

# Weekly incident summary

## Week ending 28 August 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 | 38     |
| Summarised incident total | 3      |

### Summarised incidents

| Incident type                                                                     | Summary                                                                                                                                                                                                                                                           | Recommendations to industry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| High potential incident<br>IncNot0051910<br>Underground coal mine                 | While transporting a roll of solid woven conveyor belting with a loader, the rubber made contact with the roadway and was dislodged from the loader's forks. The belt rolled downhill, broke through a segregation stopping and came to rest on a jersey barrier. | Mine operators should: <ul style="list-style-type: none"><li>ensure that risks of unplanned movement are identified and that appropriate controls are in place to manage them</li><li>review how workers and supervisors are trained to recognise the potential hazards associated with all energy sources, including unplanned movement during lifting/transporting activities.</li></ul> Workers should ensure that loads are adequately secured to prevent unplanned movement. Use slings, support cradles or suitable jigs appropriately rated for the load. |
| Dangerous incident<br>IncNot0051930<br>Underground coal mine<br>Fire or explosion | A coal mine worker driving a load haul dump (LHD) into a mine noticed smoke coming from the belt road. The worker found the off-walk side tail pulley was sparking. After stopping the belt, the worker went to find a hose and when he                           | The hazard of failed bearings must be considered in the fire and explosion risk assessment for all mines.<br><br>Mine operators must ensure:                                                                                                                                                                                                                                                                                                                                                                                                                     |

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| Incident type                                                                     | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Recommendations to industry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <p>sprayed the water on the fire, flames shot to the roof.</p> <p>The worker went to get a fire extinguisher and put the fire out before cooling the pulley bearing with water.</p>                                                                                                                                                                                                                                                                                                                                        | <ul style="list-style-type: none"> <li>adequate inspection regimes are in place for conveyor systems, particularly in areas with limited access and/or visibility</li> <li>adequate maintenance strategies and robust systems are implemented to prevent failures of conveyors or their components.</li> </ul> <p>Defective bearing management is a concern for all mines. Every mine that is operating conveyors should have a defect management system for bearings.</p> <p>Workers conducting conveyor inspections must be aware of the increased risk of bearing failure at high tension areas of conveyors.</p>                                                                                                                                                                                                                     |
| <p>Dangerous incident<br/>IncNot0051902<br/>Underground<br/>metals mine</p>       | <p>A fire occurred on an LHD that was underground after an escape of hydraulic fluid made contact with hot engine parts.</p> <p>The operator dropped a load from the bucket when a low hydraulic oil pressure alarm occurred, and the operator saw zero hydraulic oil pressure.</p> <p>The operator noticed flames glowing from the rear of the machine and activated the automatic fire suppression system to control the fire.</p> <p>A small residual fire was extinguished using a hand-held fire extinguisher.</p>  | <p>The failure of oil and fuel lines near exhaust and turbochargers are well-known causes of fire.</p> <p>When lagging is used as a control for hot surfaces, joints and transitions must be managed to minimise gaps and prevent flammable fluids flowing onto hot surfaces.</p> <p>Fuel sources and ignition points should be separated or have other controls in place to prevent fires.</p> <p>Mine operators should ensure that risk control measures to prevent the occurrence of fires underground are implemented and remain effective.</p> <p>Inspection regimes, housekeeping standards and emergency response procedures should be routinely examined to ensure minimum standards are met or exceeded.</p> <p>Mine operators should ensure stringent monitoring and quality control of maintenance and repair activities.</p> |

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| Incident type | Summary                                                                           | Recommendations to industry |
|---------------|-----------------------------------------------------------------------------------|-----------------------------|
|               |  |                             |

### 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                                                                                                                                                                                                                                                                                      |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|             | <b>International (fatal)</b>                                                                                                                                                                                                                                                                     |
| <b>MSHA</b> | <b>Fatality final report - 5 March 2026</b><br>A continuous mining machine operator died after becoming pinned between the machine and the coal rib while tramming the machine to the coal face.<br><a href="#">Details</a>                                                                      |
| <b>MSHA</b> | <b>Fatality final report - 8 September 2025</b><br>A contract haul truck driver with over 13 years of experience died when the ground under his haul truck collapsed, causing it to overturn backwards and come to rest at the base of a processed granite stockpile.<br><a href="#">Details</a> |
| <b>MSHA</b> | <b>Fatality final report – 29 July 2025</b><br>A contractor excavator operator with 7 years of mining experience, died after the excavator he was operating over-travelled his work area, causing the machine to tip forward which crushed the cab against a boulder.<br><a href="#">Details</a> |
| <b>MSHA</b> | <b>Fatality final report – 10 January 2025</b><br>A mobile bridge carrier operator with one year and 9 months of mining experience, was fatally injured when he was pinned between the mobile bridge carrier and the coal rib.                                                                   |

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| Publication                                     | Issue/topic                                                                                                                                                                                                                                                                                                                             |
|-------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                 | <a href="#">Details</a>                                                                                                                                                                                                                                                                                                                 |
|                                                 | <b>National (other, no-fatal)</b>                                                                                                                                                                                                                                                                                                       |
| <b>Resources Safety &amp; Health Queensland</b> | <b>Coal miner hit by rotating dragline</b><br>A coal mine worker was hit by a rotating dragline after dismounting the machine and entering its operational swing boundaries. The worker was hit in the head and lost consciousness but avoided further injury. Investigations into the incident are ongoing.<br><a href="#">Details</a> |

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)                                      |
| CM reference          | D26/144956                                              |
| Mine safety reference | ISR26-32                                                |
| Date published        | 4 September 2026                                        |
| Authorised by         | Deputy Chief Inspector<br>Office of the Chief Inspector |