QUARTERLY REPORT

Extractives industry

2025/26 Q2

October to December

Te Kāwanatanga o Aotearoa
New Zealand Government

WORKSAFE
Mahi Haumaru Aotearoa

About this report

This quarterly health and safety performance report has been prepared by WorkSafe New Zealand to provide extractives-specific information to mining, tunnelling and quarrying operations in New Zealand.

The information is derived from a variety of sources but the predominant source is industry itself, through notifiable incident reporting and quarterly reporting.

The report also contains information on the activities of the regulator, as well as commentary on industry performance and focus areas for regulation.

Operators should use the information presented in this report to assist them in improving safety management systems and undertaking risk assessments at their sites.

Foreword

Our goal is to lift New Zealand's performance towards world-class. Achieving this requires the commitment not just of WorkSafe, but of businesses, workers, duty holders and a wide range of other players in the health and safety system.

We want to drive better health and safety outcomes, lower the rates of harm, and build strong health and safety culture. Everyone has a role to play. Businesses must know their risks, manage them, and strive to continually improve.

As health and safety regulator, our work centres around influencing, supporting, and – when it matters – holding people to account. It's important that we're proportionate, practical, consistent and clear in all we do.

The Minister of Workplace Relations and Safety has set clear expectations for WorkSafe to take an engagement-first approach rather than enforcement-led. This means supporting businesses to manage risks proportionately, enabling industry-led guidance, and ensuring our enforcement decisions focus on clear breaches.

These expectations are in line with the work already underway to deliver the WorkSafe strategy, as well as the Health and Safety Reform work programme.

As part of those reforms, the Government has recently introduced a bill to amend HSWA. The amendment bill proposes a few changes to legislation, including refocusing the work health and safety system on critical risks, limiting duties for small businesses, strengthening approved codes of practice, reducing notification requirements, and clarifying duties for specific duty holders.

The amendment bill must make its way through the parliamentary process before changes are made. WorkSafe will continue to act on its role and support businesses with the information they need to meet their obligations. While the specifics are not yet known, we know that our commitment – and that of the extractives industry – remains the same: to creating safer, healthier, and more resilient workplaces.

This can also serve as a reminder that change management is a critical component of continuous improvement, and of health and safety.

There have been changes to the Mining Regulations, spread over four years, and changes to the competency requirements stated in the Safe Work Instruments for Extractives safety critical roles. Let's not miss the basics, such as ensuring written copies of legislation are up to date.

By staying informed, managing risks, and continually improving, all players in the health and safety system can keep getting closer to that goal.

Paul Hunt
Chief Inspector Extractives

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1.0 Industry profile

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1.2 People

1.3 Developing competence

1.1 Operations

3

Metalliferous opencast mines
Includes 1 mine under rehabilitation

21

Coal opencast mines
Includes 1 mine in care and maintenance

8

Metalliferous underground mines
Includes 1 mine under care and maintenance and 2 operating tourist mines

1

Coal underground mines
Includes 1 tourist mine under care and maintenance

4

Tunnels
Does not include tunnels that notified commencement but did not begin operating in the quarter

2

Coal exploration
Two operational coal exploration projects

72

Alluvial mines
Number of mines that have been verified (57) or have notified of an Appointed Manager to WorkSafe (15)

Includes 2 iron sands mines

994

Quarries
Number of quarries that have been verified (826) or have notified of an Appointed Manager to WorkSafe but not yet verified (168)

An important aspect of understanding the health and safety performance of the extractives industry is to understand its makeup in terms of the number and scale of operations and the number and competency of workers involved.

There were 1,169 active operations in New Zealand as at the end of December 2025.

Active mining operations include those that are operating, intermittently operating, under care and maintenance, or undertaking rehabilitation, as well as tourist mines. Active quarries and alluvial mine numbers include operations that have been verified as actively or intermittently operating (that is, visited by WorkSafe), or have notified WorkSafe of an appointed manager.

1.2 People

1,059

Metalliferous opencast mines

664 FTEs employed by mine operators and 449 FTEs employed by contractors

862

Coal opencast mines

719 FTEs employed by mine operators and 142 FTEs employed by contractors

724

Metalliferous underground mines

581 FTEs employed by mine operators and 143 FTEs employed by contractors

0

Coal underground mines

0 FTEs employed by mine operators and 0 FTEs employed by contractors

85

Tunnels

76 FTEs employed by mine operators and 9 FTEs employed by contractors

1

Coal exploration

4 workers employed by mine operators and 8 workers employed by contractors

665

Alluvial mines

Number of workers is known for 56 of the 72 alluvial mines that are verified and/or have notified of an Appointed Manager. The total number of workers has been extrapolated for the remaining 16 operations

3,279

Quarries

Number of workers is known for 796 of the 994 quarries that are verified and/or have notified of an Appointed Manager. The total number of workers has been extrapolated for the remaining 225 operations

There were 6,675 Extractives FTEs in New Zealand as at the end of December 2025. The numbers of workers will also vary from quarter to quarter. Changes in the number of quarry and alluvial mine workers largely reflect the changes in the number of active operations verified by inspectors. Part of those verifications includes determining the number of workers at each operation.

Note: Typically >95% of mining operations and tunnelling operations submit quarterly reports to WorkSafe, and the numbers of workers are reported directly from these figures.

Quarterly reports were provided by 17 alluvial mining operations (24%) and 226 active quarries (27%). That is the reason for the significant difference between the extrapolated numbers of workers and the actual number of workers reported for these sectors in Figure 2. WorkSafe will continue to extrapolate numbers of workers for quarries and alluvial mines until the reporting percentage has improved.

Figure 1 shows the total hours worked in Q2 2025/26, reported to WorkSafe in the quarterly reporting. The hours are separated into Employees and Contractors.

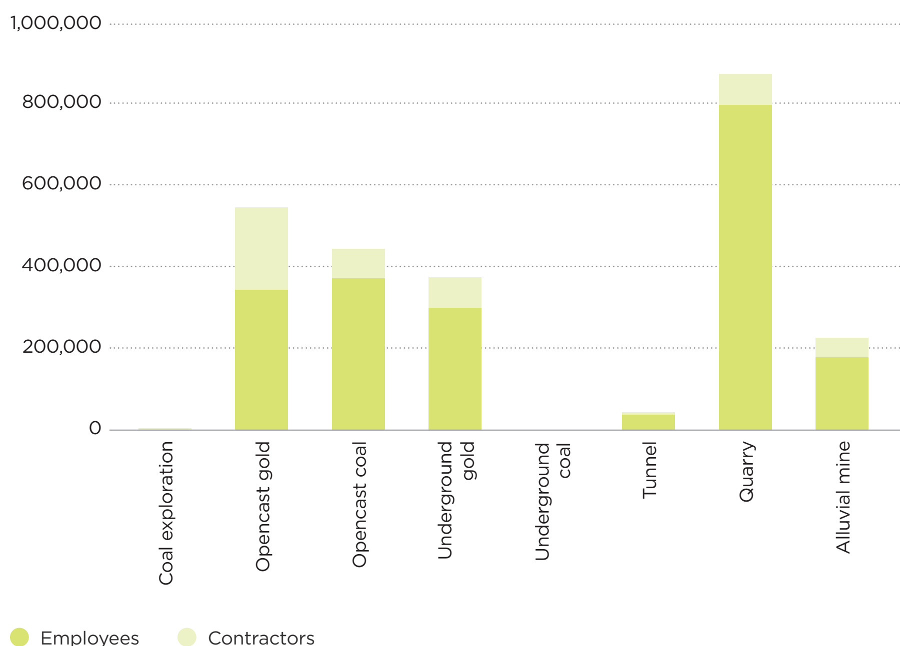

FIGURE 1: Total hours worked by sector 2025/26 Q2

Figure 2 shows the number of Full Time Equivalents (FTEs) calculated from total hours worked that were reported to WorkSafe in quarterly reports for Q2 2025/26. The hours are separated into Employees and Contractors.

