NSW Resources
Resources Regulator

Weekly incident summary

Week ending 28 March 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	36
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0048820 Construction materials Roads or other vehicle operating areas	A haul truck lost power on a ramp and rolled 30 metres backwards before coming to rest on a bench. The operator had stopped on the ramp with the motor running, waiting for another task to be completed. When the task was completed, the operator put the truck in gear, released the handbrake and took his foot off the footbrake to accelerate. The engine cut out and the truck began rolling backward. The operator pumped the footbrake and pulled the retarder up and down multiple times with no result. He couldn't use the secondary retarder as he was trying to steer the truck. He managed to steer the truck over a water diversion bund and bring it to a halt.	Mine operators must have systems in place to ensure the regular review and effectiveness of fit-for-purpose safety critical components over their lifecycle. This includes driving, braking, steering and emergency systems. Further information may be published later.

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Incident type	Summary	Comments to industry
	The cause of the failure is being investigated. 	
Dangerous incident IncNot0048838 Underground metals mine	A diamond drill offsider was hit in the abdomen and pinned against a wall by the rear of a drill string. The offsider was walking past the back of the drill string, where there was minimal space, when the drill operator selected the rod pulling option instead of the rod feeding option, resulting in the offsider being hit and trapped when the joystick was engaged. The offsider was taken to hospital to assess his injuries. 	Drill operators need to remain aware of their offsider's location when pushing and pulling rods. The carriage should not be moved if you are not aware of their position in relation to the rig. Positive communications should be established to confirm the offsider's location and to alert them when the drill is about to be activated. Mine operators should reinforce the application of drilling procedures, including the need for positive communications.

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Incident type	Summary	Comments to industry
Dangerous incident IncNot0048800 Underground coal mine	A mechanical tradesperson was driving a personnel transport inbye along a travel road, when he noticed that when he took his foot off the accelerator pedal, the engine remained at high revs. He slowed the vehicle down with the footbrake, placed the transmission in neutral and coasted into the nearest cut through. The machine failed to shut down when the main isolator was turned off. The operator shut the machine down using the strangler valve. The cause of the failure was an internal fault in the fuel pump. A linkage in the top of the fuel pump broke, and became jammed, causing the fuel rack to remain open.	This incident highlights the importance of the emergency shutdown system being able to immediately stop the machine in these circumstances. Over-revving of explosion protected diesel engine systems (Ex-DES) in a methane-rich environment presents a heightened risk. Maintaining plant in a fit-for-purpose condition is paramount. Refer to: SA05-08 Danger of methane explosion from diesel engine systems SA09-02 Diesel engines run on methane enriched atmosphere

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, Fatal slip or fall of person accident, final report** On August 4, 2024, at 12:58 pm, Curtis Diggs, a 45-year-old industrial technician from Waste-Pro USA with one month of mining experience, stepped into an opening in the floor created by the removal of a sump pump and suffered thermal and chemical burns to his body. On September 2, 2024, Mr Diggs was pronounced dead from his injuries. The accident occurred at the number 5 filter in the calcination section of the mill. The floor level of the unit contained about 2.5 to 10 centimetres of caustic, ore, and hot water estimated at 200 degrees Fahrenheit. The caustic liquid was a corrosive chemical that could cause severe skin burns and eye damage. The caustic liquid was not clear, which limited the miner’s visibility to see the opening on the floor. Investigators determined this condition contributed to the accident. The incident occurred because the mine operator did not: 1) install barricades or covers on the opening in the floor 2) maintain the floor area in a dry condition 3) conduct workplace examinations and correct hazardous conditions. 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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