Investigation information release

Date: May 2023

Fatality in underground opal mine

Incident date: 28 April 2023

Event: Fatality in an underground opal mine

Location: Coocoran opal field.

Overview

An opal miner was found deceased at the base of a 20 metre opal mine shaft.

The mine

Mineral claim 61376 is a standard class A mineral claim in an area known as 'Emu's' within the Coocoran opal fields located about 30 km north of Lightning Ridge NSW. The miner had held the claim since September 2020.

The incident

The miner was seen leaving Lightning Ridge to attend his opal claim about 6.30 pm on Friday 28 April 2023. The miner was known to work the claim alone. Friends of the miner attended his claim about 5.30 pm because they had not heard from him for several hours and were concerned for his welfare. The miner was later found deceased near the base of the shaft.

An examination of the scene found the person riding hoist and pendant control at the bottom of the shaft with the steel cable fully unspooled from the hoist's drum. The hoist's emergency arresting (lockout) device did not appear to have engaged. The hoist was operated by a Conon single phase 2 HP motor and worm drive gearbox.

Figure 1: MC 61376 with hoist and ladder/rails to person riding hoist

Figure 2: Cable from hoists drum was found completely unspooled

Figure 3: Person riding hoist found at the bottom of the shaft with unspooled cable. Note the safety breaking system has not engaged

The investigation

The NSW Resources Regulator has commenced an investigation to determine the cause and circumstances of the incident that will explore, among other things the:

- operation and mechanical condition of the person riding hoist, including the motor and gearbox
- adequacy of maintenance, testing and inspection practices for the equipment
- person riding hoist braking system(s) including emergency arresting (lockout) device
- method and adequacy of the hoist power supply
- work practices of the miner.

The investigation will consider whether any mechanical or electrical malfunction contributed to the incident. A report will be prepared for the Coroner.

Safety information

Mine operators using person riding hoists must ensure they consider risks associated with winder systems and implement measures to prevent mechanical and/or electrical failures.

All hoists must have 2 braking systems – a brake and an emergency arrestor.

Person riding hoists should be regularly tested and maintained to ensure they are operating correctly.

There are a number of health and safety duties set out in the *Work Health and Safety Act 2011* and *Work Health and Safety (Mines and Petroleum Sites) Act 2013*. These duties are applicable to people who operate material hoists and person riding hoists at opal mines.

In particular, mine operators should review the following information:

- Regulation 50 Work Health Safety Regulations 2022 - Winding systems
- Opal and gemstone mining guide

Further information

Please also refer to the following guidance materials:

- TRG Winding systems in small gemstone mines (nsw.gov.au)
- Fact sheet - winding systems for small gemstone mines
- Code of practice - Managing the risks of falls at workplaces
- Safety alert - Opal miner injured in shaft fall 2018
- Death of Brian Bryant at mineral claim 51724 in 2020
- Death of Mark Siegel at mineral claim 44507 in 2016

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 investigation

© State of New South Wales through Regional NSW 2023. You may copy, distribute, display, download and otherwise freely deal with this publication for any purpose, provided that you attribute Regional NSW as the owner. However, you must obtain permission if you wish to charge others for access to the publication (other than at cost); include the publication in advertising or a product for sale; modify the publication; or republish the publication on a website. You may freely link to the publication on a departmental website.

Disclaimer: The information contained in this publication is based on knowledge and understanding at the time of writing [May 2023] and may not be accurate, current or complete. The State of New South Wales (including Regional NSW), the author and the publisher take no responsibility, and will accept no liability, for the accuracy, currency, reliability or correctness of any information included in the document (including material provided by third parties). Readers should make their own inquiries and rely on their own advice when making decisions related to material contained in this publication.

Document control	
CM9 reference	RDOC23/99637
Mine safety reference	IIR23-04
Date published	May 2023
Authorised by	Chief Investigator, Major Safety Investigations