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Department of Local Government,
Industry Regulation and Safety



Monthly incident insights

WorkSafe Mines Safety

July 2026 edition

Issued 24 August 2026

198 notifiable
incidents in
July

 **35** notifiable
incidents
compared to
June

171 reportable
incidents in
July

 **15** reportable
incidents
compared to
June

3 Three summarised incidents in this edition

Note: Correct as of 14 August 2026.

Report a notifiable incident to
1800 678 198

Report all incidents online
[SRS – Safety Regulation System](#)

Recent prosecutions

Mine operator fined over entanglement risk

Mine operator Evolution Mining (Mungari) Pty Ltd has been fined \$200,000 and ordered to pay \$15,392.20 in costs by the Perth Magistrates Court over an incident in which a worker for a contractor suffered a crush injury and a fractured left humerus.

In the incident on 17 April 2022, the MLG Oz Limited worker became entangled in a stacker conveyor at the Mungari gold mine near Kalgoorlie. Evolution Mining pleaded guilty to contravening sections 19(1) and 32(1) of the *Work Health and Safety Act 2020*. The company failed to comply with a health and safety duty, exposing a worker to a risk of injury or harm to health. The prosecution did not allege that Evolution's failure caused the worker's injuries.

Read the [media release](#) for more information about the prosecution.

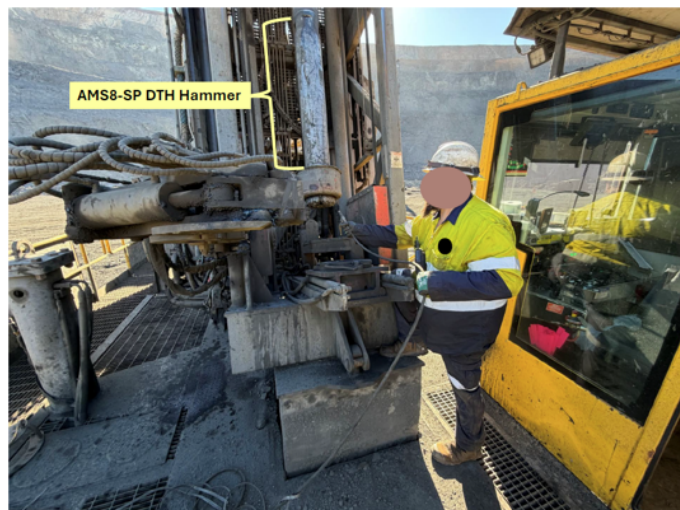
Reportable incidents

Stored energy release injures drill operator

A worker sustained a hand injury after stored energy released from a drill string during blockage-clearing activities on a blasthole drill rig. The operator identified elevated pressure readings that indicated a blockage in the drill bit and began dismantling the down-the-hole (DTH) hammer assembly to relieve pressure.

The operator separated the upper section of the DTH hammer from the drill rod string while the drill mast remained angled. Although the operator released pressure from the upper hammer section, pressurised air remained trapped within the drill string and drill bit. The operator then reconnected the assembly and directed a washdown hose into the drill bit ports to clear the blockage. When the obstruction cleared, a high-velocity discharge of air, water, oil and rock fragments expelled from the drill bit ports and struck the worker's hand.

The incident shows how residual stored energy can remain within drilling equipment even after workers complete partial depressurisation. Workers performing fault-finding and maintenance tasks can enter the line of fire when pressure sources remain trapped and work teams do not fully isolate or release stored energy before commencing work.





Takeaways

- **Follow correct depressurisation procedures:** Release all stored energy before disconnecting or dismantling drill string components.
- **Position equipment appropriately:** Set the drill mast to allow safe depressurisation of the drill bit and hammer assembly.
- **Control residual pressure:** Treat drill strings, DTH hammers and drill bits as potentially pressurised until verification confirms otherwise.
- **Remove workers from the line of fire:** Maintain exclusion zones around potential discharge points during pressure-release tasks.
- **Verify work methods:** Apply manufacturer instructions and site procedures during maintenance and fault-finding activities.
- **Supervise high-risk work:** Confirm workers have the training and competency to manage stored-energy hazards.

Detonators initiate in explosives vehicle

A worker encountered an explosives hazard after detonators unintentionally initiated inside an explosives light vehicle during charging activities underground. The event occurred after the worker placed a battery-powered cable tensioning device into

a detonator storage compartment that already contained detonators.

After completing cable tensioning work in an underground heading, the worker returned the device to the vehicle and stored it with the detonators. The worker then returned to the face to assist with charging operations. A short time later, workers heard popping sounds from the rear of the vehicle. They inspected the compartment, identified initiating detonators and a smouldering fire, moved behind the vehicle, suppressed the fire with a mine water hose and notified supervision.

The incident shows how workers can create ignition hazards when they place incompatible equipment inside detonator storage areas and compromise segregation controls. Workers involved in explosives handling can face catastrophic consequences when ignition sources and detonators occupy the same storage space.



Takeaways

- **Maintain segregation controls:** Keep detonator compartments free from equipment and potential ignition sources.
- **Follow explosives procedures:** Apply storage and handling requirements without deviation.
- **Recognise ignition hazards:** Assess battery-powered and electrical equipment before storing them near explosives.

- **Withdraw to a safe location:** Respond immediately to abnormal sounds, heat, smoke or fire.
- **Position personnel outside danger areas:** Move clear of explosives storage areas as soon as workers detect a hazard.
- **Verify competency:** Confirm workers have the training and supervision required for explosives handling activities.

Workplace behaviours expose psychosocial risk

A worker reported inappropriate workplace behaviour involving a member of a site leadership team, prompting a PCBU-led investigation into psychosocial hazards and workplace practices. The investigation substantiated concerns about unreasonable behaviour, offensive language, inappropriate comments and leadership practices that negatively affected workers.

Investigators examined the reported behaviour and the broader organisational conditions that allowed it to occur. They identified inconsistent leadership practices, poor communication, limited confidence in reporting processes, cultural issues, organisational change and workplace design factors as contributors to psychosocial risk. Workers linked these conditions to reduced morale, frustration, planning difficulties and workforce turnover. In response, the PCBU implemented leadership development programs, consultation activities, procedural reviews and a psychosocial risk assessment.

The incident shows how organisational systems, workplace culture and leadership practices can create psychosocial harm, independent of individual behaviours. Workers may face greater psychosocial risk when workplace leaders tolerate inappropriate behaviour, organisations fail to maintain trusted reporting pathways or management teams do not identify and control psychosocial hazards.

Takeaways

- **Assess psychosocial hazards systematically:** Examine organisational, cultural and leadership

factors alongside individual behaviours.

- **Develop leadership capability:** Strengthen communication, behavioural standards and people-management skills.
- **Monitor workplace culture:** Identify and address inappropriate behaviours before workers and leaders accept them as normal workplace conduct.
- **Provide trusted reporting pathways:** Support confidential and effective mechanisms for raising concerns.
- **Consult workers regularly:** Use workforce feedback to identify hazards and improve controls.
- **Review organisational change impacts:** Evaluate psychosocial risks during periods of transition.
- **Investigate underlying causes:** Examine systemic contributors when responding to workplace behaviour issues.
- **Improve control effectiveness:** Monitor and reassess psychosocial risk controls over time.

More information

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Sharing WorkSafe news alerts helps more workers, supervisors and leaders access important safety information and industry updates.

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