

# Weekly incident summary

# Week ending 5 December 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 | 41     |
| Summarised incident total | 3      |

#### Summarised incidents

| Incident type  | Summary  | Recommendations to industry   |
|--|--|---|
| Dangerous Incidents – IncNot0050301 IncNot0050302 IncNot0050304 Surface operations Leave blank | Across 2 days, 3 coal bursts occurred on a longwall face in the vicinity of shield #151, approaching the tailgate. No injuries occurred, and no personnel were in the immediate area during any event due to remote operation, stand-off controls and operational sequencing.  Incident 1 (29 Nov)  A coal burst occurred approximately 8 m from the tailgate roadway as the shearer entered the tailgate. The closest worker was 16 m away. Ejected material activated E-Stops on shields #150 and #152. Approximately one wheelbarrow of mixed-size material was expelled over the pan line. The location was about 2 m from a coal burst hazard zone identified on the authority to mine (ATM). | <ul> <li>Mine operators must:</li> <li>assess their operations for the risk of coal burst</li> <li>review and update controls in consultation with the workforce to manage the risk of coal burst</li> <li>communicate outcome of incident to workforce and any update to controls measures.</li> </ul> |

| Incident type   | Summary   | Recommendations to industry   |
|---|---|---|
|   | Incident 2 (30 Nov) A second coal burst occurred at shield #151 within a designated hazard zone. All stand-off and wait-time controls were in place and effective. No exposure to personnel occurred.   |   |
|   | Incident 3 (30 Nov)  A third coal burst occurred approximately 0.8 m from the previous event location. Only a small volume of fine coal (about 2 × 20 L buckets) was ejected, with no large fragments.  |   |
| Dangerous Incident IncNot0050327 Underground metals mine Fire or explosion  Dangerous An underground truck was transdered decline in a metalliferous mine operator heard an odd noise at fluid spraying from the engine subsequently ignited. The operator heard an odd noise at fluid spraying from the engine subsequently ignited. The operator heard an odd noise at fluid spraying from the engine subsequently ignited. The operator heard an odd noise at fluid spraying from the engine subsequently ignited. The operator heard an odd noise at fluid spraying from the engine subsequently ignited. The operator heard an odd noise at fluid spraying from the engine subsequently ignited. The operator heard an odd noise at fluid spraying from the engine subsequently ignited. The operator heard an odd noise at fluid spraying from the engine subsequently ignited. The operator heard an odd noise at fluid spraying from the engine subsequently ignited. The operator heard an odd noise at fluid spraying from the engine subsequently ignited. The operator heard an odd noise at fluid spraying from the engine subsequently ignited. The operator heard an odd noise at fluid spraying from the engine subsequently ignited. The operator heard an odd noise at fluid spraying from the engine subsequently ignited. The operator heard an odd noise at fluid spraying from the engine subsequently ignited. The operator heard an odd noise at fluid spraying from the engine subsequently ignited. | An underground truck was tramming up the decline in a metalliferous mine when the operator heard an odd noise and observed fluid spraying from the engine bay. The fluid subsequently ignited. The operator was parking the truck when the onboard fire system automatically activated. The operator called an emergency on the radio, parked, isolated the truck and proceeded to extinguish the fire with assistance from other workers using handheld fire extinguishers and a water | Mine operators must undertake rigorous fire risk assessments and, wherever practical, seek to eliminate the hazard, such as potential fuel and ignition sources.            |
|   |   | Mine operators must not merely rely on fire suppression and detection systems, which are mitigation controls and do not eliminate or minimise the risk of a fire occurring. |
|   |   | Identified controls must be effectively implemented and regularly monitored.  |
|   |   | Refer to the following for further guidance:  |
|   |   | Fires on mobile plant position paper  |
|   |   | MDG15 guideline for mobile and transportable plant for use at mines other than underground coal mines   |
|   |   |   |

#### Incident type Summary Recommendations to industry Dangerous A fire occurred on a self-cleaning magnet Mine operators must ensure: Incident located in a collection conveyor area at an adequate inspection regimes are in underground metalliferous mine. The flames IncNot0050313 place for conveyor systems. were first observed by an operator, who Underground adequate controls are in place as immediately notified the control room and metals mine part of the design of plant to initiated emergency procedures. Leave blank mitigate the risk of falling objects Video monitoring indicated that the fire selffrom magnets coming into contact extinguished approximately 10 minutes after with grease lines, creating a fire ignition. hazard.

## 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 (other, non-fatal)   |
| US Mine Safety<br>and Health<br>Administration<br>(MSHA) | USA - Safety Alert: Tensioner Bolt Failure   |
|  | On July 17, 2025, a miner at a surface limestone operation sustained serious injuries while performing repairs on a belt drive motor. During the repair process, the motor's tensioning system was being adjusted when a ¾-inch diameter all-thread tensioner bolt failed, causing the bolt to break loose and strike the miner in the face. Spring-integrated designs with constant pressure and continuous vibrations pose potential safety concerns.  |
|  | Best Practices   |
|  | <ul> <li>Ensure all miners receive thorough training to identify workplace hazards and<br/>perform tasks safely.</li> </ul>  |
|  | <ul> <li>Maintain all equipment and safety devices in proper working condition to ensure<br/>safe operation by reviewing manufacturer manuals prior to service; replace worn<br/>or damaged components; and use tightening sequences and tighten as<br/>recommended.</li> </ul>  |
|  | • Check component quality by examining bolts, washers, springs, and nuts for visible defects like rust, cracks, corrosion, thread damage or deformation.   |
|  | <ul> <li>Conduct a risk assessment before starting work to identify and control all forms of<br/>stored energy, including mechanical, electrical, hydraulic, gravitational hazards,<br/>and unintended motion of equipment.</li> </ul>   |
|  | <ul> <li>Alignment matters: Ensure all components are properly aligned before bolt<br/>installation. Misalignment can lead to uneven stress distribution within the system,<br/>possibly leading to their premature failure.</li> </ul>  |
|  | <u>Details</u>   |
|  | National (other, non-fatal)  |
| Resources Safety   | QLD - Safety Alert: Workers exposed to serious risk from falling objects   |
| & Health<br>Queensland                                   | Resources Safety and Health Queensland (RSHQ) is concerned about the increasing number of incidents involving people who were in, or potentially exposed to, hazards in designated drop zones. Since July 2023, there have been more than 300 incidents reported (across coal, mineral mining and quarries and petroleum and gas) where people have or may have been exposed to falling plant, tools, or equipment. There is a high risk that workers could be seriously or fatally injured if they are impacted by objects falling within a drop zone.  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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