

# Weekly incident summary

## Week ending 11 April 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	53
Summarised incident total	4

### Summarised incidents

Incident type	Summary	Comments to industry
Serious injury IncNot0048887 Underground coal mine Ground or strata failure	 <p>Four workers were engulfed in pulverised material following an unexpected dynamic energy release from stone in a mine roof.</p> <p>The workers were standing on a continuous miner work platform at the time, and were pushed off the platform by a pressure wave.</p> <p>Three of the workers were partially buried and material had to be moved to free them.</p> <p>The workers were all taken to hospital for treatment.</p> <p>The cause of the incident is yet to be determined.</p>	<p>This incident is under investigation and further information will be published at a later date.</p>

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Incident type	Summary	Comments to industry
<p data-bbox="124 645 368 674">Dangerous incident</p> <p data-bbox="124 689 320 719">IncNot0048912</p> <p data-bbox="124 734 368 763">Open cut coal mine</p> <p data-bbox="124 779 405 853">Roads or other vehicle operating areas</p> 	 <p data-bbox="464 645 1023 752">A dozer collided with the position 6 tyre of a loaded haul truck on an active dump causing the tyre to blow out.</p> <p data-bbox="464 775 1034 1104">The dozer operator expected the truck operator to dump on the left-hand side of the tip face. The truck operator went to the right-hand side of the tip face following a previous truck dump position. There was no communication between the operators on the correct dump position for the truck. The dozer operator was aware the truck was on the dump.</p> 	<p data-bbox="1066 645 1465 1088">The consequences of vehicle operators not establishing positive communications with other vehicle operators can, and has been, fatal. Despite the prevalence of site procedures, operator training and the introduction of driver assistance systems, many operators continue to ignore the importance of following basic procedures.</p> <p data-bbox="1066 1111 1453 1290">Operators have a responsibility to establish positive communications every time they interact with another vehicle.</p> <p data-bbox="1066 1312 1433 1491">Other plant operating nearby should be sighted and visual contact should be maintained where possible while manoeuvring at the tip face.</p> <p data-bbox="1066 1514 1449 1621">Visual aids and segregation should be implemented before relying on procedural controls.</p>
<p data-bbox="124 1653 411 1682">High potential incident</p> <p data-bbox="124 1697 320 1727">IncNot0048918</p> <p data-bbox="124 1742 368 1771">Open cut coal mine</p> <p data-bbox="124 1787 405 1861">Roads or other vehicle operating areas</p>	<p data-bbox="464 1664 1034 1843">A wheeled loader was loading a rear dump truck with coal when the bucket hit the truck body and a handrail. Coal material tipped from the bucket and broke the cab window. The operator was uninjured.</p> <p data-bbox="464 1865 1034 1973">The incident occurred on night shift and there was no lighting plant in operation at the time of the incident.</p>	<p data-bbox="1066 1664 1465 1917">Pre-task inspections of work areas should be undertaken to identify and manage the hazards present. This should include confirming that lighting is adequate for the tasks being conducted in the area.</p> <p data-bbox="1066 1939 1453 2007">Mine operators should require workers to set up lighting plant</p>

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Incident type	Summary	Comments to industry
		<p>before commencing loading activities outside daylight hours.</p>
<p>Dangerous incident IncNot0048930 Underground metals mine</p>	<p>A boilermaker suffered an electric shock while operating a metal inert gas (MIG) welder at the screen building. The boilermaker was leaning against the screen while welding, creating an earth path from his elbow to the screen.</p> 	<p>Mine operators should verify that workers carrying out welding activities have identified appropriate earthing points, their personal protection equipment (PPE) is dry, and they are appropriately trained. Welding machines must be isolated when not in use.</p> <p>Appropriate electrical protection must be in place on all portable electrical equipment. Portable equipment leads should be regularly tested and tagged. Any leads with visible damage should be repaired or discarded before use. Refer to:</p> <ul style="list-style-type: none"><li>• <a href="#">Technical reference guide – Hot work (cutting and welding) at mines and petroleum sites.</a></li><li>• <a href="#">Safety bulletin SB19-03 Welding-related electric shocks increase</a></li></ul>

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## Other Resources Regulator publications

### Investigation information release IIR25-04 Worker seriously injured after roof collapse engulfs drill rig at gold mine

The Resources Regulator in NSW has launched a causal investigation to understand the factors that led to a worker injury and drill rig engulfed after a significant roof collapse. The incident occurred at Cowal Gold Mine, operated by Evolution Mining Pty Ltd, on 9 March 2025.

During operations, a significant roof collapse occurred, the jumbo drill rig and operator cabin was engulfed and partially buried. The drill rig operator suffered a laceration while extricating himself from the jumbo and material, but the offsider was not injured.

The Regulator’s investigation will consider the cause and circumstances of the incident, including operation of plant and equipment involved and practicable steps available to guard against it.

The Regulator has provided some guidance material, which can be found in the investigation information release.

Following the completion of the investigation, an investigation report will be published.

[Read the investigation information release \(PDF, 284.62 KB\)](#)

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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