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Department of Local Government, Industry Regulation and Safety

WorkSafe Western Australia Mines Safety

Monthly incident insights

WorkSafe Mines Safety

June 2025 edition

Issued 16 July 2025

193 notifiable incidents in June

145 reportable incidents in June

17 notifiable incidents compared to May

6 reportable incidents compared to May

3 Three summarised incidents in this edition

Note: Correct as of 15 July 2025.

Report a notifiable incident to **1800 678 198**

Report all incidents online SRS – Safety Regulation System

Recent prosecutions

Quarry fined after worker breaks back and site not held

Kimberley Quarry Pty Ltd was fined a total of $167,000 for a June 2022 incident in which a screening machine operator fell more than 3 m and sustained multiple injuries, including a spinal fracture, and the company didn't hold the site for a WorkSafe investigation.

At Geraldton Magistrates Court in June 2025, Kimberley Quarry pleaded guilty to two offences under the *Work Health and Safety Act 2020*—exposing workers to a risk of death, injury or harm to health ($160,000 fine) and failing to preserve the site of a notifiable incident ($7,000 fine).

The screening machine operator was supervising a routine task at the Kimberley Quarry-operated Chapman Valley Quarry. The screening machine operator and a less experienced colleague were working on the top deck of a horizontal screener, removing wire screen panels weighing between 15 kg and 30 kg each before throwing them on the ground below. The two workers were carrying out the frequently assigned job at a height of about 3.18 m without either edge protection or a fall restraint system in place. When the screening machine operator threw one of the screens from the horizontal screener, the panel's wire hooks caught on their jumper and pulled them off the screener. Their fall resulted in internal bleeding, ligament damage, a sprained wrist and elbow, a forearm laceration and several back injuries, the most severe of which was a fractured L2 vertebra. After emergency services personnel transported the screening machine operator by ambulance to Geraldton Regional Hospital and before a WorkSafe inspector arrived at Chapman Valley Quarry, Kimberley Quarry's site supervisor directed other workers to complete the task of changing the horizontal screener's screens.

Read the media release

Refinery fined after spill injures workers, including students

Alcoa of Australia Limited was fined $400,000 and ordered to pay $5,536.70 in costs after an uncontrolled release of caustic liquid at its Kwinana refinery in September 2022 caused workers, including school students on a work experience placement, to receive burns.

At Rockingham Magistrates Court in March 2025, Alcoa pleaded guilty to failing to ensure, so far as was reasonably practicable, the health and safety of workers under the *Work Health and Safety Act 2020*, thereby contravening sections 19(1) and 32(1). Alcoa exposed the workers to a risk of death, injury or harm to health.

The workers received caustic burns that required first aid and subsequent medical attention after a

discharge drainpipe released liquid uncontrollably during an emergency pump change.

Read the media release | Read the prosecution summary

Reportable incidents

In the dust

A worker at the primary crusher was carrying out clean-up and housekeeping duties when personal monitoring measured respirable silica levels at about six times the exposure standard.

While the worker was wearing a disposable respirator, it wasn't the most effective choice for the conditions. A disposable respirator can only offer a protection factor of up to 10 times the exposure standard—and that's only if its wearer is cleanly shaven and wears it correctly for the entire exposure period.

Generally, industry compliance with respirable silica dust standards is excellent, but WorkSafe Mines Safety knows that workers in primary crusher areas, exploration drilling activities and sample preparation in laboratories face the greatest risks. The health management plan of this reportable incident's site specified it should include high-risk personnel, but the worker wasn't a member of a health monitoring program.

Key takeaways

- **Identify hazards**—Respirable silica dust is a reasonably foreseeable hazard that could give rise to risks to health and safety [r. 34].
- **Use control measures**—Substituting (wholly or partly) or implementing engineering controls to address the hazard of respirable silica dust is the most effective measure in the hierarchy [r. 36(3)]. However, if it's impossible to eliminate a hazard, personal protective equipment may be necessary [r. 36(5)]. A disposable respirator isn't always the best choice—a powered air-purifying respirator offers better protection and greater reliability.

- **Supply health monitoring**—A mine operator must provide health monitoring if respirable silica dust presents a risk of an adverse effect on a worker's well-being, and valid detection techniques exist [r. 675F].

At full blast

Two shotfirers were lucky not to be hurt when a piece of flyrock, debris ejected from blast sites during controlled explosions in mining operations, landed unexpectedly close to them.

The workers were parked 320 m from an overburden blast when one hole, which had a reduced stem height, expelled a 1 kg rock farther than they'd predicted would happen.

The large projectile struck their vehicle's windscreen. Fortunately, this reportable incident had no physical casualties, but it could've had serious consequences.

Key takeaways

- **Reassess blast exclusion zones**—If blast conditions change, review exclusion zones to ensure they're still appropriate.
- **Formalise changes to key documents**—Approve, circulate and communicate updates to explosives management plans, blast guards and exclusion zone safe work instructions.

On collision course

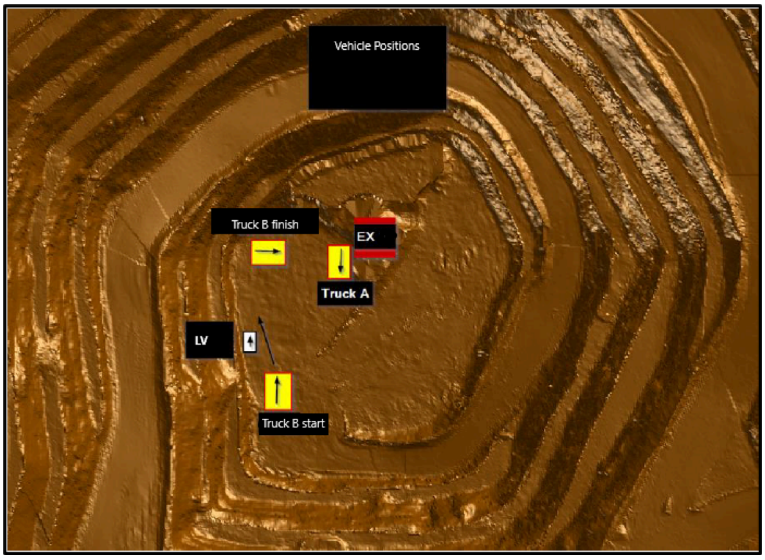
A dump truck almost collided with a light vehicle on a mine site after training shortcomings exposed workers to safety risks.

The operator of the light vehicle (LV) obtained approval from the area's excavator operator before they parked on the pit floor. LV's operator activated their vehicle's hazard lights and waited for a loaded dump truck (Truck A) to leave. LV's operator didn't expect an unannounced dump truck (Truck B) to pass within five metres of their vehicle. Truck B's operator had clear visibility of the LV throughout their manoeuvre, but they hadn't spoken with other parties before they made their move.

This reportable incident's root cause was poor training. It emerged a work colleague had told Truck B's operator that "stationary vehicles with hazard lights on don't require a call-up." The operator's inexperience meant they didn't question this information or verify it with anyone else. The training content didn't adequately cover vehicle passing and interaction requirements.

Key takeaways

- **Review training content and course leaders—** Ensure training materials and the people delivering them provide accurate, up-to-date information.
- **Communicate vehicle interaction distances—** Make sure workers understand and apply safe passing distances and exclusion zones for all vehicle types and sizes.
- **Implement virtual safety zones—**Consider system-based virtual safety zones for all vehicles to help prevent unsafe interactions.
- **Reevaluate traffic management plans—**Carry out control reviews following near-miss incidents.



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