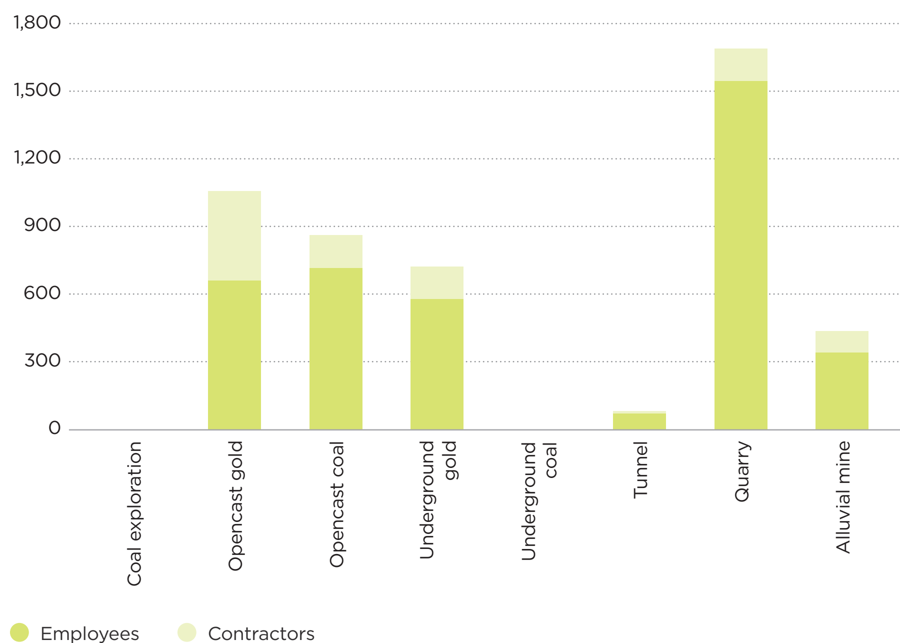

FIGURE 2: Number of FTEs by sector 2025/26 Q2

1.3 Developing competence

WorkSafe has responsibility for setting competency standards in the Extractives Industry. Improving the competence of the people in the industry is one of the most important aspects of improving health and safety performance. WorkSafe appoints the New Zealand Mining Board of Examiners (BoE) to recommend competency requirements, conduct oral examinations and to issue, renew, cancel or suspend Certificates of Competence (CoCs).

The BoE is currently working hard on the increasing numbers of renewals required to be processed each week. For the second time, the original 800 CoCs issued in 2015–2016 when the BoE regime commenced are due for renewal. The first time this occurred was in 2020–2021, and the Board received about 600 renewal applications over 15 months. On that occasion significant time was taken to process some applicants. It was the 'first renewal' phase and applications, and particularly CPD logbooks, were often incomplete. During that time the BoE spent considerable time going back to applicants to assist them to complete the application correctly. Plus, the sheer numbers of applicants made renewals a particularly time-consuming part of the BoE function.

This time around the BoE has set up the processing system to be paper free in general, and the processing of a good number of applicants is happening every week. Note that in Table 2 below, 70 applicants were renewed in Q2 – these were the first of the increased renewal applicants. The pace of processing the subsequent CoC renewals has been maintained, and a good, complete application should be processed in a period of no longer than 2 or 3 working months (none were processed over the Christmas period). Applicants who have incomplete logbooks will be contacted with an opportunity to remedy the application, and these applications might take a bit longer.

In general, the BoE have noticed an improvement in the quality of the applications from last time for those now renewing for the second time.

There have been some delays in scheduling new CoC examinations. For several reasons, the BoE experienced a 200% increase in the number of applications to be examined during July 2025 to December 2025 (87 applications in 6 months versus 85 for the previous full 12 months).

Scheduling the examinations requires the BoE Secretariat to arrange a three person examination panel, and we are dependent on suitably qualified CoC holders being available, all of whom have full-time jobs. This was difficult to achieve over the Christmas period, and resulted in no exams being undertaken from mid-December until the end of January which has created a backlog of applicants.

The BoE has quite a few exams now scheduled for this year and has also started a 'standing exam panel' concept, where we have a group of BoE panel members who commit to being available one day a week to conduct oral examinations, therefore enabling us to schedule three oral exams each week from the waiting applicants as a catch-up action. This process has commenced.

The BoE thinks this approach might be utilised going forward. Currently, we have batched exams for a few weeks each couple of months. This allows us to get the correct CoC holders on the panels and schedule up to thirty exams over a two-week period. While we will still do this, the BoE do see some advantages to having regular exam slots available each week.

Table 1 provides a summary of oral exams conducted during the quarter.

TOTAL NUMBER OF ORAL EXAMS HELD Q2 OCT–DEC 25	TOTAL PASSES	SUCCESS %
35	22	63

TABLE 1: Oral exams conducted

Table 2 provides a summary of all CoCs issued during the quarter and the current number of CoCs in circulation at the end of Q2 2025/26.
Note: We no longer report Life Time CoCs.

COC TYPE	TOTAL COCs RENEWED Q2 Oct–Dec 2025	TOTAL NEW COCs ISSUED Q2 Oct–Dec 2025	TOTAL TTRMA COC ISSUED Q2 Oct–Dec 2025	TOTAL NUMBER OF CURRENT COCs
A-grade Quarry Manager	22	6	0	340
B-grade Quarry Manager	10	5	0	431
A-grade Opencast Coal Mine Manager	9	1	0	57
B-grade Opencast Coal Mine Manager	2	0	0	50
A-grade Tunnel Manager	2	0	0	40
B-grade Tunnel Manager	4	1	0	81
A-grade metalliferous mine manager	0	0	0	2
B-grade metalliferous mine manager	4	1	0	11
A-grade alluvial mine manager	0	1	0	2
B-grade alluvial mine manager	0	0	0	
Site Senior Executive	4	2	0	58
First-class Coal Mine Manager	5	0	0	14
First-class Mine Manager	3	0	0	23
Coal Mine Deputy	2	0	0	24
Coal Mine Underviewer	1	0	0	20
Mechanical Superintendent	0	0	0	23
Electrical Superintendent	0	0	0	23
Ventilation Officer	1	0	0	6
Mine Surveyor	1	0	0	13
Manager to manage the quarrying operation specified in the certificate (Site Specific)	0	0	0	4
Winding Engine Driver	0	0	0	1
Total	**70**	**17**	**0**	**1,208**

TABLE 2: Certificates of Competence issued and in circulation

2.0 Health and safety performance

IN THIS SECTION:

2.1 Notifiable events

2.2 Injuries

2.3 Types of events

2.4 Extractives sector focus areas

2.5 Regulator comments

2.6 High potential incidents

2.7 High potential incidents – investigation outcomes

2.1 Notifiable events

For all extractive operations, notifiable events are required to be reported to WorkSafe under S23(1), S24(1) and S25(1) of the Act, and under Schedule 5 of the Regulations. Notifiable events include any notifiable incidents, notifiable injuries or illnesses, or fatalities.

The tables below show the number of notifiable events and the number of operations that notified events for the previous four years and for Q1 and Q2 of 2025/26 for mines and tunnels (Table 3) and quarries and alluvial mines (Table 4).

MINES AND TUNNELS	2021/22 QUARTERLY AVERAGE	2022/23 QUARTERLY AVERAGE	2023/24 QUARTERLY AVERAGE	2024/25 QUARTERLY AVERAGE	2025/26 Q1	2025/26 Q2
Number of notifiable events	20	21	22	22	26	22
Number of operations that notified events	11	10	11	9	9	6

TABLE 3: Mines and tunnels – notifiable events and operations that notified events

QUARRIES AND ALLUVIAL MINES	2021/22 QUARTERLY AVERAGE	2022/23 QUARTERLY AVERAGE	2023/24 QUARTERLY AVERAGE	2024/25 QUARTERLY AVERAGE	2025/26 Q1	2025/26 Q2
Number of notifiable events	14	17	18	21	15	27
Number of operations that notified events	13	15	17	18	14	25

TABLE 4: Quarries and alluvial mines – notifiable events and operations that notified events

Figure 3 shows the number of notifiable events reported to WorkSafe by sector from January 2024 to December 2025.

