



## DEATH OF MINE SURVEYOR IN ROCKFALL

In his findings as a result of an inquest into the death of a mine surveyor in a rockfall in an underground mine during 1997, the Coroner made the following general observations regarding the prevention of similar deaths in the future:

- *That the final scaling of underground excavations be carried out at close quarters using a scaling bar from a platform attached to the bucket of a loader or an IT unit or similar vehicle;*
- *That regular scaling of all main access ways is considered to be an appropriate method of ensuring that the risk of unexpected rock fall is minimised;*

and

- *That the necessary scaling procedures should be implemented regardless of cost and time considerations.*

In findings related to the specific circumstances of this particular incident, the Coroner recommended that measures be taken to:

- *Ensure the ready availability of mining industry sponsored emergency monitoring service contacts to serve mines in remote areas;*
- *Ensure the ready availability of purpose-designed emergency service vehicles;*

and

- *Ensure compatibility between the types of stretcher available on mines and those used both in mining industry sponsored and in publicly sponsored emergency vehicles, so as to minimise the unnecessary movement of injured persons.*

It is requested that employers and managers in the mining industry consider their own operations in the light of these recommendations and implement any necessary additional controls.

It should be noted that a Code of Practice is being developed through MOSHAB for the securing of backs in headings of extended height and width, in accordance with recommendation 1.8 of the Report on the Inquiry into Fatalities in the WA Mining Industry.

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