Weekly incident summary

Week ending 16 May 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	37
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0049082 Open cut coal mine Fire or explosion 	A boilermaker was using a grinder while working on the chassis rails of a dump truck. The sparks from the grinder ignited a trolley-mounted tray containing brake-cleaning fluid that was beneath the truck. One worker moved the trolley clear of the truck and 2 workers attempted to smother the fire with cloths. Unfortunately, this only added fuel to the fire. The trolley was wheeled outside the workshop and tipped over, allowing the burning liquid to spread across the ground. Another worker used a dry chemical powder extinguisher to put out the fire. Nobody was injured during the incident, although workers were exposed to	Workers are reminded that they have duty under the Work Health and Safety Act to comply with all reasonable instructions, policies and procedures that mines have in place. Mine operators must have processes in place to ensure that the controls identified within site procedures and permits are implemented. Workers must be trained regularly about how to respond in an emergency such as a fire. Workers should be aware of the location of emergency equipment and mine operators should conduct regular emergency management training. Work procedures should not allow for flammable liquids to be in the vicinity of hot work.

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Incident type	Summary	Comments to industry
	smoke, extinguishing medium and the fire.  	
Dangerous incident IncNot0049096 Underground metals mine	A worker suffered an electric shock when his finger made contact with the plug of a welder while he was fault finding in a boilermaker bay. The welder was unplugged during testing, indicating a possible fault within the welder.	The Resources Regulator is concerned about the increasing number of electric shocks being reported across the industry recently. Mine operators are reminded that they must ensure that equipment is fit-for-purpose and maintained in a state without risk to workers, with regular maintenance and inspection systems in place. Refer to the Safety Bulletin: • SB20-03 Electric shocks in the mining industry
Dangerous incident IncNot0049100 Construction materials	A boilermaker has suffered an electric shock from a caddy welder.	People involved with welding activities should remain insulated from their welding jobs. Welding gloves are not electrical insulators. Damp gloves and clothing can increase the likelihood of suffering an electric shock. Appropriate electrical protection must be in place on all portable electrical

Incident type	Summary	Comments to industry
		equipment. Portable equipment leads should be regularly tested and tagged. Any leads with visible damage should be repaired or discarded before use. Refer to: • Technical reference guide- Hot work (cutting and welding) at mines and petroleum sites. • SB19-03 Welding-related electric shocks increase

Other Resources Regulator publications

Investigation report: Serious injury to a worker conducting work on a mobile screen

The Resources Regulator in NSW has issued an investigation report into an incident in 2023 where a worker's arm was surgically amputated by emergency services personnel to free him after it was entangled in the idler drum of a moving conveyor belt on a mobile screen.

Investigators found several factors contributed to the worker being exposed to the risk of serious injury or death, including that it was common practice for workers to track the mobile screen's conveyor belt with the guards removed.

The investigation also identified numerous instances where health and safety features of the mobile screen including guarding, emergency stops and lanyards were not installed, removed or not functioning appropriately.

Read the full investigation report and its recommendations to industry (PDF, 907.81 KB).

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
	International (fatal)
MSHA	**USA - Fatal powered haulage accident, final report** Luis Sanchez-Robles, a 22-year-old thin-veneer saw operator with 7 months of mining experience, died after a pallet of stone weighing about 2132 kg was lowered onto him on 30 January 2025 at 3:30 pm. Mr Sanchez-Robles drove his personal vehicle to the thin-veneer saw area and began cutting stone to customer specific dimensions. At 2:45 pm Wilberth Balderas, Thin Veneer Saw Lead, instructed Mr Sanchez-Robles to change material and start using the Lueders charcoal gray blocks. At 3:25 pm, Mr Sanchez-Robles motioned for Roberth Gonzalez, the front-end loader operator, to bring another pallet of stone. While Mr Gonzales was bringing the pallet of stone, Mr Sanchez-Robles was moving a

Publication	Issue/topic
	large piece of stone that had fallen in front of the staging platform. Mr Gonzalez approached the staging platform in the front-end loader, lost sight of Mr Sanchez-Robles, and unknowingly lowered the pallet of stone onto him. Mr Balderas shouted at Mr Gonzales to stop and lift the pallet of stone off Mr Sanchez-Robles. When the pallet was lifted, Mr Sanchez-Robles stood up and fell backwards onto the staging platform. The incident occurred because the loader operator was moving the loader while his visibility of the staging platform and the miner was blocked. Details
MSHA	USA - Fatal powered haulage accident, final report Troy Tarr, a 32-year-old haul truck operator with 9 weeks and 2 days of experience, died when the ground at the dump point failed, causing the haul truck to roll over multiple times and come to rest at the base of the primary crusher stockpile on 5 November 2024 at 1 pm. The incident occurred because the mine operator did not: 1) ensure the dump point could support the load of the haul truck 2) conduct an adequate examination that would ensure the haul truck operator dumped material a safe distance back from the edge of the unstable dump point 3) ensure that the haul truck operator wore a seat belt. Details
	National (other, non-fatal)
Resources Safety & Health Queensland	**QLD - Uncontrolled movement of coal stacker boom** A raw coal stacker boom was in the process of lowering into position when it rapidly and unexpectedly luffed up fully. Although a coal mine worker was on board at the time, he was not injured. Initial investigations indicate the hydraulic luffing cylinder detached at the bottom due to bolts failure, allowing the mass of the counterweight to drive the boom into the air. Learnings: • It is recommended that stackers and other mobile equipment for handling bulk materials be assessed by a structural specialist against the requirements of the latest standard. • Develop and implement plans to meet the intent of current design and operations standards. • In particular, pay attention to the configuration where a luffing hydraulic cylinder (or the parts it is attached to) is operating in tension and a component fails. • Note that components such as bolts tend to wear or corrode over time. Safety factors that had been built in when new reduce accordingly. • A dual cylinder design is often safer if, in case of a failure, the second cylinder is able to hold the boom. Details

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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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