No images? Click here

Department of Local Government, Industry Regulation and Safety

WorkSafe Western Australia Mines Safety

Monthly incident insights

WorkSafe Mines Safety

July 2025 edition

Issued 19 August 2025

208 notifiable incidents in July

150 reportable incidents in July

15 notifiable incidents compared to June

5 reportable incidents compared to June

3 Three summarised incidents in this edition

Note: Correct as of 19 August 2025.

Report a notifiable incident to
1800 678 198

Report all incidents online
SRS – Safety Regulation System

Recent prosecutions

Deputy Chief Magistrate imposes WA's record WHS fine

Elizabeth Woods, Deputy Chief Magistrate of Western Australia, imposed the largest work health and safety fine in the State's history when she fined Big Bell Gold Operations Pty Ltd $945,000—five per cent higher than the previous record of $900,000—after a truck fatally struck a worker at its Big Bell underground gold mine.

A wholly owned subsidiary of Westgold Resources Limited, Big Bell Gold Operations pleaded guilty to an offence under the *Mines Safety and Inspection Act 1994* of failing to provide and maintain a working environment in which an employee of a contractor

wasn't exposed to hazards. This offence doesn't indicate that the breach caused the fatal incident at the mine near Cue in the State's Mid West. However, it highlights a failure in terms of safe systems of work.

Read the media release

Reportable incidents

Lathe entanglement

A worker sustained serious injuries to their forearm and wrist after becoming entangled in the rotating chuck of a lathe. The operator was wearing gloves, which contributed to the entanglement.

Rotating machinery—such as lathes—poses a significant risk of entanglement, especially when operators wear loose clothing, jewellery or gloves. This incident underscores the importance of strictly adhering to safe operating procedures and engineering controls when working with high-inertia rotating equipment.

The safety devices fitted to the lathe were:

- a foot-operated brake;
- a manual handbrake to immediately halt rotation; and
- emergency stop buttons to de-energise the lathe.

While these safety devices are critical, it's important to note that de-energising a large lathe doesn't immediately halt its rotation. Due to the lathe's high rotational inertia, it can continue to spin for several minutes unless an effective braking system is in place.

Key takeaways

- **Identify hazards**—Never wear jewellery or loose clothing, including gloves, when operating lathes or other rotating machinery.
- **Use controls**—Ensure rotating equipment is fitted with effective braking systems to stop moving parts quickly in an emergency.
- **Assess risks**—Conduct task-specific risk assessments and ensure that workers know the

hazards of stored energy and rotating mass.
- **Test tools**—Regularly inspect and try out emergency stops and braking systems as part of maintenance programs.

This incident serves as a powerful reminder that, even with controls in place, operator awareness and strict procedural compliance remain essential. An investigation is ongoing.

Road train rollover

A road train rollover occurred on the haul road access route to a gold mine, resulting in serious injuries to the operator.

The incident took place as the operator was navigating a sweeping bend while hauling ore. The cab and the first trailer overturned, while the remaining two trailers remained upright.

The operator sustained multiple fractures, lacerations and bruising. Initially, the site medic treated the injured worker before an aerial medical transport crew evacuated them to a metropolitan hospital.

According to reports, the road condition was good, with routine grading and dust-suppression measures in place.

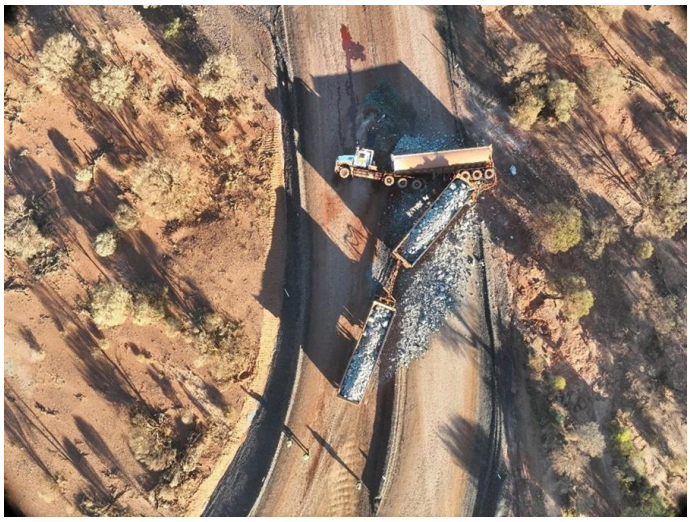
Actions taken immediately included:

- preserving the scene;
- capturing photographs and vehicle camera data; and
- dispatching inspectors to the site to begin the investigation.

Key takeaways

- **Identify hazards**—Confirm vehicle operators know hazard identification and response procedures, especially for haul roads.
- **Inspect vehicles**—Foster robust vehicle inspection and maintenance regimes, including thorough pre-start checks.

This incident focuses attention on the risks associated with operating heavy vehicles on haul roads, particularly in challenging terrain. An investigation is in progress to identify contributing factors and prevent recurrences.



Alleged sexual harassment

A mine operator received a report of alleged sexual harassment involving a site-based medical professional and a contractor. It was alleged that, following an initial consultation for a shoulder injury, the medic performed massages involving multiple areas of the contractor's body without consent and on multiple occasions.

While reviewing its systems of work for preventing and addressing inappropriate workplace behaviour, the mine operator identified several contributing factors and control gaps:

- Job insecurity and reporting hesitancy—The affected worker was a contractor who, despite completing site induction and behaviour training, didn't feel empowered to report the conduct or stop the treatment. They expressed concern that reporting the matter could negatively impact their

future opportunities. Since it was only their second swing, they were unsure whether the behaviour was typical for the team, which further delayed their decision to report it.

- Witnessed behaviour and missed escalation—The contractor's employer informed the mine operator that two other workers had previously expressed concerns regarding the medic's physical and verbal behaviour, which they felt indicated a lack of professional boundaries. The supervisors of these workers didn't escalate their reports to the mine operator, despite the references to on-site events.
- Role clarity and scope of practice—While physical contact was a required aspect of the medic's duties, the investigation found that expectations, role scope and boundaries had been neither clearly defined nor communicated within the medical team.
- Environmental and supervision risks—The medical centre was located in a low-traffic area of the site, particularly during the night shift. On some shifts, the medic worked alone without supervision due to staffing limitations within the Emergency Response Team.

Key takeaways

- **Audit procedures**—Review existing controls for managing inappropriate workplace behaviour, including psychosocial hazards, and look beyond individual actions to consider contributing environmental and organisational factors.
- **Highlight pathways**—Emphasise reporting mechanisms, particularly for contractors who may feel disempowered to speak up despite completing workplace behaviour training.
- **Set expectations**—Communicate site-specific arrangements to contractors that include clear protocols and reporting requirements for on-site psychosocial risks and incidents.
- **Check designs**—Acknowledge that factors such as work location, supervision levels and role clarity can influence exposure to psychosocial hazards and should be regularly examined.

Visit www.worksafe.wa.gov.au to learn more about us.