Resources Regulator
Department of Regional NSW

NSW GOVERNMENT

Investigation information release

Date: May 2024

Driller's assistant seriously injured at CSA mine

Incident date: 11 April 2024

Event: A contract worker suffered serious injuries during drill rig operations

Location: CSA mine, Louth Road, Cobar NSW

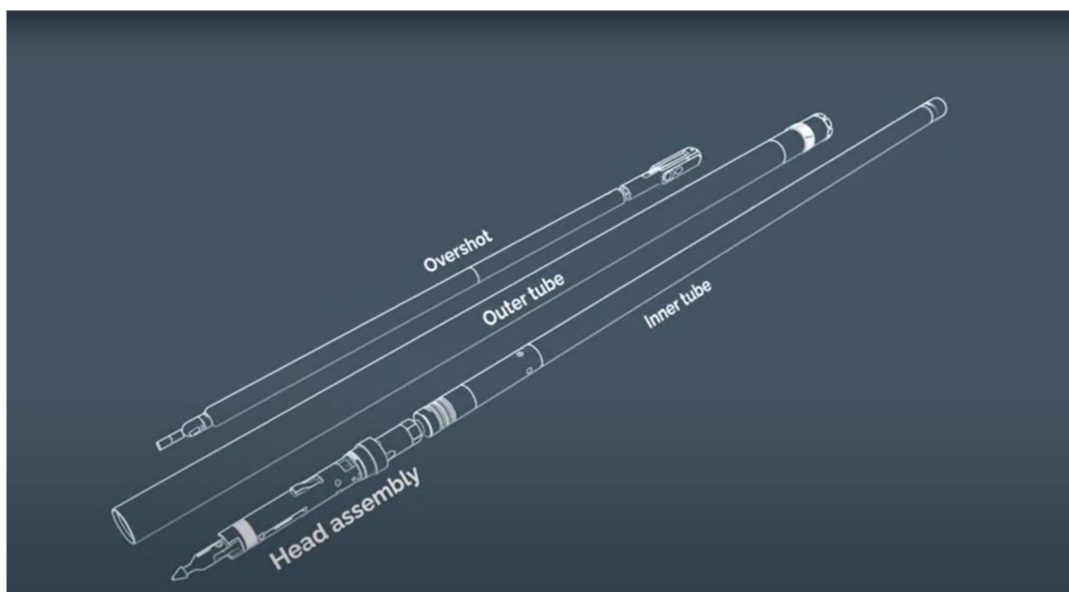
The mine

The CSA mine is operated by Cobar Management Pty Limited, a subsidiary of Metals Acquisition Corp. (Australia) Pty Ltd. CSA is an underground mine about 11 kilometres from Cobar in central NSW. At the time of the incident, the mine was operating at depths of 1.9 kilometres below the surface and produced about 40,000 tonnes of copper per annum. The mine engaged HMR Drilling Services Pty Ltd to conduct underground diamond drilling using Boart Longyear drill rigs.

The incident

Two workers, operating a Boart Longyear drill rig, were conducting diamond drilling at the 8470 EXP level of the mine about 1.35 am on 11 April 2024. Drilling operations were conducted by a driller and a driller's assistant, with each worker having specific tasks. Drilling operations were conducted to obtain core samples from the ground using an outer tube, an inner tube and an overshot (**figure 1**).

Figure 1: Parts used to obtain core samples



One of the tasks conducted by a driller's assistant included the operation of an overshot (**figure 2**). An overshot was connected to a drill rig's winder via a steel cable. It is manually lowered into an outer tube after which a locking pin (ezy-lock) connects it to the inner tube that contains a core sample. The overshot is then retracted by operation of the drill rig's winder, extracting the inner tube with the core sample. When not in use the overshot was normally positioned on the jump up stand.

Figure 2: Photo of the overshot with inner pictures of the locking pins and cable connection

