

Weekly incident summary

Week ending 3 October 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.

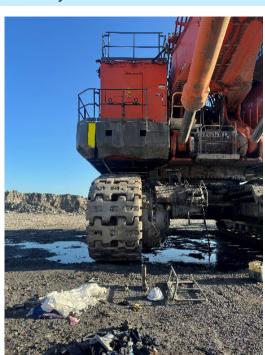
Туре	Number
Reportable incident total	40
Summarised incident total	3

Summarised incidents

Incident type	Summary	Recommendations to industry
Serious injury IncNot0049876 Open cut coal mine	While pressure washing an excavator in preparation for service, a worker fell 4 metres to the ground and suffered multiple fractures.	A mechanical engineering control plan must set out the control measures for injury to people caused by working on plant and the catastrophic failure of structures.
	The worker was relocating after pressure washing the excavator near the right-hand boom cylinder when the ladder gate failed at the base.	The following matters must be taken into account when developing a control measure:
	The ladder gate was a single stanchion design and the weld at the base of the stanchion failed.	 Inspecting and testing plant or structures, including testing safety critical functions or components.
		 Identifying, assessing, managing and rectifying defects that affect the safety of plant or structures.
		Mine operators should confirm that access systems are included in routine maintenance inspections on all plant. This includes the failure

Incident type

Summary



Recommendations to industry

mode of the support stanchions or posts, and the weld quality between the support stanchions or posts and the base plate. For more information about working at heights refer to SafeWork Code of practice:

Managing the risk of falls at workplaces.



Serious injury IncNot0049919 Construction materials

A worker suffered a broken femur after being hit by a concrete pump boom.

The worker was trying to empty a concrete boom following the failure of a seal on the truck's concrete pump. Stored energy caused the boom to move and hit the worker in the leg causing a compound fracture of the femur.

This incident is under investigation and further information may be published later.

Dangerous incident IncNot0049965 Open cut coal mine Fire or explosion

A haul truck operator saw oil pouring underneath an excavator and alerted the excavator operator.

The excavator operator moved the excavator along the bench and idled it down to carry out an inspection from ground level. From there, the excavator operator saw large amounts of oil leaking from the machine. The operator shut down the

Maintenance systems must be comprehensive and should consider all reasonably foreseeable risks of fire or explosion. The systems should be routinely examined to ensure minimum standards are met or exceeded. Mine operators should ensure stringent monitoring and

Incident type

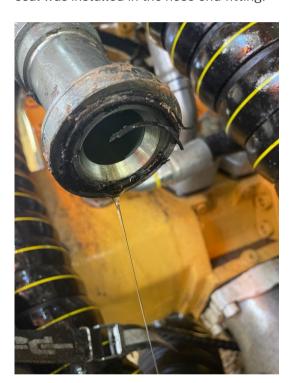


Summary

excavator with the E-stop at the entrance to the pump room where oil was seen spraying and dripping from the high-pressure manifold block mounted between the power packs.

The operator returned to the engine bay and saw flames over the right-side engine and activated the fire suppression system.

An initial investigation identified a blown rubber seal in a flange-type connection of a high-pressure pump delivery hose to the pump distributor block. The wrong type of seal was installed in the hose end fitting.



Recommendations to industry

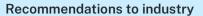
quality control of maintenance and repair activities.

The person with management or control of plant at a work place must ensure that the maintenance, inspection and, if necessary, testing of plant is carried out by a competent person.

The maintenance must be carried out in accordance with the manufacturer's recommendations where available.

Incident type

Summary





Other publications of interest

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

Publication	Issue/topic
	National (other, non-fatal)
Resources Safety and Health Queensland	Safety alert: Diesel ignition event near fuel source
	A coal mine worker was injured when an ignition occurred when they were standing on the rear of a bulldozer near the fuel cap. Initial investigations suggest fuel vapours ignited, causing the worker to be burned. The injured worker was given medical attention, and an investigation is underway.
	• Ignition occurred close to the fuel tank cap area of the bulldozer, which operates on diesel.
	• While diesel itself is not highly flammable in liquid form at room temperature, its vapours can ignite if they mix with air in the right proportions and are exposed to an ignition source such as a flame or spark.
	Vapour ignition is more likely in enclosed spaces or at elevated temperatures.
	It is recommended that coal mine workers be made aware of this incident and the risk of serious injury or fatality arising from ignition near fuel sources, properties of hazardous substances (e.g. diesel fuels) including the production of flammable vapours under certain conditions, as well as the risk of ignition sources while refuelling or near an open fuel cap.

Publication	Issue/topic
	Safe work procedures must be followed, with regular reinforcement of these procedures.
	<u>Details</u>
Resources Safety and Health Queensland	Safety alert: Failure of pneumatic actuator on knife-gate valve
	A worker at a concentrator suffered serious injuries when they were hit by the end cap of a pneumatic actuator for a knife gate valve when it detached under pressure.
	Two workers were attempting to free the knife gate using pressure from a nitrogen gas cylinder.
	The knife gate valve was at the base of a floatation bank and was normally used to drain the float bank when required. It was fitted with a bore, double-acting pneumatic actuator. This type of valve and actuator are commonly found in processing plants.
	The knife gate valve was normally operated pneumatically (air-powered) via the plant compressed air system using a directional control valve. The plant compressed air system at the concentrator operated at 600kPa.
	The knife gate became stuck, and the two workers were tasked with freeing it.
	The workers were trying to free the knife gate using pressure from a nitrogen gas cylinder, fitted with a single-stage nitrogen regulator and connected to the actuator via lines and fittings. The injured worker was positioned directly in front of the actuator due to the location of the valve and length of tubing available.
	A nitrogen 'rig', consisting of a D2 size nitrogen cylinder, single-stage regulator, lines, a ball valve and fittings had been previously used at the plant to help free stuck valves by providing the pneumatic actuator with greater gas pressure than the 600kPa plant air. This method had previously been used successfully.
	Initial investigations indicate the single-stage nitrogen regulator experienced an event that allowed an overpressure of the actuator.
	The body and end cap of the actuator were constructed from aluminium, with the end cap threaded into the body and a rated working pressure of 1,000kPa. The end cap separated from the body at this location (the joint).
	Initial testing indicated these types of pneumatic actuators experienced end cap separation at pressures of approximately 2,700kPa to 3,200kPa.
	Typical pressures for full D2 size nitrogen cylinders are 16,300kPa to 20,000kPa.
	<u>Details</u>

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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