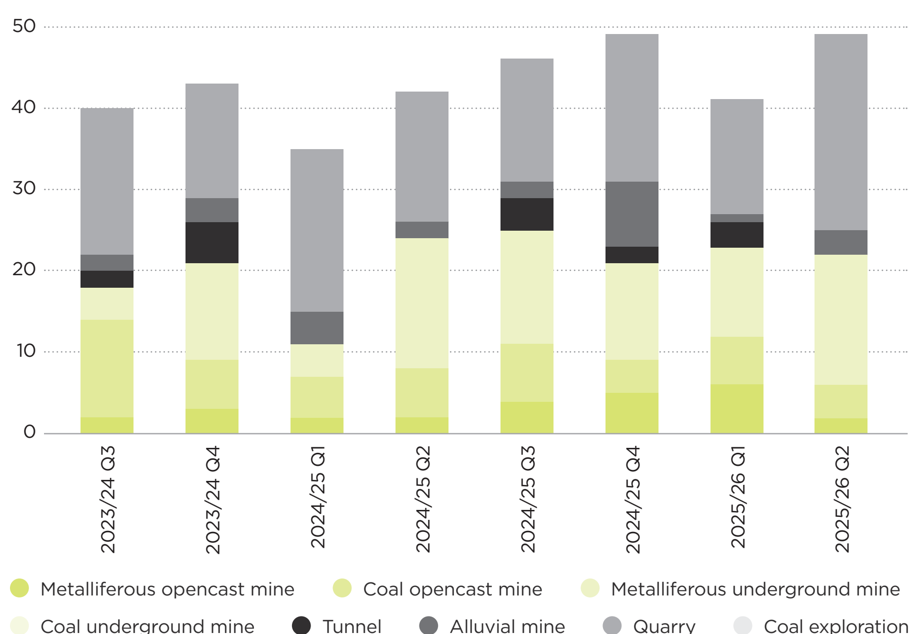

FIGURE 3: Notifiable events by sector

2.2 Injuries

Additional information about injuries is reported to WorkSafe in the form of Quarterly Reports and Records of Notifiable Events under Schedules 6 and 8 of the Regulations.

Figure 4 shows the number of injuries by injury type reported to WorkSafe from October 2022 to December 2025. The graph also shows the rolling 12-month average for the Total Recordable Injury Frequency Rate (TRIFR), the rate of recordable injuries that occurred per million hours worked. The current rolling 12-month average TRIFR is 1.99. Rates have fluctuated over past two years without any clear trend.

While TRIFR is not the only measure indicating the health of the industry, it is a useful indicator of how workers are being injured and should be interpreted in conjunction with other data such as notifiable event information.

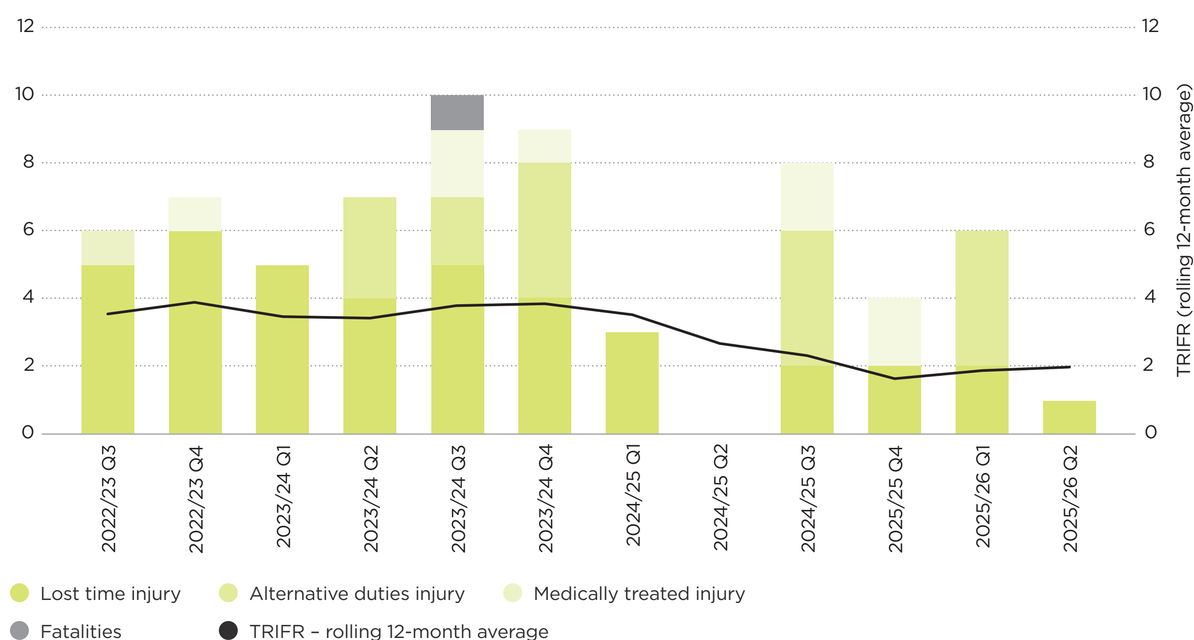

FIGURE 4: TRIFR

The following injury definitions are taken from Schedule 8 of the Regulations:

- **Lost-time injuries** are events that involved injury or illness of a mine worker that resulted in the inability of the worker to work for one day or more (not including the day of the event) during the reporting period (whether the worker is rostered on that day or not).
- **Alternative duties injuries** are events that involved injury or illness of a mine worker that resulted in the worker being on alternative duties during the reporting period.
- **Medical treatment injuries** are work-related injuries to mine workers that required medical treatment during the reporting period but did not require a day lost from work or alternative duties (other than the day of the event).

2.3 Types of events

Figure 5 shows the notifiable event categories for events notified to WorkSafe in the previous 12 months. The data shows that 51% of notifiable events in the past 12 months have occurred in relation to vehicles and plant (34%), and fire, ignition, explosion or smoke (17%). These two categories are broken down in more detail in the following section. A further 12% of notifiable events in the past 12 months occurred in relation to ground, geotechnical and other structural failures.

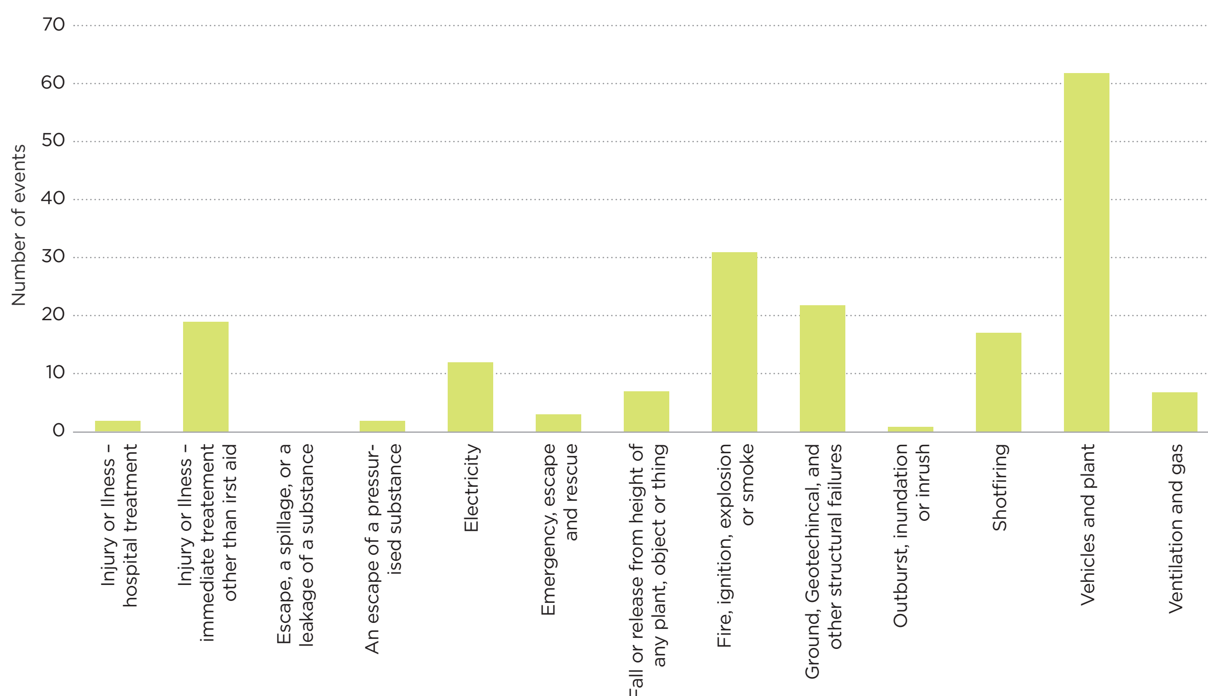

FIGURE 5: Notifiable event categories for the previous 12 months

2.4 Extractives sector focus areas

Where there is a high frequency of notifiable events in any Schedule 5 category, we have broken these events down in more detail to identify key focus areas. We will target our inspections to ensure that operators have adequate controls in place to address these risks.

