Weekly incident summary

Week ending 4 April 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	45
Summarised incident total	3

Summarised incidents

Incident type	Summary	Comments to industry
Dangerous incident IncNot0048853 Open cut coal mine Roads or other vehicle operating areas 	A dozer rolled onto its side when travelling over wet material on one track and mounted a large rock with the other track. The operator was able to exit the dozer and was unharmed. 	Pre-task inspections of work areas should be undertaken to identify and manage hazards. This includes confirming lighting is adequate for the tasks being conducted. Dozer operators should remain situationally aware while the dozer is in motion and continually assess the work area for hazards. Pre-task inspections of work areas must be monitored and confirmed by supervisors. Refer to the safety bulletins: SB19-01 Rise in dozer incident putting operators at risk SB19-10 Dozer incidents increase despite warnings
Dangerous Incident IncNot0048854	While dumping a load at a tip head, the ground gave way beneath haul truck,	Tip heads and dumps must have suitable inspection regimes in place. Changes in conditions, such as wet

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Open cut coal mine Roads or other vehicle operating areas 	causing the back of the truck to sink up to the axle. 	weather, should trigger an increase in inspection frequency. Design of dumps and catch bunds should consider areas where water can accumulate. When dumping near bodies of water or mud, strict controls should be implemented based on robust risk assessment processes. Refer to the safety bulletin: SB20-01 Failure of highwalls, low walls and dumps.
Dangerous incident IncNot0048860 Underground coal mine	The operator of a load haul dump (LHD) machine carrying a concrete kibble applied the park brake so that a worker could operate the controls on the kibble to empty out the concrete. The worker observed that the kibble had tilted and moved away from the area adjacent to the kibble. The kibble released from the LHD quick detach system (QDS) plate, falling from a height of about 2 metres to the ground. Nobody was injured. 	When attaching equipment to a QDS, operators should ensure that there is a reliable connection between the tongue of the QDS and the attached implement before engaging in any activity. Workers should have the necessary information and training in QDS adaptors to carry out reliable connections.

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	Jose Lara, a 52-year-old continuous mining machine operator with over 16 years of mining experience, died when a portion of the mine roof fell on him on 25 September 2024 at 12:03 am. The accident occurred after Mr Lara travelled inbye the last row of roof support to extend the tubing slider after a cut was taken. The incident occurred because the mine operator did not ensure all miners worked or travelled under a supported roof. Details
MSHA	William Harger, a 64-year-old electrician from Eaton Corporation, with over 38 years of electrical experience, was burned from an arc flash from 4,160-volt components in an electrical panel on 9 August 2024 at 2:47 pm. On August 22, 2024, Harger died from his injuries. The accident occurred because the mine operator and the contractor did not: • ensure that the disconnecting device to an electrical circuit was locked out and tagged out before work began • ensure proper protective equipment was worn before working in an energized electrical panel • ensure that the contracted electrician received the proper site-specific hazard awareness training. Details
MSHA	Grzegore Sychla, a 58-year-old electrician with over 10 years of mining experience, died after being hit by an underground LHD machine on 7 November 2024 at 5:40 pm. According to interviews, Mr Sychla travelled underground to the electrical rebuild shop and began his regular duties of repairing motors for various equipment. At 5:05 pm, the crusher in unit 43 stopped functioning. Corey Cline, underground maintenance supervisor, called Mr Sychla on the underground phone and assigned him to troubleshoot the crusher. Mr Sychla travelled to unit 43 in a utility vehicle and parked in the crusher control panel area. At 5:40 pm, Mr Sychla reset the breaker and put the crusher back into operation. Mr Sychla got into his utility vehicle and began to back out of the crusher control panel area. At the same time, Travis Stigall, production operator, who had been operating an LHD machine to clean up overspill from the crusher's feed hopper, was travelling forward into the crusher control panel area with the LHD bucket raised approximately 93 cm off the floor. The LHD collided with Mr Sychla's utility vehicle, pushing it approximately 3 m forward and causing Mr Sychla to either fall or jump out of the utility vehicle. Mr Sychla was then run over by the front left tyre of the LHD. The LHD loader was then put in reverse, dragging the utility vehicle underneath the LHD bucket for 3 m, until Mr Stigall saw Mr Sychla on the ground.

Publication	Issue/topic
	The incident occurred because the mine operator did not place signs or signals that warned of hazardous conditions at appropriate locations. Details
	National (other, non-fatal)
WorkSafe WA	Autonomous trucks were hauling mine waste on night shift at an open pit mine. The control room operator directed an autonomous haul truck to turn right at an intersection and perform a loop so it could be positioned under an excavator bucket on the pit floor. The intersection and turnaround loop existed in the control system, but the intersection was not physically signposted or marked on the ground to alert manually operated vehicles. A manned water cart was travelling in the opposite direction when the autonomous truck was about to turn to right. The water cart driver was not aware of the autonomous truck's assigned path and, on recognising it, tried to take evasive action. The two vehicles collided, resulting in significant damage to the autonomous truck. The water cart driver received minor injuries. Direct causes: • The travel paths of the autonomous truck and water cart intersected. • The turnaround loop for the autonomous truck was released for use in the control system but the corresponding intersection was not delineated on the ground, nor its intended use communicated. • On detecting the water cart in its assigned path of travel, the autonomous truck's speed (about 40 km/h) and response time meant it could not prevent the collision. Contributory causes: • The change management processes for planning and assigning roads in the control system were inadequate. • An awareness system was set up in the water cart to allow the driver to monitor the autonomous truck's path. However, at the time of the collision, the water cart driver was not fully aware of the intended path of the autonomous truck. Details
WorkSafe WA	A haul truck arrived at a workshop for maintenance with no tyres fitted in position 4 or 5 in February 2020. The position 6 tyre casing blew out 15 days later. Four workers were working on the haul truck near the tyre. One worker was thrown backwards by the percussive shock wave and knocked unconscious. Two other workers suffered minor injuries (ringing in ears and light bruises). The workshop walls were damaged, and projectile shrapnel was found up to 17 m from the position 6 tyre. During the 15 days, the truck had not moved, and the tyres were cold. The tyre casing that failed was a 46/90R57 size, of steel radial construction and with only 2,000 hours of recorded service. Direct causes: • The direct (physical) cause was cut damage on the outside edge of a tread lug of the tyre. This exposed the steel reinforcing layers to air and moisture resulting in progressive corrosion and separation damage that reduced the integrity of the tyre casing to resist internal pressure.

Publication	Issue/topic
	Contributory causes: • The tyre was not disposed of when it was removed from service in October 2018. It had a large cut caused by a rock during operation which, over time, allowed moisture to enter the steel cord area causing corrosion. • The tyre was stored in the elements for 16 months before being fitted to transport the truck to the workshop. • The decision to return the discarded defective tyre to service was not based on an inspection and assessment by a suitably competent person. • The site did not have a safe system of work for the inspection of tyres used for transportation purposes. • The damage to the tyre was not obvious due to the steel cord corrosion being internal. • People in the workshop were working near fully inflated tyres. 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	
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