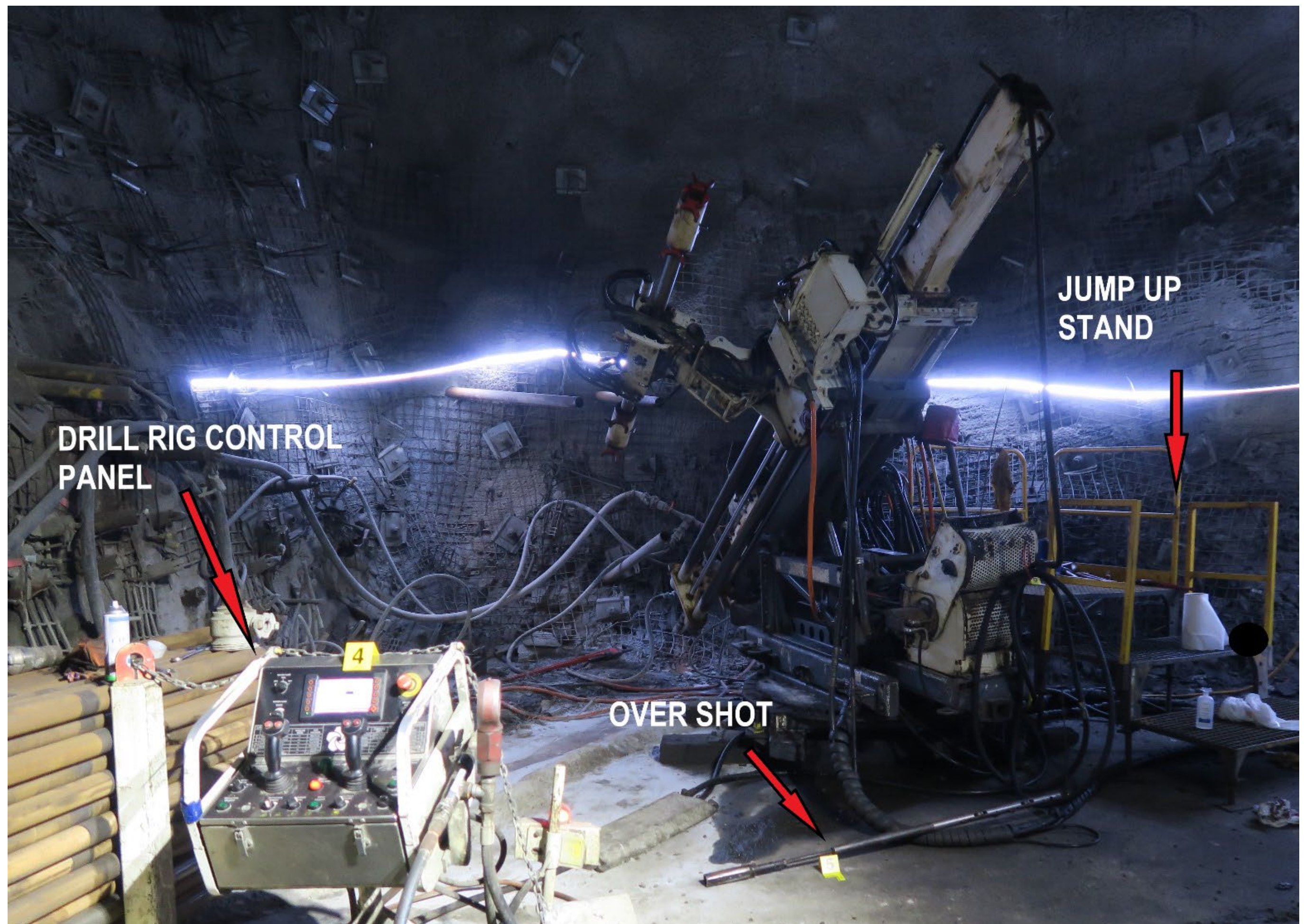
On this occasion during the drilling process, there was a miscommunication between workers regarding a task. This resulted in the driller's assistant leaving and returning to the jump up stand several times. About this time, the diamond driller was operating the drill rig control panel to retract the head to align the outer-tube level with the drill rig mast. The purpose of this was to position the outer tube so the driller's assistant could insert the overshot.

While operating the control panel, the driller saw the driller's assistant in the vicinity of the jump up stand. A short time later, the driller saw the assistant fall backwards off the stand onto the ground, a height of about half a metre. The driller ran to help and found the worker unconscious with serious head injuries.

At the time of writing it was unknown what caused the assistant to fall backwards. The overshot had not been inserted into the drill rod, and immediately after the incident, the driller saw the overshot suspended by a cable about 1 metre from the top of the mast. The overshot was swinging back and forth. It was not known where the overshot was situated or stored immediately before the incident.

The diamond driller immediately sought assistance via the two-way radio. Nearby workers attended the scene and provided first aid to the injured worker who was transported to the Cobar hospital. The injured worker was later transferred to Westmead Hospital.

Figure 3: Photo of the drill rig, control panel, overshot and jump up stand at incident site – 8470 EXP level



The investigation

Inspectors and investigators from the Regulator responded to the incident. An investigation began to determine the cause and circumstances on the incident, which will explore, among other things, the:

- mechanism of the incident
- operation of the plant and equipment involved in the incident
- instruction, training, experience, work practices, and supervision of workers
- adequacy of the design of plant and equipment involved in the incident
- adequacy of the mine and contractors' safety management systems, including risk assessments and procedures.

Safety information

Mine operators and plant contactors are reminded of their duty to manage the risk to health and safety associated with an object falling (the risk) on a worker in accordance with *clauses 54 and 55* of the *Work Health and Safety Regulation 2017* by, so far as reasonably practicable, taking the following steps in the following order and in combination:

1. Eliminating the risk, or
2. minimising the risk by providing:
    a. adequate protection against the risk through a safe system of work that:
        i. prevents an object from falling freely, or
        ii. arrests the fall of a falling object if prevention is not reasonably practicable.
    b. A secure barrier or an exclusion zone that prohibits entry by workers into the fall zone.

Further information

Please refer to the following guidance materials:

- NSW Resources Regulator facts sheet, falling objects metalliferous mines and large quarries, July 2022
- MDG-15 Mobile and transportable plant for use on mines and petroleum sites
- Managing the risks of plant in the workplace, SafeWork NSW December 2022
- How to manage work health and safety risks, SafeWork NSW August 2019

About this information release

The Regulator has issued this information to draw attention to the occurrence of a serious incident in the mining industry. Further information may be published as it becomes available.

Visit our website to:

- learn more about our work on causal investigations and emergency response
- view our publications on other causal investigations

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