Figures 6 and 7 break down the two largest notifiable event categories in the past 12 months into the corresponding Schedule 5 sub-categories. The data shows that for notifiable events related to fire, ignition, explosion or smoke, 97% involve fires on plant, mobile plant or in buildings associated with mining or tunnelling activities, and 3% involves the outbreak of a fire on the surface or underground. The vehicle and plant-related notifiable events involve collision of mobile plant with other plant (48%), overturning of mobile plant (39%), and unintended movement or brake failure (13%).

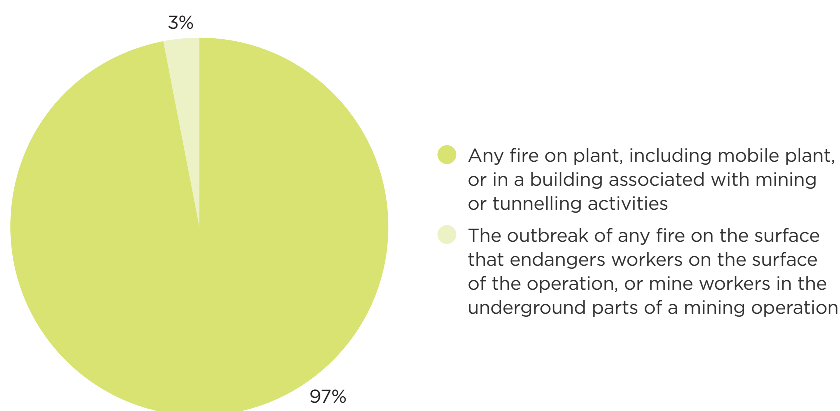

FIGURE 6: Fire, ignition, explosion or smoke-related notifiable event sub-categories

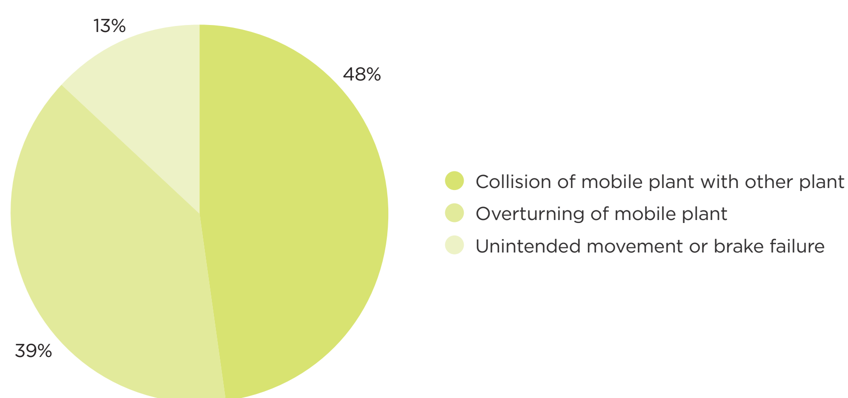

FIGURE 7: Vehicles and plant-related notifiable event sub-categories

Consistency of reporting

Mining and tunneling data are received from a high proportion of those operations and are considered to be accurate. Notifiable events were reported by 15% of operations in the past quarter, and quarterly reports were submitted by 100% of operations this quarter.

Quarrying and alluvial mining data are received from a much lower proportion of those operations and are likely to be less accurate. Notifiable events were reported by 2.3% of operations in the past quarter. Quarterly reports were provided by 17 active alluvial mining operations (24%) and 226 active quarries (27%).

2.5 Regulator comments

Both site managers and WorkSafe inspectors conduct inspections on Extractive sites. Why are there often different outcomes?

Preparation

A WorkSafe inspector normally does some preparatory work to understand the general workplace rules and then sets about the inspection to verify that the standards and practices stated are in fact implemented as the systems describe them. The inspectors will do their best to confirm that the site generally complies but always realise that they are only observing a snapshot of compliance at the time of the inspection.

At an Extractive site, a competent person is allocated the duty of undertaking an inspection on a site by the PCBU; the requirement to inspect is a legal responsibility. The person undertaking the inspection is normally the designated manager or a supervisor.

The person conducting the inspection should understand the site requirements and standards to a high level of detail. They should also have good knowledge of past issues or areas of potential noncompliance based on day-to-day observations. The managers have to ensure that the site is operating safely all day, every day. They should be able to see issues developing or reoccurring and should see patterns and trends developing.

Inspection outcomes

If daily inspections are completed correctly, some issues regularly observed by WorkSafe inspectors should never occur. No one conducting an inspection should ever walk past any hazard or risk which poses an immediate risk of serious injury or death to a person.

For example, they should never walk past:

- unguarded or exposed machinery
- failed lockout or energy isolations
- working at heights without protection (or circumstances where this could occur – rails missing etc)
- unsafe electrical systems
- improper hazardous substance storage or handling
- any equipment that is faulty or dangerous
- workers incorrectly working in such a manner that it creates any hazard, or is not compliant with the site rules
- workers not wearing or using correctly prescribed PPE
- any breach or noncompliance of a requirement that is included in a PHMP, PCP or other health and safety system, that is, inadequate ventilation, non-working water sprays, inadequate bunding etc.

If any of the situations listed are observed during the inspection, work should be stopped and the situation rectified immediately. Too often WorkSafe inspectors find situations which have obviously developed over a period of time which have not been dealt with when they first occurred.

Ensuring that an inspection is completed, and that any safety issues that pose a risk of harm are dealt with immediately, is a basic responsibility for all operators.

2.6 High potential incidents

A high potential incident at a mine, quarry or tunnel is an event, or a series of events, that causes or has the potential to cause a significant adverse effect on the safety or health of a person.

High potential incidents – 2025/26 Q2

Table 5 provides a summary of high potential incidents notified to WorkSafe in Q2 2025/26. The summaries are an abridged version from the operator's notification report.

INCIDENT DATE	SUMMARY	CONSIDERATIONS
Oct 25	While starting the engine of a production drill rig, the cable that connects to the starter motor has smoldered and produced a small flame. The flame was put out by a hand held fire extinguisher, machine battery isolated, scene preserved, site investigation begun and WorkSafe inspector notified.	– Fire or explosion – Mechanical – Emergency management – Supervision – Training
Oct 25	Following the completion of a routine delivery and unloading process, the delivery truck reversed and proceeded through the designated turnaround area. During this manoeuvre, the trailer made contact with the parked light vehicle, causing it to be displaced by approximately one metre. This movement resulted in the front left corner of the light vehicle being forced into the workshop wall. No injuries were reported as a result of the incident.	– Roads and vehicle operating areas – Risk assessment – Supervision – Training
Oct 25	During the blasting, fly rock from blasting has impacted a storage shed inside the exclusion zone. No one was hurt in the event.	– Shotfiring – Risk assessment – Supervision – Training
Oct 25	Dump truck operator had been carting to a feed stockpile for the crusher, and it appears they have backed up too far up the stockpile, causing the dumper to be on too much of an angle to tip off, had raised the hoist and the back end of the dumper has rolled over.	– Roads and vehicle operating areas – Risk assessment – Supervision – Training
Oct 25	Loader operator not checking behind before reversing and collided with another loader.	– Roads and vehicle operating areas – Risk assessment – Supervision – Training
Oct 25	While carting a load to the stockpile area, an operator was trying to miss some potholes. As they veered to the right of the road to miss them, the back tyres went into the swale on the side of the road and this caused the back end of the dump truck to slide, resulting in the tray to be tipped over.	– Roads and vehicle operating areas – Risk assessment – Supervision – Training
Oct 25	Dump area slumping following adverse weather conditions. All bund walls were in place, and the trucks were dumping on the surface. There was no injury to any person and no damage to any equipment.	– Ground or strata instability – Tips, ponds and voids – Risk assessment – Supervision – Training
Oct 25	Excavator operator was mucking out when they came across a booster in the face.	– Shotfiring – Risk assessment – Supervision – Training

