Weekly incident summary

Week ending 2 May 2025

This incident summary provides information on reportable incidents and safety advice for the NSW mining industry. To report an incident to the NSW 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	47
Summarised incident total	4

Summarised incidents

Incident type	Summary	Comms to industry
Dangerous Incident IncNot0049004 Open cut coal mine Roads or other vehicle operating areas	While travelling on a wet section of road, an empty haul truck lost traction as a mobile manufacturing unit (MMU) was passing on the opposite side. The haul truck slid along the road and crossed the centre line before ending up at 180 degrees from the intended direction of travel. The haul truck missed colliding with the MMU by about 8-9 metres.	Workers must operate vehicles at a speed that is appropriate to the prevailing conditions. Mine operators should ensure that, after rain events and when operating in wet weather conditions, adequate systems are in place (including statutory inspections) to check road conditions and communicate these conditions to the workforce. When developing control measures to manage the risks of operating vehicles, mine operators must consider

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	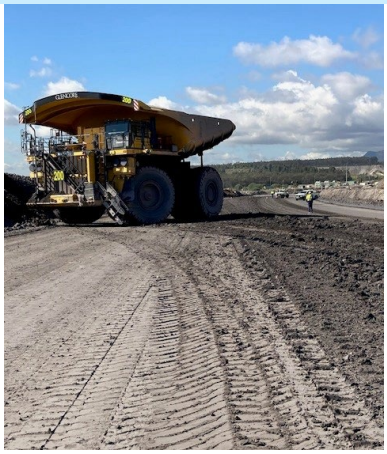	mobile plant operating characteristics including stopping distances, manoeuvrability, and speeds for both loaded and unloaded vehicles.
Dangerous Incident IncNot0049015 Industrial minerals Choose an item.	Two fitters finished a job in an elevated work platform (EWP) and were about to travel back to the park area while still in the basket. The workers tried to retract the outriggers but they failed to work, so they attempted to elevate the basket to free up the hydraulics. The basket, which was about 5 m off the ground, then tipped forward. The EWP safety system activated, and the workers safely lowered to ground. The EWP was a hired unit. 	Mechanical engineering control plans must set out the control measures for the unintended operation of plant. This must include function testing as part of the introducing plant to site process, and pre-use inspections by operators. Mine operators should ensure: • all pieces of hired equipment have a thorough mechanical and electrical inspection to assess the plant's operation • thorough pre-work inspections are carried out by competent people • hired equipment is maintained in accordance with a suitable maintenance strategy considering the original equipment manufacturer's recommendations and relevant Australian Standards. For elevated work platforms (EWPs) this should include AS 1418.10 and AS 2550.10.

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Incident type	Summary	Comms to industry
Dangerous Incident IncNot0049020 Open cut coal mine Roads or other vehicle operating areas	A CAT 992K wheel loader was travelling slowly up a ramp approaching the centre haul road intersection. The operator failed to see a light vehicle (LV) with 2 occupants onboard, waiting at the intersection. The LV was waiting to turn right onto the haul road. As the loader approached from behind, the LV operator became aware that it was getting into close proximity and took evasive action turning left onto the active haul road to avoid a collision. The loader operator was unaware that the LV was in its travel path and failed to stop, continuing through the intersection. It was not until the loader operator was contacted via the two-way radio that they became aware of the near-miss event. The bucket carry position on the loader may have been a contributing factor to reducing visibility for the operator.	Inattention and distraction while driving can have fatal consequences. Vehicle operators must maintain situational awareness and remain focused on the task to manage risks while driving. The operator must ensure that their visibility is not impeded before proceeding to drive. Principal hazard management plans for roads or other vehicle operating areas should consider all factors that may affect operator concentration. Collision detection and avoidance systems, visual aids, and segregation should be implemented before relying on procedural controls.
Dangerous Incident IncNot0049024 Open cut coal mine Choose an item.	Three workers were securing a dredge cab onto a truck trailer using straps when the cab gradually rolled off the trailer and fell to the ground. One worker was tightening a strap at the time the cab began to topple and had to take evasive action. The cab weighs about 2 tonnes. 	Mine operators must have systems in place for loading, securing and transporting plant and associated components of plant. Workers must be trained and deemed competent prior to participating in the loading and securing of plant. Operators must identify the risk of loads shifting, especially when there is steel on steel contact and where there is the potential for a load to shift or topple if straps are overtightened.

Other publications of interest

The incidents are included for your review. The NSW 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)
US Mine Safety and Health Administration (MSHA)	17 April 2025 On 29 January 2025, at approximately 7:20 am, Steven Fields, a 55-year-old drill operator with 20 years of mining experience, died when rock fell from a highwall and struck the cab of the drill he was operating. At approximately 7:20 am, Ethan Rogers, Front-End Loader Operator, was tramming his front-end loader into the pit and saw a large rock fall from the highwall onto the drill operated by Fields. Rogers called out to Fields on the radio but received no response. Hager was in his pickup truck near the pit and heard a "thump." Hager drove his pickup truck into the pit, ran up to the drill, and determined Fields passed away due to the extent of the damage to the drill's cab. The incident occurred because the mine operator did not: 1) ensure the drill operator did not work under a dangerous highwall 2) ensure hazardous areas were scaled before work was performed in the pit 3) conduct an adequate examination of the highwall 4) provide adequate experienced miner training to the drill operator. Details
	National (other, non-fatal)
WorkSafe Victoria	30 April 2025 **WA - Operator ejected from cabin was not wearing seatbelt** A quarry employee was operating an articulated dump truck (ADT) on a haul road. The ADT's front right wheel hit a windrow, causing the vehicle's cabin to rock violently. The force of the rocking ejected the operator from the cabin. The ADT continued along the haul road under its own power until it travelled over an edge and overturned. The ADT operator, who was admitted to hospital with serious injuries, was not wearing a seatbelt at the time of the incident. 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	
ISSN:	2982-1010 (online)
CM9 reference	D25/22950
Mine safety reference	ISR25-18
Date published	9 May 2025
Authorised by	Deputy Chief Inspector Office of the Chief Inspector