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Subject: Death of an airleg miner in a rockfall – Coroner’s comment and recommendation

In his record of his investigation into the death of an airleg miner in September 2006, which was concluded recently, the State Coroner made the comment and recommendation noted below.

The deceased was struck while working on drilling stripping holes in the sidewall of his work area. He was struck by a large rock, which fell under gravity from the point of intersection of the backs and sidewall.

At the inquest, there was debate about the adequacy of the ground support (and the clarity of written instructions issued about it) and the lighting available to the deceased. A possible factor in the death was the ability to distinguish (with the lighting available – a standard cap-lamp) between two rock types of very similar appearance and to identify rock structure and discontinuities that may have revealed the presence of a wedge-shaped block of rock that could, potentially, fall under gravity if not adequately supported.

The Coroner commented that, in his view, the case had highlighted the need to have additional sources of light available in such mining areas where it might be important to be able to distinguish differences in rock type and to easily identify potentially adverse structures in the rock.

The Coroner also recommended that:

“… when airleg miners are working as contractors underground and are required to install ground support, they be provided by mine management with a short document which clearly identifies the precise extent of ground support required, including the circumstances in which it appropriate for those miners to exercise their discretion to provide additional support.”

The Coroner’s comment and recommendation in this case are drawn to the attention of the managers of underground mines where airleg operations are carried out, with the further recommendation of the mines safety inspectorate that they are reviewed and acted upon where they may be applicable to those operations.

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