INCIDENT DATE	SUMMARY	CONSIDERATIONS
Oct 25	Watercart reversed up a bank and over turned.	– Roads and vehicle operating areas – Risk assessment – Supervision – Training
Oct 25	A loader reversed into a dump truck backing up to dump a load at the feedstock. There was no injuries and only superficial damage to the loader and damage to the front bumper, lights and steps of the dump truck.	– Roads and vehicle operating areas – Risk assessment – Supervision – Training
Oct 25	During operation, the pin a crusher door is hinged on, came undone and fell out. This resulted then in the other side of the door rattling open, and the door fell 2m to the ground. Material started falling out of the door, and the plant operator shut the plant down as soon as they realised what was happening. No persons were in the vicinity at the time.	– Falling objects – Mechanical – Risk assessment – Supervision – Training
Oct 25	During a high wind event, the roof of a shed peeled off. The roof has flown about 100m from the plant.	– Environment – Risk assessment – Supervision – Training
Oct 25	An ADT dump truck entered the switchback corner. Initial investigation seems that the oversize rock being carried has shifted once the ADT rounded the bend and was straightening up, causing the rear inside tires to slide and hold the inside drain for about 15m before catching an edge and has flipped the bin. The cab stayed upright and the driver was not injured in any way, their seatbelt was on and they seemed to be doing a consistent speed for that corner.	– Roads and vehicle operating areas – Risk assessment – Supervision – Training
Oct 25	No injury. Suspected misfire of the explosive charge.	– Shotfiring – Risk assessment – Supervision – Training
Nov 25	ADT came around a bend too wide, wheels ended up in swale of the haul road and they have overcorrected. The tray started swaying and then has gone over.	– Roads and vehicle operating areas – Risk assessment – Supervision – Training
Nov 25	A digger operator unearthed a undetonated booster with the detonator still attached.	– Shotfiring – Risk assessment – Supervision – Training
Nov 25	A large rock has fallen from the high wall on to a blast pattern. The rock fall occurred while the team were loading a drill pattern. The rock landed 2m away from any personal. No injuries occurred. The shot had not been connected for firing.	– Ground or strata instability – Risk assessment – Supervision – Training
Nov 25	Bogger operator turned into a stub where an isolated and unattended agitator was parked. Operator made contact with the chute of the agi.	– Roads and vehicle operating areas – Risk assessment – Supervision – Training
Nov 25	Operator has exited the bogger to check isolation points and noticed smoke coming from the battery compartment. Operator has isolated the batteries, lifted the battery compartment lid and noticed a small flame coming from battery. Operator has activated AFFF system and extinguished flame with the hand held extinguisher.	– Fire or explosion – Mechanical – Emergency management – Supervision – Training

INCIDENT DATE	SUMMARY	CONSIDERATIONS
Nov 25	Operator failed to use pos-comms when entering the work area, backed down the ramp into the dozer as it was pushing out material on ramp. Operator looked to see where dozer was on initial entrance to ramp and proceeded to back down. The dozer had shifted position by the time truck was backing down and made contact with the fuel tank causing damage.	– Roads and vehicle operating areas – Risk assessment – Supervision – Training
Dec 25	While traveling back to the load point after dumping its load, a haul truck was turning at a junction, lost traction and spun around approximately 90 degrees.	– Roads and vehicle operating areas – Risk assessment – Supervision – Training
Dec 25	A wall failure occurred during routine tiphead pushing, resulting in the dozer becoming submerged. The operator evacuated safely, no injuries occurred.	– Ground or strata instability – Tips, ponds and voids – Risk assessment – Supervision – Training
Dec 25	When conducting re-entry personnel identified misfire in the shoulder of the development cut and a second one in the ore drive cut.	– Shotfiring – Workplace inspections – Risk assessment – Supervision – Training
Dec 25	Haul truck collided with a dozer when the dozer reversed into the area where the haul truck was going to dump its load.	– Roads and vehicle operating areas – Risk assessment – Supervision – Training
Dec 25	Loader operator identified that a bolt was protruding out of the truck tub, loader operator attempted to push this down and impacted the top of the truck cab.	– Job planning – Risk assessment – Supervision – Training
Dec 25	The shot was fired on 4 November 2025. It was a poor performing shot due to suspected product issues. Due to the shot failing to move correctly we were digging off the larger rocks on the top of the top of the shot, thowing them down the face and then using the rock breaker to break them up. During this process the operator came across a larger boulder with a lead sticking out of it. The operator stopped and called the drilling/blast department. We came out inspected it and cut the lead. Assessing the lead it looks like it has been fired, however the the large rock and perfect drill hole left us worried. We told the operator to stay well away from the rock. We went and got a air compressor to flush the drill hole and inspect it. We got the drill hole partially flushed before getting the digger in to remove the top of the boulder. Once this was removed we continued flushing the hole, we came across emulsion and then once we got to the bottom of the hole we found a booster with the detonator still connected to it. We retrieved the booster and detonator from the hole and it is in our magazines awaiting inspection.	– Shotfiring – Risk assessment – Supervision – Training
Dec 25	Bogger operator bogging heading, identified a flicker/flame and activated AFFF to extinguish.	– Fire or explosion – Mechanical – Emergency management – Supervision – Training
Dec 25	Operator was using an LHD to back fill a stope. They completed filling one void and started to work their way forward cleaning up the drive. They was unaware of another void around the corner and has driven towards it. The LHD stopped with the tyres on the brow and the bucket resting on the other side of the void.	– Tips, ponds and voids – Risk assessment – Supervision – Training

INCIDENT DATE	SUMMARY	CONSIDERATIONS
Dec 25	Land slump in early hours of Tuesday 16 December 2025.	– Ground or strata instability – Workplace inspections – Risk assessment – Supervision – Training
Dec 25	Went to relocate lighting plant, hooked up lighting plant to LV, went to start it to lower hydraulic mast and it had no power to start, so went round and isolated it and tried to start again, it was turning over slowly then sped up so stopped trying to start it and turned it to glow while pumping the fuel line. Tried to start again and the battery exploded.	– Fire or explosion – Mechanical – Emergency management – Supervision – Training
Dec 25	Truck hauling up the decline underground. Operator could smell smoke. While pulling truck off decline noticed flame from engine area. Parked safely, activated AFFF, exit truck and finish extinguish with handheld.	– Fire or explosion – Mechanical – Emergency management – Supervision – Training
Dec 25	Light vehicle was parked with driver at the wheel at the remote chain 15–20m in from the entrance of the drives downhill toward the same chain and the brakes went hard and failed and ran into a parked light vehicle.	– Roads and vehicle operating areas – Mechanical – Risk assessment – Supervision – Training

TABLE 5: High potential incidents – 2025/26 Q2

Table 6 and Figure 9 shows the number of high potential incidents per quarter during the last two years for all extractives operations.

QUARTER	Q3 JAN-MAR 2024	Q4 APR-JUN 2024	Q1 JUL-SEP 2024	Q2 OCT-DEC 2024	Q3 JAN-MAR 2025	Q4 APR-JUN 2025	Q1 JUL-SEP 2025	Q2 OCT-DEC 2025	TOTAL PREVIOUS 12 MONTHS
Number of high potential incidents	25	29	27	35	32	32	28	32	**124**

TABLE 6: High potential incidents per quarter

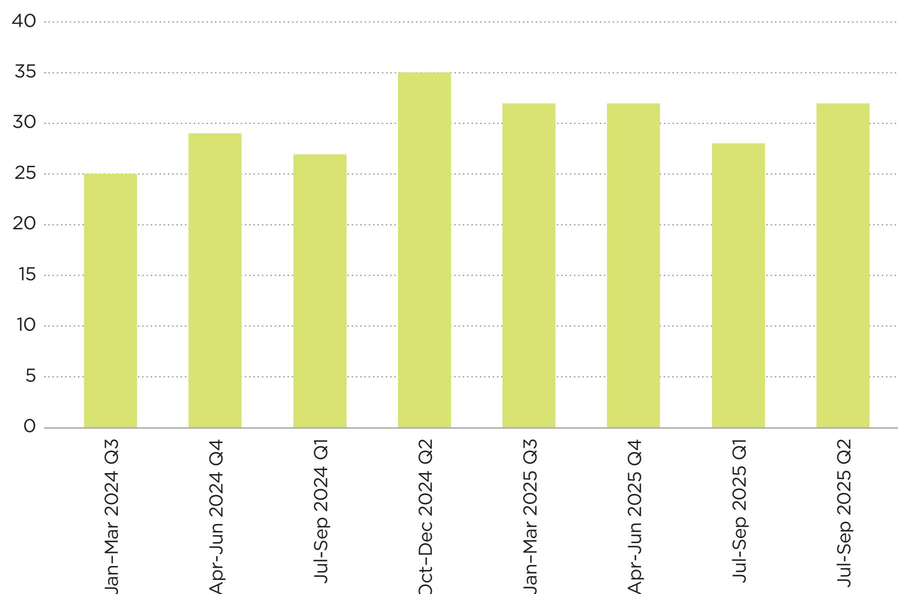

FIGURE 8: High potential incidents per quarter

2.7 High potential incidents – investigation outcomes

High potential incident case study

TABLE 7: High potential incident – investigation outcomes case study

Aug 25	A wall failure occurred during routine tiphead pushing, resulting in the dozer becoming submerged. The operator evacuated safely, no injuries occurred.

