

Weekly incident summary

Week ending 7 August 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	40
Summarised incident total	3

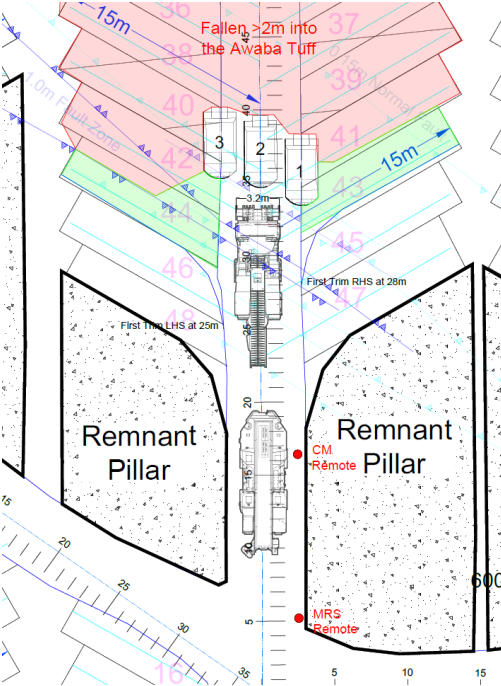
Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident IncNot0051793 Underground coal mine Fire or explosion 	While travelling underground, a worker observed smoke near a conveyor drive head and belt starter area. Investigation identified the conveyor belt rubbing against the conveyor structure at the boot end. There was no flame present, however glowing rubber embers and melted rubber were found on the ground. The conveyor had not activated the carbon monoxide (CO) monitoring system, with levels recorded at 6 ppm. Initial investigation identified that the walk-side belt wander switch was incorrectly adjusted, allowing the belt to track out of alignment and contact the structure. Previous belt tracking issues may have contributed to the condition. The belt was immediately stopped and isolated, the affected area was made safe and hot rubber was cooled with water.	Mine operators should ensure: - conveyor belt wander protection devices are correctly positioned, maintained, and routinely function tested to prevent belts tracking out of alignment and contacting conveyor structures - inspection programs verify that protection systems remain effective and that recurring belt wander issues are investigated and addressed.

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Incident type	Summary	Recommendations to industry
Dangerous incident IncNot0051808 Underground metals mine Fire or explosion 	A small fire occurred underground involving combustible materials located at the base of a data box. Initial investigation identified rags and cardboard present in the area at the time of the incident. A 415V cable that had previously supplied a tele-remote barrier, which had since been removed from service, remained energised and had not been isolated. It is believed the energised cable was the ignition source for the fire. The fire was identified and extinguished with no injuries reported. The area was made safe and an investigation commenced to determine the circumstances that led to the cable remaining energised following removal of the associated equipment. 	Mine operators should ensure: - electrical installations, modifications, and maintenance activities comply with AS/NZS 3000 Wiring Rules in surface and metalliferous operations. Pay particular attention to Clause 1.5.11.4 (Voltage in Unused Conductors) to ensure all disconnected, redundant, or unused conductors associated with energised circuits are terminated and protected at both ends as if live, preventing injury, equipment damage, and fire from induced or residual voltages - all redundant electrical cables are removed or isolated - housekeeping standards prevent combustible materials accumulating near electrical equipment.
Dangerous incident IncNot0051811 Underground coal mine Ground or strata failure 	While undertaking pillar extraction with a continuous miner a secondary goaf fall caused an overpressure event (windblast) that injured 3 workers near the production face. The injured workers were assisted from the mine by members of the production crew.	The matter is currently under investigation. In the interim, mine operators should: - regularly review and maintain Windblast TARPs to ensure they remain current and effective - ensure decisions regarding assigned TARP levels are supported by appropriate analysis and documented rationale - ensure that the mine's permit to mine or authority to mine effectively manages hazards identified - ensure verification processes are in place to support the implementation

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Incident type	Summary	Recommendations to industry
	 Incident scene, looking inbye from shuttle car to continuous miner and mobile roof support.  Location drawing for face equipment at time of incident.	and ongoing effectiveness of hazard controls.

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 has released the final report into the April 2026 death of a shuttle car operator who was struck by falling roof rock. The investigation found the mine operator failed to prevent work under unsupported roof, follow the roof control plan, and conduct an adequate on-shift examination. <u>Details</u>

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Publication	Issue/topic
International (other, non-fatal)	
International Council on Mining & Metals (ICMM)	ICMM's latest safety performance report shows that while fatalities decreased in 2025 compared with the previous year, the overall trend since 2021 remains upward, indicating that progress in improving safety is slowing. ICMM members recorded 39 fatalities in 2025, with one-third linked to 2 catastrophic events involving major mining hazards such as falls of ground, inrushes and outbursts. Details
National (fatal)	
Resources Safety & Health Queensland	Resources Safety and Health Queensland has reported an increase in serious hand injuries in Queensland's petroleum and gas industry, with incidents involving severe trauma, fractures and amputations. 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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