Weekly incident summary

Week ending 13 June 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	2

Summarised incidents

Incident type	Summary	Comments to industry
Serious injury IncNot0049234 Open cut coal mine	A fitter had several fingertips amputated when his hand was crushed in a hoist cylinder while he was trying to replace a torque converter seal on a water truck.	Mine operators must have clearly defined procedures that are enforced via supervision when workers are engaged in tasks involving moving parts that have significant stored energy. The hierarchy of controls must be considered when determining the controls to be implemented to minimise/eliminate risk to workers. Workers entering within the footprint of operating mobile plant for testing or inspecting must do so in accordance with site procedures. The shift supervisors review of the job safety and environmental analysis (JSEA) must specifically verify that the allocated controls have been determined with consideration for the hierarchy of controls.

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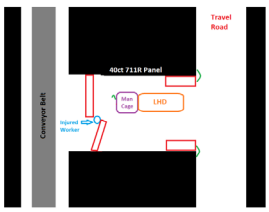
Incident type	Summary	Comments to industry
Serious injury IncNot0049256 Underground coal mine	While conducting a major ventilation change, a ventilation officer was crushed between a set of double doors. The incident occurred on the inbye set of doors where the restraining device to hold the door open to the rib line failed, allowing it to swing shut while the ventilation officer was trying to open the second door. The officer was released from between the doors when a load haul dump (LHD) pulled the door open. Before this, manual attempts by workers to open the door had failed. The worker suffered displaced rib fractures in both front and back of the right ribcage and a scapula fracture. Incident Scene after door to rib securing failed  	Ventilation pressure is a known hazard and mine operators' procedures for major ventilation changes should identify controls for the associated risks. Mine operators must have a procedure in place for major ventilation changes. The procedure should also outline the sequence to follow when opening and/or closing doors including how doors are to be restrained. Mine operators should check machine doors to ensure that suitable restraints are in place when opened. Workers should not be put in a position where they can be caught between doors.

Other Resources Regulator publications

Rock falls from unsupported face, hitting worker

The Resources Regulator in NSW has published a safety alert after an incident in which a worker was hit on the head and shoulder by a 2-3 tonne rock, highlighting the dangers of working near unsupported ground.

Two workers were changing an underground development face when a large rock dislodged from a wedge failure at the face, at a height of about 2.5 metres.

The Regulator has investigated the incident and published a list of recommendations, as well as a supporting video for industry.

Read the full safety alert (PDF, 206.85 KB)and watch the video.

Worker struck by conveyance in winder shaft

The Resources Regulator in NSW has published an investigation information release after an incident where a worker was hit when the man cage was being lowered through the stage.

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Read the Investigation information release IIR25-05 Worker struck by conveyance in winder shaft.

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 (other, non-fatal)
MSHA	**USA - Safety alert: Bulldozer incident** A bulldozer fell into a void above a feeder on 22 May, 2025. The loose material from the coal pile collapsed around the bulldozer, engulfing the bulldozer and trapping the miner inside the cab. The bulldozer was equipped with a submarine kit, consisting of high-strength glass, self-contained self-rescuers, and two-way communication. Between January 2020 and May 2025, there were 7 entrapment accidents involving bulldozers. Best practices: • Maintain stability. Do not operate equipment directly over feeders and clearly mark the location of the draw holes. • Identify and communicate significant changes in feed rate that may indicate the presence of a void in the stockpile. • Stock equipment cabs with safety equipment. Include emergency oxygen, remote shut offs, and two-way communication. Ensure all safety devices are properly maintained. • Install high-strength glass certified for at least 40 psi with a frame and supports designed to withstand the added loading of entrapment conditions. • Train miners and other people at the mine to identify and address or avoid hazards related to surface mobile equipment. • Always wear seatbelts when operating mobile equipment and stay in the cab to ensure safety. • Identify currently available and newly emerging feasible technologies that can enhance safety at the mine and evaluate whether to adopt them. 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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