THE INCIDENT

A CAT D8T dozer was pushing out material that had been unloaded by dump trucks onto firm ground. The operator was building out the material past terra firma ground to form a base for the wall extension over water. A significant amount of material was intentionally kept in front of the blade to allow for controlled slumping during this process.

While pushing, the operator felt the rear of the dozer suddenly drop. They immediately looked back and observed the sand giving way behind the machine. The rear left-hand side of the ripper frame began to sink into the water as the supporting material failed.

The operator exited the machine through the right-hand side door, moved along the right track, jumped down onto the sand in front of the blade, and climbed up to firm ground safely.

After the operator exited, the dozer continued to sink until it became approximately 90% submerged in water. No injuries occurred, and the operator remained unharmed.

KEY FINDINGS FROM THE PCBU INVESTIGATION

The primary cause of the incident was the loss of ground support beneath the tiphead, resulting in a sudden slump behind the dozer. The underlying material (slimes and saturated sand) was unable to support the applied load as the wall construction extended over water. The failure occurred when the weight of placed sand exceeded the bearing capacity of the underlying slimes and waterlogged material, causing the rear section of the dozer to drop and sink.

- The pond beneath the tiphead consists of slime-rich, highly saturated material with low shear strength. This type of material is known to lose stability under additional load, especially when compacted or pushed outward over water.
- A water discharge line was located approximately 5m beyond the tiphead toe. The presence of moving water may have contributed to erosion, softening, or undermining of the tiphead foundation. Lack of knowledge if the underground discharge line was operational prior to starting shift meant operators were unaware of the potential erosion risk below the tiphead.
- Controlled slumping is a standard method when extending walls over water. Despite appropriate procedure, slumping can become unpredictable when interacting with soft substrate or unknown underground erosion. Slumping risk assessments did not fully account for how the soft slime layers would interact with extended wall construction over water.
- Subsurface conditions beneath tailings/slimes areas cannot be visually inspected during operations. The underlying failure zone was not identifiable before the event occurred.
- With trucks tipping for approximately one week, the cumulative load and outward push of material progressively increased pressure on the tiphead edge.
- There was no geotechnical trigger, warning system, or test method to confirm when the tiphead load was approaching the failure threshold.

FIGURE 9:
Incident scene

REGULATOR COMMENTS AND RECOMMENDATIONS

Principal hazard management plans (PHMPs) for tips, ponds or voids must include:

- procedures and processes to ensure the safe design, construction and maintenance of tips, ponds or voids
- a geotechnical assessment
- road design and traffic movement
- tipping rules
- records of tipped material
- an inspection and monitoring regime.

When choosing control measures to manage risks at tips, consider:

- the geology of the area (particularly the foundation of the tip, foundation materials and tip materials)
- the quantity, type, and rehabilitation of overburden
- the type and size of mobile plant to be used
- access roads for vehicles and pedestrians
- preparation of the receiving area
- settling requirements, drainage and runoff controls
- stabilising methods, including inspections
- the risk of spontaneous combustion
- controlling public access
- any other hazards (for example, overhead power lines).

Tip construction procedure

All tips should have a construction procedure to follow when dumping. This procedure should:

- describe how the tip design, from the geotechnical assessment, will be implemented by the workers
- specify the overall slope angle, maximum heights of batter slopes and minimum bench widths
- consider the type of material being dumped and the dumping method
- consider the size and type of vehicles being used
- include windrow specifications
- be easily understood by workers.

3.0 Regulatory insights

IN THIS SECTION:

3.1 Contractor management – don't be fooled by documentation

3.2 Featured case study – Black Reef

3.1 Contractor management – don't be fooled by documentation

Having assessed health and safety documentation and the implementation of systems at workplaces for over 30 years, I see contractor management as one of the hardest aspects to get right at the implementation stage.

I recently visited a mining operation to look at contractor management. The visit started off well, and the health and safety documentation that the leading contractor supplied to the mine operator clearly was comprehensive. On paper, the contractor appeared to understand the risks associated with construction. The question was, did they implement their systems and did the same apply to the sub-contractors?

The mine operator appointed a contract manager to oversee the project and the performance of the contractors. The mine operator had confidence that the health and safety culture of their contractors was good. So how did the inspection go?

The inspection was unannounced, so Murphy's law applied and the contractor's most senior person on site was not there. The second in charge was unfamiliar with some important risk controls normally seen in the construction industry such as work area access control points, scaffolding standards, exclusion zones in lifting areas and use of tag-lines to position loads.

There were seven workers within the fall zone (Dropped object risk zone) of the item being lifted by a crane. Rigging failures do occur, and the weight of the large item being lifted by the crane would have crushed several of these workers. had it dropped. The load was being maneuvered into position using the workers' hands. This again places the workers directly next to a potential dropped object or exposed to crush injuries caused by a load bumping against a stationary object. Tag-lines aid in distancing the worker from the mass (energy) of the moving object.

The load was also being lifted over a light vehicle. There were no controlled parking zones or restrictions on accessing the vehicle during the lift.

Mobile scaffolds were set up reaching two lifts with no stabilizing outriggers and a stepladder was in use. The health and safety documentation provided to the mine operator clearly identified falls from height as a risk to workers, yet no one on site could explain the situations where step ladders or scaffolds would be used and to what standard they should be installed to.

A steel fixing sub-contractor was asked, 'Is there anything that could be done to make your job safer?' The sub-contractor listed off a couple of very good additional controls and appeared frustrated that the main contractor did not have them in place.

So, what is the answer to ensuring examples like the above do not happen at your operation and how do I crack the contractor management nut? Active, daily, eyes-on monitoring of contactors is essential, don't be fooled by the paperwork.

1. **Prequalification and selection**: Evaluate contractors based on their safety records, technical competence for high-risk activities (for example, working at heights or in confined spaces), and whether their system includes critical risk control verification i.e. do they have a system of checking that the important risk controls are applied consistently.
2. **Detailed scope and risk assessment**: Define a precise scope of work and ensure they conduct work-area-specific hazard identifications. Ensure contractors provide a Safe Work Method Statement (SWMS) or Job Safety Analysis (JSA) that explicitly detail controls (that meet good industry practice) for identified critical risks.
3. **Site-specific induction and training**: Mandatory orientations for all personnel to communicate site rules, emergency procedures, and specific critical risk zones before any work begins.

4. **Permit-to-work (PTW) systems**: Implement formal authorisation processes for high-risk tasks – such as hot work, excavations, or electrical work – to verify that all necessary controls are in place before a task is started.
5. **Defined accountability and governance**: Explicitly assign responsibility for each critical control.
6. **Active supervision and monitoring**: Conduct regular site inspections, 'safety walk' interactions, and audits to verify that agreed-upon risk controls are being used in the field. This includes daily pre-start meetings and frequent toolbox talks.
7. **Performance reporting and review**: Maintain transparent reporting of near-misses and incidents. Conduct post-project evaluations to capture lessons learned and continuously improve risk management processes for future projects.

Dave Bellett
Manager Extractives

3.2 Featured case study – Black Reef

On 8 March 2006, a tragedy unfolded at a small privately owned underground coalmine on the West Coast of the South Island of New Zealand.

Two miners primed a coal face with explosives; they walked back to a cross passage to shelter from the blast. After firing the shot, the men heard a rumble.

