Prosecution Summary of Conviction

RUC Mining Contractors Pty Ltd (ACN: 051 252 549)

LEGISLATION:		*Work Health and Safety Act 2020*				
Charge	**Charge Number**	**Sentenced Date**	**Regulation**	**Section**	**Penalty**	**Offence Date**
1	**KA 4411/2024**	**05/09/2025**		**19(1) 32(1)**	**$540,000**	**11/10/2022**
2	**KA 4412/2024**	**05/09/2025**		**19(1) 32(1)**	**(Global fine 1 & 2)**	**11/10/2022**

BREACH (2 charges)

Being a person conducting a business or undertaking, did not, so far as was reasonably practicable, ensure the health and safety of a worker while the worker was at work in the business or undertaking, and by that contravention exposed the worker to a risk of death or of injury or harm to the worker's health, contrary to sections 19(1) and 32(1) of the *Work Health and Safety Act 2020.*

DETAILS

Summary
On 11 October 2022, a senior driller employed by RUC Mining Contractors Pty Ltd (RUC) at St Ives Gold Mine – Hamlet Underground Mine, near Kambalda, Western Australia was killed at work. This mine was owned by a mining company which had engaged RUC to conduct raisebore drilling work. Raise boring is a drilling technique used to create vertical or near-vertical shafts or raises (upward passageways).

The senior driller was working with and training a probationary offsider. They were disassembling a reamer attached to a drill string by unbolting and removing wings attached to the centre box of the reamer at the base of a raise (a ventilation shaft) which had been drilled through raise boring.

The process used to disassemble the reamer involved lowering the reamer to the bottom of the hole it had drilled, placing a portion of the circular reamer head positioned under supported ground, and with additional protection for workers by means of safety curtains made of rubber conveyor belt material bolted to the rock backs and hung vertically over the reamer head to act as a physical barrier to deflect rockfalls and subsequent ricochets. The reamer was to be rotated so that the parts of it being worked on at any time were under supported ground and behind the safety curtains. After the reamer head had been fully stripped, it was to be removed from the drill string through cutting a burnout ring on the drill string and then moved away from the hole.

At approximately 4pm, the senior driller was standing on the top of the reamer head while undoing bolts on the top of it. The offsider was standing on the ground close to the edge of the reamer, feeding the senior driller the air hose for the rattle gun he was using. At that time, the senior driller was standing close to the safety curtains but under unsupported ground. A rock fall occurred, striking the senior driller and causing the offsider to fall to the ground. The senior driller was killed instantly, and the offsider suffered minor injuries.

RUC Procedures
At the time of the incident RUC had a procedure in place for the installation of the curtains: “Conveyor Curtain Installation Procedure”. This procedure provided that safety curtains are regarded as “safety critical items” acting as a physical barricade to prevent injury or death from falling or ricocheting rocks. The procedure provided that “no deviation/alteration to the design specifications and installation procedure shall be permitted”. Under this procedure, the suspended pieces of conveyor belt comprising the curtains were required to overlap by 300mm to create an effective barricade.

Prior to the incident
By the evening of 10 October 2022 RUC nightshift workers had completed the raisebore drilling of the ventilation shaft. They had hung safety curtains onto rails installed into the rock back by a jumbo operator employed by the mine contractor.

The nightshift workers had brought the reamer to the base of the raise, pulled it as far out of the open hole as possible and secured it by a chain and ‘come along’ on a torque plate located on the left-hand wall of the mine drive. The curtains were intended to hang down and drape over the reamer.

Normally the reamer would be centred in the hole through being secured by chains to two torque plates on the walls on each side of the hole. However, the workers were unable to secure the reamer to the right-hand wall of the drive as the torque plate installed there had previously been knocked off the wall by a bogger. As a result, the reamer head was not properly placed behind the brow under supported ground – it was swinging to the left and was not centred in the drive. As a result, the curtains were not draping properly over the reamer head. There was one curtain flap hanging down on the right side which could not be properly draped over the reamer.

The senior RUC nightshift worker had decided that a torque plate needed to be installed on the right-hand wall so that the reamer head could be properly centred and secured. He contacted the min contractor and made a booking for early the next morning shift for the mine contractor to install a torque plate on the right-hand wall. The RUC nightshift workers told the RUC dayshift workers about this plan at a handover meeting.

The installation of the second torque plate was delayed. Instead of doing this in the morning, the mine contractor jumbo driver was not able to do it until around 2:30pm but the RUC workers told him that they wanted to continue what they were doing and the torque plate task was postponed to the nightshift.

During the dayshift from approximately 11am to 3pm, the RUC Area Manager visited the area where the RUC workers were. He saw the safety curtains and observed that they were not completely overlapping. Also, at 11.41am, the area where the RUC workers were working was visited by a certified underground supervisor employed by the mining company. The mining company supervisor asked the RUC workers about the task they were undertaking. They told him that what he had observed, including the installed safety curtains, was their standard procedure for the job – all work was to be carried out whilst under supported ground and behind the safety curtains.

During this dayshift while the RUC Area Manager was present and assisting the senior driller and his offsider, a rock fell against the rear of the reamer, behind the curtains. They stood back from the reamer for between five to ten minutes to ascertain if further rock falls would occur before deciding to recommence work on the reamer. After they recommenced work the senior driller climbed on top of the right-hand side of the reamer and began work on removing further bolts from the large right-hand side wing. The Area Manager instructed the senior driller to climb off the reamer as he was of the belief that he was working too close to the curtains directly underneath the hole, i.e. under unsupported ground.

At 3:00pm the Area Manager decided that given the time of day, the reamer should be put back in the hole and rotated so that another side of it could be brought under supported ground to be worked on. He told the others of that plan and he left to go up to the surface with the offsider.

Incident
On the offsider’s return to the location at 3:57pm, he and the senior driller continued dismantling the reamer, undoing bolts to remove wedges (which hold the reamer wings in) on the surface of the reamer.

The senior driller was working on top of the reamer at or near the spot where the Area Manager had earlier seen him and told him to move from. The offsider was standing on the ground in front of the reamer away from the hole, feeding the air hose for the rattle gun used by the senior driller on top of the reamer.

Just after 4:00pm the offsider heard a loud noise and was knocked off his feet to the ground. He called out to the senior driller but received no response. Using his cap lamp, the offsider found the senior driller lying deceased on top of the reamer. The senior driller had been struck by a rock and was fatally injured in the same location that the Area Manager had previously seen him working and told him to move from.

The offsider declared an emergency using his hand-held radio. Shortly afterwards workers from the Mine arrived at the incident scene to carry out emergency procedures, to convey the injured offsider to the surface to receive medical treatment, and effect removal of the senior driller's body.

Changes made as result of incident
RUC updated the Conveyor Curtain Installation Procedure to emphasise that curtains are to overlap by a minimum of 300mm and that under no circumstances are personnel to work beyond the brow. It also includes the instruction:

> 7.10 Once all curtains are hung, closely check that the curtain coverage is from wall to wall, that curtains drape onto the floor and that the overlap is to standard. If any gaps are identified, correct as required prior to performing the next task.

OUTCOME	Pleaded guilty – convicted and fined
FINE	$540,000 (Global)
COSTS	$8414.00
COURT	Magistrates Court of Western Australia – Kalgoorlie