

Weekly incident summary

Week ending 22 May 2026

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	48
Summarised incident total	3

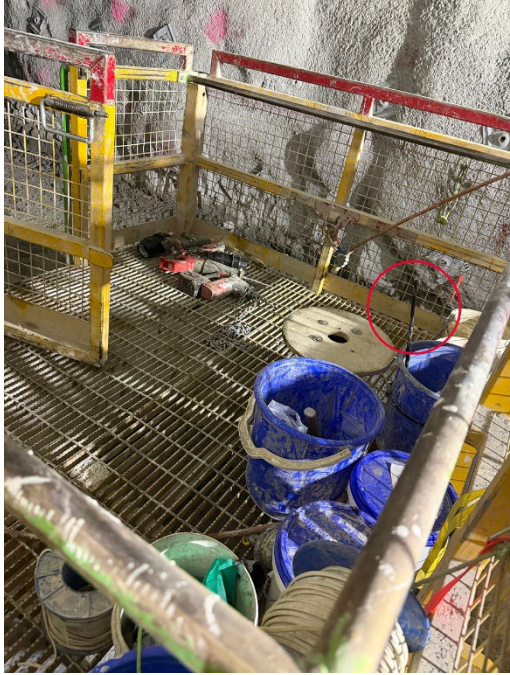
Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous Incident IncNot0051320 Underground metals mine Roads or other vehicle operating areas	A dump truck was reversing near a portal when the truck collided with the rear left of the tray of a light vehicle (LV) parked in the LV parking area. The LV started and moved forward up the bund as far as they could but couldn't avoid the collision. The LV had two occupants in it at the time. The LV was on the trucks off-side, and the truck operator was not aware the LV was there. The truck operator was a trainee with the trainer in the dickie seat at the time.	Designated light vehicle parking areas that are in close proximity to operating mobile plant should have adequate protection in the form of berms or windrows. The berms or windrows should be constructed using suitable, solid materials and be of height, density and profile to enable an effective barrier. The minimum height required is generally half the wheel height of the largest vehicles using the road. Refer to Layer 2 of the layered defence approach in the Resource Regulator's technical reference guide: Surface ROVOA. Layer 2 focuses on vehicle separation control measures. These control measures are designed to physically separate vehicles from potential hazards and should include berms, earth mounds or barriers.

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Incident type	Summary	Recommendations to industry
	 	
Dangerous incident IncNot0051384 Underground metals mine Leave blank	A service crew worker was working out of a man basket attached to a loader when he lost his balance and fell backwards onto a length of reinforcement bar (Reo) sticking out of a bucket. The piece of Reo impaled the worker for a brief period causing an internal cut requiring 4 stitches. The elevated basket was being controlled by another worker on the ground who had the radio handpiece held between his legs and the cord of the handpiece was wrapped around the loader joystick. When the worker moved, the cord engaged the joystick and the basket moved quickly without warning, causing the worker in the basket to lose his balance.	Mechanical engineering control plans must set out the control measures for the unintended operation of plant. When work is required to be done using a raised platform, mines should consider the appropriate plant for the circumstances, considering the risks for workers on the platform arising from unintended movement. Consideration should be given to the use of fit-for-purpose equipment, where reasonably practicable, such as elevated work platforms (EWPs) specifically designed for working at heights. Workers must be trained and competent in the use of equipment that is under their control and always keep their attention on the task at hand. Workers should pay attention to housekeeping and ensure that items placed

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Incident type	Summary	Recommendations to industry
		in buckets do not protrude and pose a risk to others.
Dangerous Incident IncNot0051373 Underground metals mine Roads or other vehicle operating areas	A haul truck was tramping down a decline and stopped when the operator got a call from another truck coming up the decline. The haul truck was intending to reverse out of the way of the oncoming truck when he saw a light vehicle (LV) coming down the decline behind him. The truck remained stationary waiting to see where the LV was going but it didn't slow down and collided with the position 4 tyre of the haul truck. The LV operator sustained minor injuries and was taken to hospital for scans and treatment.	Inattention and distraction while driving can have fatal consequences. Drivers should remain focused on the task at hand and not be distracted while driving. This includes staying alert, being aware of their surroundings, and maintaining control of the plant and machinery they operate. Fatigue policies require workers to arrive at work rested and ready for a full shift and report fatigue events as they occur.

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Incident type	Summary	Recommendations to industry
		

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)	40-year-old contract field service technician who died from burns after a pressurised hydraulic line ruptured and caught fire The Mine Safety and Health Administration has released final reports into a 40-year-old contract field service technician who died from burns after a pressurised hydraulic line ruptured and caught fire on 22 December 2025.

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Publication	Issue/topic
	<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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Document control	
ISSN:	2982-1010 (online)
CM10 reference	D26/77352
Mine safety reference	ISR26-19
Date published	29 May 2026
Authorised by	Deputy Chief Inspector Office of the Chief Inspector