially before initial goaf formation.

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Dangerous incident IncNot0049960 Underground coal mine Fire or explosion 	A fire occurred on the tail pulley of a longwall conveyor. A burning smell was identified by tradesmen and a 300 mm flame was seen in the vicinity of the off-walk side tail pulley bearing. Workers isolated the tail pulley area to remove foreign material around the tail pulley in the hours leading up to the event. They suspected this was the cause of the heating/smell of burning that was reported. Once the belt was restarted, within a few minutes of restarting, temperatures spiked, and the flame was seen from the off-walk side of the tail pulley and was extinguished.  	Mine operators must develop effective controls to ensure operation and maintenance of the longwall conveyor bootend does not result in a bearing failure and fire in the hazardous zone. Where necessary, mine operators should conduct a design review of the longwall bootend to determine if it is fit-for-purpose. Mine operators must have a system to identify and change-out worn or damaged bearings. People conducting inspections must be aware of the increased risk of bearing failure at high tension areas. Further information: NSW code of practice: Mechanical engineering control plan.

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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.

Document control	
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