A large body of water suddenly entered the mine from nearby abandoned workings and engulfed the two miners in a torrent of water and rock. Robert James McGowan (aged 39 years) was killed; the mine manager was trapped underground for several hours and was later rescued.

Robert's wife and two young children lost a husband and father. The impact on their lives remains, albeit 20 years later.

The mine never re-opened.

Why did this tragedy occur when the industry at the time were aware of the risks of inrush? Why did the miners continue to mine near the old workings that they knew were there?

The story of Black Reef and why the accident occurred can be summarised by four key themes.

Assumption of safety

About a year prior to the accident, a privately owned company with no previous mining experience purchased the mine. The owner of the company worked on the surface of the mine and relied on his two workers underground to produce coal. The mine owner knew mining was getting close to a neighbouring abandoned mine so he asked a geologist to take a look and provide advice about the relative distance between the old mine and where they were working.

The miners did not hear back from the geologist nor did they receive a report. The miners assumed that this silence from the geologist meant all was well. This assumption proved to be fatal

FIGURE 10:
Emergency response

Inexperience

The underground manager held a coal-mine deputy qualification and the owner on the surface relied on him for mining knowledge. A coal mine deputy is like a supervisor of a work crew and in larger coal mines, they report to an undermanager then to a first-class underground coalmine manager. Deputies do not normally make decisions about where to mine or how to manage inrush risk. These tasks are normally performed by a team such as surveyors, mining engineers, geotechnical engineers, and a first-class underground coalmine manager.

The deputy knew the company was small, he knew that there were limited funds for experts and due to his inexperience, felt he could continue mining. Due to his limited competency, he failed to recognise that the increasing water seepage in the days prior was connected to the neighbouring mine. He too assumed that because the geologist hadn't said anything, that all must be well.

Professional duty of care

The geologist told investigators that he had concerns about what the miners were doing but had not got around to telling them albeit several months had passed since his visit to the mine and the inrush event. The geologist was a member of a professional organisation that had a code of conduct outlining that if risks are identified by their members, they must be communicated to clients. Because the owner of Black Reef had no mining knowledge, the deputy was inexperienced in such complex mine design issues, they relied on the voice of an expert to warn them. Had the geologist communicated their concerns to the miners, Robert's death may have been avoided.

Weak regulation

There were three fundamental weaknesses to the regulations 20 years ago:

- a deputy was able to manage a small underground mine despite having no experience with inrush risks
- the regulations surrounding the management of inrush risks lacked detail and relied on probe drilling ahead but not in the floor or roof. In this case the water came up from the floor of the face, something that probe drilling under the regulations at the time would not have detected
- the requirement for an accurate instrument-based survey of mine workings carried out on a regular basis was not explicit.

Fortunately, today, due to legislative change following Robert's accident, a deputy cannot manage an underground coal mine. Further legislative change followed the Pike River mine disaster, and now a comprehensive, evidence-based inrush management plan is required. The plan also requires an independent peer review by a suitably qualified person outside of a company structure. Regular surveys carried out by qualified professionals are also required.

Could this happen today?

Why bring up an accident that occurred 20 years ago? Assumptions, inexperience and experts not communicating concerns could still occur today. It is so important to learn from past tragedy. Many managers of mines today would have been teenagers at the time of Black Reef and have no knowledge of it. Goldmines in NZ are going deeper than ever before to reach the orebody, they are mining near old workings; changing conditions underground must trigger a stop, check and confirm methodology, assumptions have no place in mining.

Valma McGowan, Robert's wife offers this advice to the industry:

> "When this such unexpected tragedy occurred, I didn't realise the impacts it would create. Not only the immediate and ongoing loss of a husband, father and brother, but it would cause ongoing chaos for the rest of our lives.
>
> 'Ongoing financial stress going from 2 fulltime incomes to just one ACC benefit. 4 years of Court hearings, lifelong anxiety/PTSD disorders in children living with the fear that if this could happen to their dad it could also happen to me – their mum then they would have no one. This was a huge burden for a 4- and 6-year-old to face.
>
> For me it wasn't only the struggle of raising 2 children alone and providing for them, it was that it could happen to another family... and it did in fact, to many families, and each time we had to relive our own personal grief again and again. It created a need for me to fight to protect other people and through this I faced criticism and was labelled as being anti-mining which is not the case – I am all for mining as long as it is done safely." It's been a long hard 20 years.
>
> "Personally, if I could offer suggestion to anyone in the mining industry it would be: "Do not be complacent, do not take unnecessary risks. Don't let those that we have lost be lost in vain - learn from their deaths and our losses – safety first". I am grateful for the improvements in the industry however they alone do not make it safe – there is always need for improvement - we all need to remember this.
>
> I wish you safe mining.
> Val"

Mrs McGowan kindly agreed to contribute to this article.

4.0
The regulator

IN THIS SECTION:

4.1 Our activities

4.2 Assessments

4.3 Enforcements

4.1 Our activities

The Extractives Specialist Health and Safety Inspectors at WorkSafe use a range of interventions to undertake their duties. Inspectors strive to achieve the right mix of education, engagement and where required enforcement. This section of the report includes a summary of the interventions used by the Extractives Inspectors during the quarter.

4.2 Assessments

Proactive assessments aim to prevent incidents, injuries and illness through planned, risk-based interventions. Reactive activities are undertaken in response to reported safety concerns or notifiable events. Assessments can be either site- or desk-based in nature.

For proactive site-based assessments, the objectives of each visit are agreed and the appropriate inspection tool is selected. Targeted assessments and regulatory compliance assessments can take several days on site with a team of inspectors attending. These multi-day inspections may be 'targeted' to assess the controls in place for a particular principal hazard (for example, WorkSafe has been targeting 'roads and other vehicle operating areas' as a result of the high number of notifiable events in this area), or they may involve a more general assessment of 'regulatory compliance'. Site inspections and targeted inspections are generally completed in a one day site visit but can also focus on specific topics.

As well as site-based assessments, the Inspectors spend considerable time undertaking desk-based assessments. Proactive desk-based assessments include the review of Principal Hazard Management Plans (PHMPs), Principal Control Plans (PCPs), mine plans, and high risk activity notifications. Responding to notifiable events and safety concerns may involve a site-based or desk-based assessment, or both.

Table 8 shows the range of assessments undertaken in Q2 2025/26 by sector.

		ASSESSMENTS	MINE	TUNNEL	ALLUVIAL MINE	QUARRY
Proactive	Site-based	Regulatory compliance assessments				3
		Site inspections	5	0	4	28
		Targeted inspections	2	1	2	1
	Desk-based	PHMP/PCP review	7			
		Mine plan review	24	13		
		High risk activity				
Reactive	Site-based	Concerns – inspection				6
		Notifiable events – inspection	1			2
	Desk-based	Concerns – desk-based	1			2
		Notifiable event – desk-based	19	0	2	22

TABLE 8: Proactive and reactive site and desk based assessments conducted in Q2 2025/26

Figure 11 shows the number of proactive and reactive site- and desk-based assessments undertaken by the regulator in Q2 2025/26. This quarter 38% of our activities were site-based, and 62% of activities were proactive.

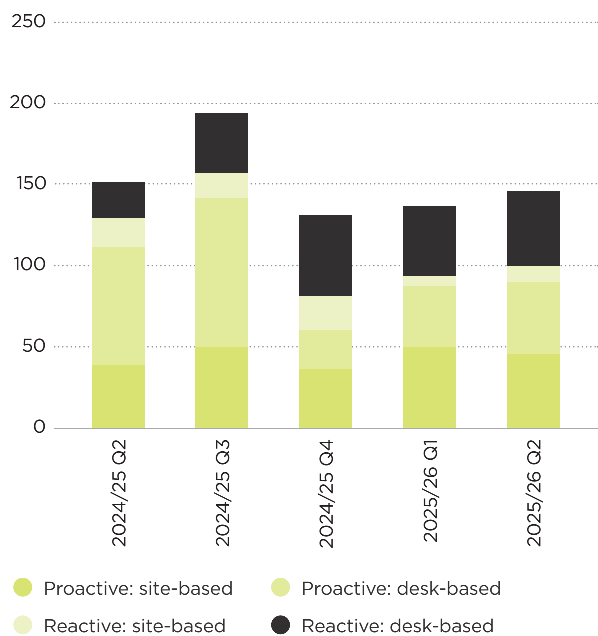

FIGURE 11: Proactive and reactive site and desk-based assessments

Figure 12 shows the number of assessments undertaken by the regulator in Q2 2025/26 by sector. This quarter, 45% of our assessments were for quarries, 40% for mines, 10% for tunnels and 5% for alluvial mines.

