



Monthly incident insights

WorkSafe Mines Safety

September 2026 edition

Issued 15 October 2026

207 notifiable
incidents in
September



1

notifiable
incident
compared to
August

172 reportable
incidents in
September



6

reportable
incidents
compared to
August



Three summarised incidents in this edition

Note: Correct as of 14 October 2026.

Report a notifiable incident to
1800 678 198

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

Recent prosecutions

Mine owner and operator fined \$810,000 over worker injury

Mine owner and operator FQM Australia Nickel Pty Ltd has been fined \$810,000 and ordered to pay \$11,096.20 in costs by the Albany Magistrates Court over an incident in which a worker suffered a serious spinal injury.

On 18 March 2023, the injured worker was carrying out maintenance on the Saprolite Stacker at FQM Australia Nickel Pty Ltd's Ravensthorpe Nickel Operation

processing plant when a heavy plant component known as a Roman Shield moved and struck him. The injured worker required spinal fusion surgery, extensive treatment and rehabilitation. The injured worker continues to experience ongoing pain and reduced mobility.

FQM Australia Nickel Pty Ltd pleaded guilty to contravening sections 19(1) and 31(1) of the *Work Health and Safety Act 2020*. The company failed to comply with a health and safety duty and, by that failure, caused serious harm to a worker.

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

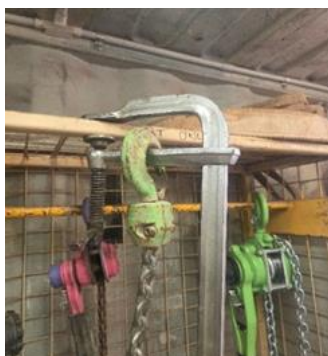
Reportable incidents

Improvising lifting arrangement fails during plate reinstallation

Workers narrowly avoided injury after a chain block and 190-kilogram steel plate fell more than 10 metres during refurbishment work on a leach tank.

Maintenance workers were reinstalling the steel plate on the tank's upper ring when they substituted an F-clamp for a beam clamp specified in the approved lifting method. The manufacturer did not design, rate or approve the F-clamp for lifting or load suspension. Workers observed movement in the hand-tightened clamp, briefly stopped work and re-tightened it before resuming the task. Shortly afterwards, the clamp detached from the beam, causing the chain block and steel plate to fall to the tank floor below.

The incident shows how substituting equipment in high-risk lifting tasks can undermine critical controls when workers do not reassess the lifting method and verify that lifting equipment is suitable for its intended purpose. Workers can increase their exposure to dropped-object hazards when they continue lifting activities after identifying signs that lifting arrangements may be failing.



An example of an F-clamp and chain block arrangement



An example of a beam clamp

Takeaways

- **Plan lifts in detail:** Identify lifting equipment, anchorage methods, load paths, support arrangements and critical controls before starting work.
 - **Verify suspension and anchorage points:** Confirm all lifting attachment points are suitable, secure and capable of supporting the intended load.
 - **Use equipment only for its intended purpose:** Select lifting devices and anchorage equipment, inspect them before use and verify they can safely support the intended load.
 - **Maintain effective supervision:** Actively supervise high-risk lifting activities to verify workers follow approved controls and work methods.
 - **Reassess changes to lifting methods:** Stop work and reassess risks whenever workers change a lifting method or substitute equipment.
 - **Encourage intervention:** Empower workers to stop work immediately when they identify unsafe conditions, equipment substitutions or control failures.
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Light vehicle leaves mine road in dust plume

A worker narrowly avoided injury after a light vehicle left a mine road and entered a drainage area when bulldust reduced visibility.

The light vehicle was travelling behind another vehicle when it encountered a dense dust cloud generated by the leading vehicle. Calm conditions prevented the dust from dispersing, significantly reducing visibility. After entering the dust plume, the driver lost sight of key visual references, including road edges and windrows. While slowing the vehicle, the driver was unable to identify a change in road alignment and continued straight ahead, leaving the roadway, crossing a windrow and entering a drainage area before coming to a stop.

The incident shows how dust can rapidly remove critical visual references and increase the risk of vehicle incidents on mine roads. Workers can reduce their exposure to these hazards by maintaining safe separation distances, adjusting their speed to conditions and stopping when visibility becomes significantly impaired.

Takeaways

- **Treat dust as a critical driving hazard:** Recognise that reduced visibility can significantly increase the risk of vehicle incidents on haul roads and access roads.

- **Adjust driving to conditions:** Reduce speed and increase following distances whenever dust, adverse weather or other visibility issues are present.
- **Maintain safe separation distances:** Keep adequate spacing between vehicles to minimise exposure to dust generated by other road users.
- **Respond to reduced visibility:** Slow down and stop in a safe location when dust clouds prevent drivers from identifying road edges, windrows or changes in road alignment.
- **Identify and manage recurring dust hazards:** Inspect and maintain roads prone to dust generation and implement effective dust suppression controls.
- **Maintain situational awareness:** Monitor road alignment, changing conditions and environmental factors that may affect safe vehicle operation.
- **Review traffic and road management controls:** Consider dust-prone areas when assessing road design, maintenance requirements and traffic management arrangements.

Suspected exhaust fan failure starts accommodation fire

A suspected failure of a wall-mounted exhaust fan started a fire in the bathroom of a room within a mine accommodation facility.

Initial findings indicate the exhaust fan may have malfunctioned and overheated, causing hot material from the fan assembly to fall onto toilet paper stored on top of the toilet and ignite a fire. The building fire alarm system activated, alerting nearby personnel. A passerby entered the room, extinguished the fire using a dry chemical powder extinguisher and confirmed no occupants were present before emergency response personnel attended and secured the area.

The incident shows how electrical equipment faults can create ignition sources in accommodation facilities and how layered controls, including equipment maintenance, fire detection systems and emergency response arrangements, can limit the consequences of fire. Workers can reduce the risk of fire escalation by maintaining equipment, managing combustible materials and responding quickly when fire detection systems activate.

Takeaways

- **Maintain electrical equipment:** Regularly inspect and maintain fans and electrical fixtures to prevent overheating and failure.
- **Control combustible materials:** Store paper products and other combustible items away from potential heat or ignition sources.

- **Ensure fire detection systems are operational:** Verify alarm systems remain functional to support early detection and response.
- **Support effective first response:** Provide accessible firefighting equipment and train personnel to respond appropriately to fire events.
- **Apply precautionary controls:** Isolate affected areas and evacuate nearby occupants when necessary to reduce exposure during fire incidents.
- **Investigate faults promptly:** Identify and rectify equipment issues as soon as possible to prevent recurrence.

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