

SECTION III.—ACCIDENTS.

The following is a summary of coal-mining accidents during 1918, with their causes:—

| | Fatal Accidents. | | Serious Non-fatal Accidents. | |
|--------------------------------------|-------------------------------------|-------------------|---|---|
| | Number of Separate Fatal Accidents. | Number of Deaths. | Number of Separate Non-fatal Accidents. | Number of Persons injured, including those injured by Accidents which proved Fatal to their Companions. |
| Explosions of fire-damp or coal-dust | ... | ... | 1 | 1 |
| Falls of ground | 6 | 6 | 8 | 10 |
| Explosives | ... | ... | ... | ... |
| Haulage | ... | ... | 2 | 2 |
| Miscellaneous—Underground... .. | ... | ... | 12 | 12 |
| On surface | ... | ... | ... | ... |
| Totals | 6 | 6 | 23 | 25 |

The death-rate from accidents was 1.50 per 1,000 persons employed, or 2.95 deaths per 1,000,000 tons of coal produced.

All of the six fatalities were due to falls; with proper care most of these would have been avoided. The explanation for nearly all of the fatal accidents was the usual concealed joint known to miners as "greasy," "slippery," or "sooty" "backs." The most reliable preventive of such dangers is provided for in the regulations—viz., by systematic timbering right up to the face, and by the frequent use of sounding-rods and ladders for high places. During my inspections I seldom visit a colliery without finding one or more cases of needless risk being taken by miners by failure to support the roof and face of their working-places.

In the case of William Downs, killed by a fall at Blackball Colliery, the evidence at the inquest showed that there was no sounding-rod or ladder in the working-place, although the overhanging coal which fell was 15 ft. above the floor. In the case of Frank Mitchell, killed by a fall in the Wareatea Section of the Coalbrookdale Colliery, it is probable that if the use of props and bars had been insisted upon by the management, as instructed by Inspector Newton and myself, this accident would not have occurred.

The following is a description of fatal accidents in connection with coal-mining operations during 1918:—

| Date. | Name and Situation of Colliery. | Name, Age, and Occupation of Person killed. | Description of Accident, and Remarks. |
|------------------|---|---|---|
| 1918. 17 Jan. | Blackball Colliery, Blackball | William Downs (32), miner | In H level, Section 17, of the panel workings, he was with his mate employed bringing back in a retreating manner overhead coal from above a split through a pillar. The split was about 6½ ft. high and 5½ ft. wide when first driven. The coal-seam 18 ft. above its floor contains a clay band about 1 ft. in thickness, above which the top coal is left unworked for a roof. He was preparing a shot in the overhanging coal and band at a height of about 15 ft. above the floor, when a fall occurred without warning, covering him and inflicting injuries from which he died the following day. No sounding-rod or ladder was provided in the place to enable an examination of the overhead coal and roof, which is in this mine extremely treacherous, and has caused several fatal accidents. The Coroner, when giving his verdict at the inquest, stated that "sounding-rods, prickers, and ladders should be provided in any place where the height exceeds 9 ft. or 10 ft. But I do not find that in this case deceased's death was in any way caused by the want of any of these appliances." There is no provision in the Coal-mines Act or Regulations that they shall be supplied. |
| 4 April | Westport-Stockton Colliery, Manga- tina | Edward John Paterson (32), miner | He was working with his mate in a lift off a pillar in D section of the mine when about 10 cwt. of coal fell without warning from a slippery joint, striking and killing him almost immediately. The height from the floor to the strong sandstone roof was about 10 ft. A clay parting occurred in the coal-seam 2½ ft. below the roof; from this parting the joint extended 3 ft. to the roof. At the inquest the mate of deceased stated that the face of the lift where the fall occurred was practically square and did not overhang; no sprag or face prop was set. The Coroner's jury found that no blame was attachable to any one. The circumstances raise a doubt as to the adequacy of the roof-support prior to the fall. The "slippery joint" was then invisible, but such must everywhere be anticipated by systematic timbering. |