Weekly incident summary

Week ending 28 February 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.

Type	Number
Reportable incident total	51
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
High potential incident IncNot0048660 Open cut coal mine	While unloading a freight delivery truck with a forklift, the forklift loading board made contact with the mezzanine deck on the truck, and dislodged it from its locating pins. The deck fell to the lower level. Nobody was injured.	Incidents such as this serve as a reminder of the need to have no-go zones and/or safe standing zones in place where there is a possibility for energy release when there is a risk of objects falling from a height.

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Incident type	Summary	Comments to industry
		
High potential incident IncNot0048656 Coal processing plant	A loader was taking a bucket of run-of-mine (ROM) coal from a stockpile when a portion of the stockpile collapsed onto the bucket and the left-hand side front wheel. The loader could not reverse out because of the additional weight of the material in and around the front of the machine. The loader operator was uninjured and was able to get out of the machine. 	Mine operators are reminded of the potential hazards associated with stockpiles. Before starting work, supervisors and equipment operators should inspect and assess the work area to determine if hazards are present - such as the potential for material bridging and subsequently collapsing. Planning for the work must include identifying hazards, risk assessment and control. Refer to: Technical reference guide - Stockpiles and reclaim tunnels Additionally, workers must be familiar with different stockpile material properties and how this influences material behaviour on stockpiles.

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Incident type	Summary	Comments to industry
High potential incident IncNot0048652 Underground coal mine	A load haul dump machine (LHD) operator was climbing into the machine and went to close the door before starting the machine. The operator grabbed the steering wheel to brace himself while closing the door and the steering wheel and shaft dislodged from the orbital valve. Corrosion was identified as an issue. 	Vehicles need to be fit-for-purpose with regular maintenance and inspection systems in place. This must include critical systems such as steering.

Other Resources Regulator publications

Safety Bulletin SB25-01 Complaints about blasting notices increase

There has been an increase in complaints about blasting from owners and occupiers of land or structures adjacent to NSW mines.

The Resources Regulator has received 12 complaints related to blasting activities at mines throughout NSW over the past 6 months. Half of these complaints related to notifications of blasting activities, 10 were related to quarries and 2 were large open-cut mines.

Read the full bulletin and recommendations.

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.

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Publication	Issue/topic
	International (fatal)
MSHA	**USA – Fatality, 11 August 2024 – Fatal powered haulage accident, final report** On August 11, 2024, at 12:05am, Leonard Barnes, a 62-year-old surface miner with over 5 years of mining experience, died while shovelling rock from a belt conveyor. Mr Barnes was on top of the belt inside the C1 head roller housing when the counterweight dropped, causing the belt to move forward and Mr Barnes fell into the chute below. The mine operator directed and allowed miners to work where there were known safety hazards, and did not follow the belt conveyor inspection, cleaning, and lockout procedures. The accident occurred because the mine operator did not: 1. ensure Mr Barnes wore fall protection, and 2. block the belt conveyor against hazardous motion before performing maintenance. Details
MSHA	**USA – Fatality, 16 November 2024 – Fatal machinery accident, final report** On November 16, 2024, at 8:30am, Scott Rhodes, a 50-year-old excavator operator with over 7 years of mining experience, died when he became entangled in a log washer. The accident occurred because the mine operator did not: 1. de-energise and block the log washer against motion while performing maintenance, and 2. provide task training on log washer maintenance procedures. Details
MSHA	**USA – Fatality, 25 July 2024 – Fatal powered haulage accident, final report** On July 25, 2024, at 11:10pm, Brian Brotzman, a 44-year-old plant laborer with over one year of mining experience, died when material engulfed him against the inclined stacker belt conveyor feed chute. Mr Brotzman was kneeling and shovelling on the incline stacker belt conveyor when the stacker belt conveyor unexpectedly rolled backward. The accident occurred because the mine operator did not: 1. block the stacker belt conveyor against motion 2. install a backstop or brake on the stacker belt conveyor drive unit to prevent the stacker belt conveyor from rolling backward and causing a hazard to miners, and 3. provide task training on safe maintenance and repair procedures for belt conveyors. Details
	International (other, non-fatal)
NZ MinEx	**New Zealand Safety Alert** **Uncontrolled movement of truck**

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Publication	Issue/topic
	A dump truck was transporting overburden from a haul road to a ramp. While approaching the right-hand corner of the ramp, the truck came to a complete stop in the windrow. No-one was injured in the incident, however, the sector encounters too many incidents involving loss of control of vehicles. Details
	National (other, non-fatal)
Worksafe Victoria	**Safety Alert – Operating mobile plant on raised ramps and elevated stockpiles** An incident has occurred within a quarry where a frontend loader overturned while topping up edge protection on the left-hand side of a ramp. The employee involved in the incident was an experienced operator of mobile plant. The employee lost control of the mobile plant and became trapped when it toppled over. The employee was able to call for help and exit the plant safely, without suffering any injuries. 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.

Document control	
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