

Weekly incident summary

Week ending 18 July 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	39
Summarised incident total	3

Summarised incidents

Incident type	Summary	Recommendations to industry
Dangerous incident IncNot0049471 Open cut coal mine	The wheel of an articulated dump truck dislodged from the wheel assembly while in operation, causing the cab to come to rest on the ground. The dump truck had completed its ninth load for the day and was unloaded when the incident occurred. The wheel nuts became loose and eventually stripped the thread on the wheel studs, causing the wheel to become dislodged from the assembly. The machine was recently purchased at an auction by the contracting company.	Before use at a site, plant should be assessed against the mine's introduction to site process. Introduction to site should include: • checking the mobile plant to the mine's engineering standards and their mechanical engineering control plan • checking the functionality of all safety critical systems • checking the plant has been maintained and is in a fit-for-purpose condition to enter the mine site. All plant should have pre-start inspection undertaken by a trained and competent person to ensure the plant is safe to operate.

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Incident type	Summary	Recommendations to industry
		Refer to <u>MDG 15 Mobile and transportable plant for use on mines and petroleum sites for further guidance.</u>
Dangerous incident IncNot0049472 Open cut coal mine Ground or strata failure 	While backing up to tip a load, the windrow slumped causing a dump to drop down at the rear. Preliminary investigation suggests that soft material at the toe of the dump caused the windrow to fail. 	When designing a dump, ground stability should be a primary consideration. Material consistency, wet conditions and dipping ground stability should be considered. Inspections should verify dump integrity. Areas that do not meet the standard should be demarcated, communicated and remediated to meet the standard.
High potential Incident IncNot0049440 Underground coal mine	A mine loader was unable to be restarted after shutting down. The low water shutdown float was modified with a piece of rubber hose attached to the float arm to seal off the air pressure for the safety circuit. The float was retained with a safety clip and not the recommended stainless steel split pin. 	Alterations to design-registered plant is not permitted unless authorised. The low water shutdown float is a critical control of the diesel engine system that ensures a water barrier is present to prevent propagation of flames or sparks from the diesel engine system. Mine operators must have controls in place to ensure work carried out on explosion-protected diesel engine systems (ExDES) is authorised and carried out by people who are trained and competent for that work. Fitters who are required to work on ExDES should be trained on the specific requirements for maintenance and repair of ExDES to ensure that engine maintenance is

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		carried out in such a manner as to maintain the explosion-protection properties and engine system reliability. Maintenance work orders are to be reviewed upon completion with additional work orders raised for any emerging or not completed work.

Other Resources Regulator publications

Worker seriously injured by ventilation double doors

The Resources Regulator has published a safety alert following an incident that occurred during a planned major ventilation change involving a set of double machine doors, on 13 June at a mine in the Wollongong region.

One worker suffered significant injuries after becoming trapped between the doors, highlighting the risks associated with uncontrolled movement of ventilation infrastructure under pressure.

The Regulator has published a list of recommendations to prevent further incidents. There is also a supporting video.

[Read the full safety alert \(PDF, 384.14 KB\)](#) and watch the [video](#).

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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