

Weekly incident summary

Week ending 1 May 2026

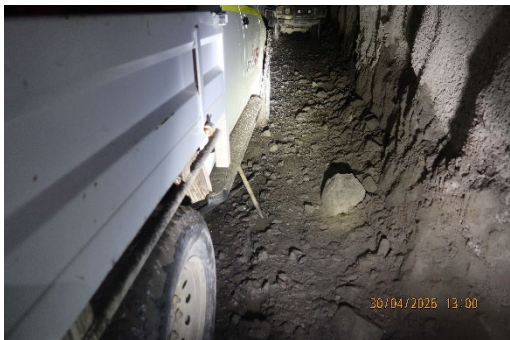
This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the NSW Resources Regulator: phone 1300 814 609 24 hours a day, 7 days a week.

At a glance

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

Type	Number
Reportable incident total	51
Summarised incident total	3

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous Incident IncNot0051226 Underground metals mine Roads or other vehicle operating areas	An operator was driving a light vehicle in a decline when the vehicle ran over a drill steel that had fallen on the roadway. The drill steel penetrated the floorboard of the light vehicle just behind the driver's seat. 	Mine operators should have a minimum house keeping standards to include inspection of roads. Workers should ensure drill rods are secure before transporting.

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Incident type	Summary	Recommendations to industry
		
Dangerous Incident IncNot0051221 Underground coal mine	While opening a 6-inch gate valve on a standpipe in preparation to recommence drilling, a blockage in the drill hole released, causing gas and water to surge through the gas drain line. This caused the u-tube discharge pipe to rotate 180 degrees. Nobody was in the vicinity of the pipe at the time. 	When planning tasks workers must consider how components can move and adequately plan to control this risk. Isolation procedures should include the management of stored energy, including gravity, and consider the rotation of components. For this task, consideration should be given to adequately securing the discharge pipe to prevent unintended movement.
High potential Incident IncNot0051232 Underground coal mine Fire or explosion	At the beginning of service, workers discovered a deliberately crimped safety circuit hose on a load haul dump (LHD). The nightshift operator admitted to fitting a clamp on the hose as he was concerned the cement he was transporting would set should the LHD shutdown.	Shutdown systems are critical safety systems on diesel engines used in underground coal mines. Workers must not place bypasses or overrides on systems without following the relevant procedure at the mine. Workers are reminded of their obligation in the <i>Work Health and Safety Act 2011</i> section 28 to: • take reasonable care for his or her own health and safety, and • take reasonable care that his or her acts or omissions do not adversely affect the health and safety of other persons. • comply, so far as the worker is reasonably able, with any reasonable

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Incident type	Summary	Recommendations to industry
		instruction that is given by the person conducting the business or undertaking to allow the person to comply with this Act, and co-operate with any reasonable policy or procedure of the person conducting the business or undertaking relating to health or safety at the workplace that has been notified to workers.

Other publications of interest

These 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)
US Mine Safety and Health Administration (MSHA)	The US Mine Safety and Health Administration (MSHA) has released its final report into the death of a worker engulfed by material at a silo access door. The US Mine Safety and Health Administration (MSHA) has released its final report into the death of a worker engulfed by material at a silo access door while clearing a blockage. MSHA found the operator lacked effective material handling controls, requiring entry into an entrapment hazard from caving or sliding material. <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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