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Department of Local Government,
Industry Regulation and Safety



Monthly incident insights

WorkSafe Mines Safety

October 2025 edition

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Note: Correct as of 14 November 2025.

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Reportable incidents

Workers inadvertently cut live electrical cable

Workers using a grinder to remove a redundant conveyor inadvertently cut into a live electrical cable after they incorrectly assumed that all nearby cables had been de-energised.

The electrical supervisor had confirmed to the workers that the conveyor motor was redundant and its electrical cables were safe to cut. However, the workers mistakenly thought that other nearby cables were also redundant and de-energised.



Findings

The cut electrical cable was not part of the redundant conveyor and was still live, posing a serious risk of electric shock, arc flash or electrocution. The incident did not result in any injuries, but it highlighted critical failures in electrical isolation, verification and supervision.

Takeaways

- A qualified person must test and verify that all electrical components are de-energised before work begins on equipment.
- Electrical supervisors must consider the complexities of tasks and the capabilities of workers when they are assigning jobs involving electrical cables or exposed electrical equipment.
- Sites should involve electrical supervisors in all high-risk work assessments, and all job hazard/safety analysis processes should include electrical verification and isolation steps.
- In Western Australia, the Electricity (Licensing) Regulations 1991, the Work Health and Safety (Mines) Regulations 2022 and several Australian Standards, including AS/NZS 3000:2018 (Electrical installations, known as the Wiring Rules) and AS/NZS 4836:2023 (Safe working on or near low-voltage electrical installations and equipment), govern electrical isolation requirements.

Summary

Workers must treat all electrical work as live work until proven otherwise. Assumptions can lead to catastrophic work health and safety consequences.

Isolation, testing and supervision are essential controls to prevent serious injuries or deaths.

Worker momentarily trapped between sea containers

A worker was momentarily trapped between moving and stationary sea containers after a container shifted unexpectedly during a non-routine forklift operation to facilitate a quarantine inspection.

A sea container moved after the forklift operator lifted its lid. The worker managed to withdraw without injury, although they went to the hospital as a precautionary measure. Site management preserved the scene before a WorkSafe inspector attended and reminded everyone of the exclusion zone and pedestrian-plant separation requirements.



Findings

Exclusion zones and pedestrian–plant separation were not maintained because the worker was too close to the operating mobile plant, which created a foreseeable crushing hazard and potential for a serious incident. The non-routine task lacked specific risk controls.

Takeaways

- Sites must maintain pedestrian–plant separation at all times.
- Traffic management and exclusion zones must reflect real site conditions, and mine operators must enforce them consistently.
- Non-routine tasks require dedicated planning and supervision.

Summary

Employees can sustain serious injuries when employers expose them to mobile equipment without effective controls. Sites must plan, verify and enforce critical controls, exclusion zones and safe operating procedures for all tasks, especially non-routine work.

Mine operator strengthens harassment prevention systems

A mine operator with systems in place to reduce the risks associated with psychosocial hazards in its workplace received several reports of sexual harassment involving an experienced worker.

The experienced worker claimed that the conversations had been “reciprocal”.

Findings

The mine operator investigated both the specific allegations and its broader systems for managing inappropriate workplace behaviours. After identifying opportunities to strengthen its systems—addressing power imbalances, isolation risks and professional boundaries—the mine operator implemented on-site improvements, which included:

- Introducing additional supervisory check-ins to ensure that all workers, particularly new or vulnerable groups—such as culturally diverse, neurodivergent or LGBTQIA+ employees—have safe and accessible channels for raising concerns.
- Reviewing risk registers and re-engaging with groups with higher psychosocial risk profiles to strengthen controls.
- Reducing isolation, improving oversight and increasing check-in frequency because many of the inappropriate conversations and behaviours occurred in operator cabs during paired work tasks.
- Reinforcing behavioural expectations, clarifying what informed consent looks like in conversation and reissuing training on the distinction between intent and effect in workplace conduct.

Takeaways

- Review and test behavioural controls, particularly following incidents or changes in work groups, to ensure expectations are clear, training remains effective and supervision is adequate.
- Engage health and safety representatives, managers and workers in open dialogue to identify gaps in understanding or emerging risks.
- Strengthen leadership capabilities so that managers recognise psychosocial hazards and launch early interventions, thereby reducing the onus on workers to initiate complaints.
- Maintain strong oversight of roles involving training, mentoring or isolated work, where power imbalances and reduced visibility can elevate the risk of inappropriate behaviours.

Summary

This case is a good example of a mine operator that had systems in place relating to harassment prevention but recognised that continual reviews and improvements are necessary, particularly following worker reports. A respectful workplace depends on not only clear policy but also consistent leadership, active supervision and a shared understanding of appropriate conduct. The mine operator's actions strengthened these elements and reduced the risk of sexual harassment incidents in the future.

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