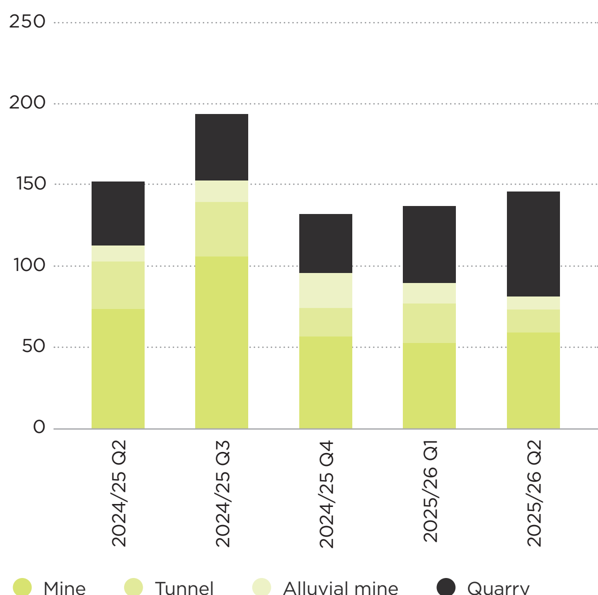

FIGURE 12: Assessements by sector

4.3 Enforcements

Enforcement actions issued by WorkSafe include prohibition and improvement notices and directive letters. Enforcement actions are issued according to our Enforcement Decision Making (EDM) Model when health and safety issues are identified through assessments.

Figures 13 and 14 show the number of enforcement actions issued in Q2 2025/26 by notice type and by sector. This quarter, a total of 100 enforcement actions were issued. Of those, 4% of were prohibition notices, 31% were improvement notices, and 65% were directives. The majority of the enforcement actions were issued to the alluvial mining 16%), and quarrying (72%) sectors.

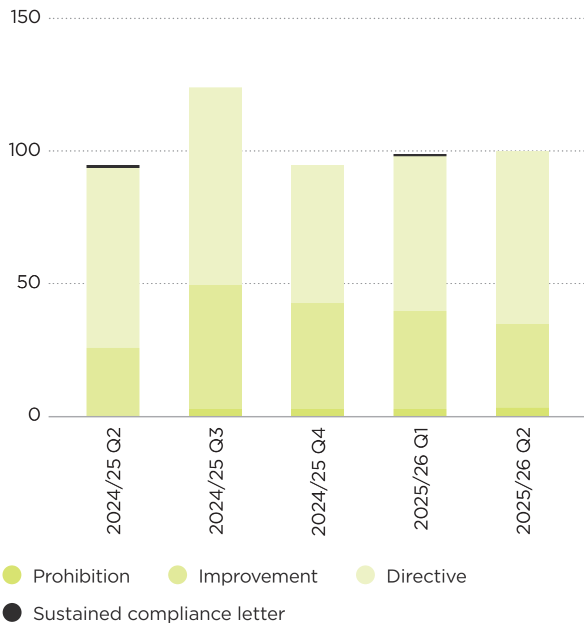

FIGURE 13: Enforcement actions issued by type

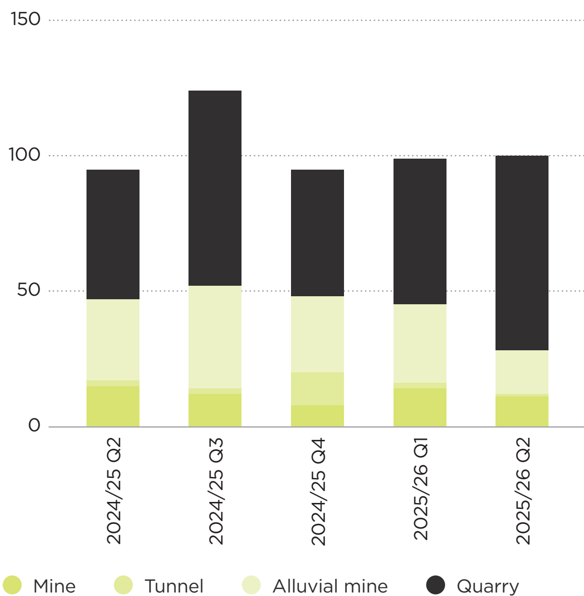

FIGURE 14: Enforcement actions issued by sector

Figure 15 shows the number of enforcement actions issued in Q2 2025/26 by category, and provides an indication of the key areas of concern to our inspectors. This quarter, the majority of enforcement actions were issued for health and safety issues relating to roads and other vehicle operating areas (20%), guarding (19%), and health and safety management systems (18%).

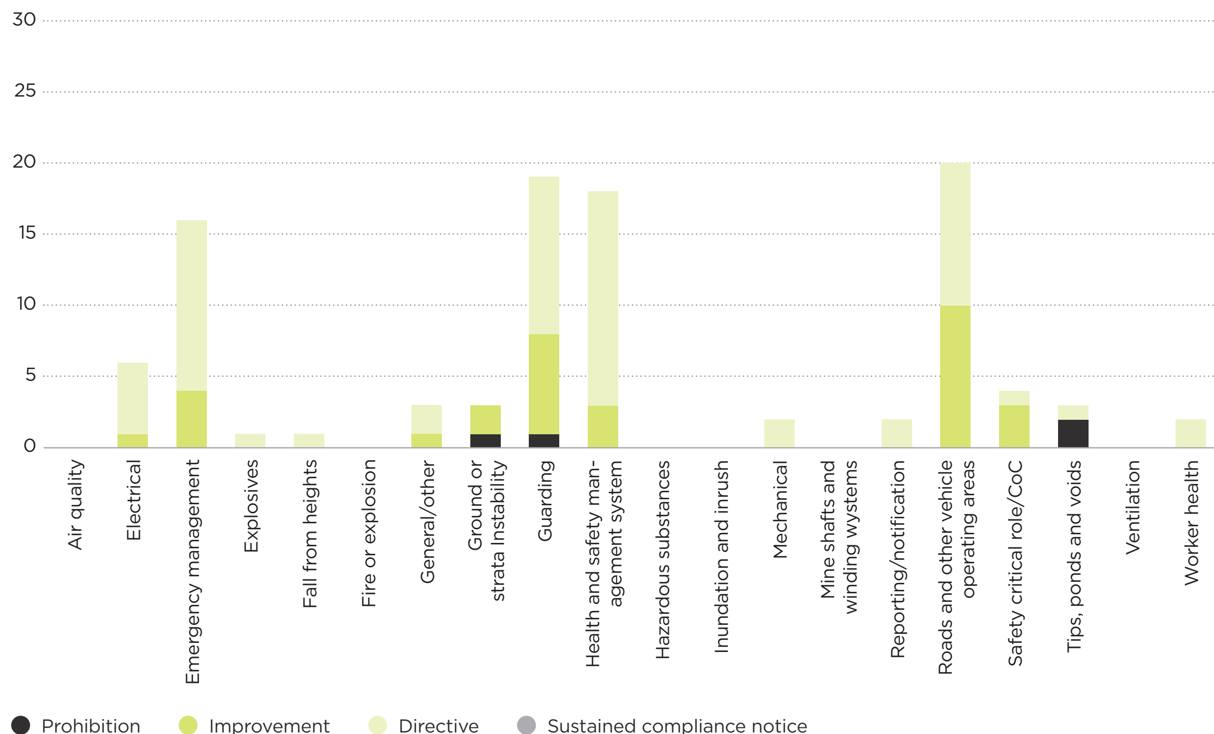

FIGURE 15: Enforcement actions issued by category 2025/26 Q2

Regulator activity comment

Inspection numbers continue to track favorably against the 2025/2026 plan. Enforcement actions taken also remains similar for the last quarter. Note the low level of enforcement in the tunnel sector is proportionate to the significant reduction in tunnelling activity in New Zealand in recent times. The proportion of enforcement actions by categories remains constant. Inspectors have been focusing on emergency preparedness, and they continue to review H&S management systems at quarry sites.

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