FATAL ACCIDENTS AT MINING OPERATIONS OTHER THAN COAL-MINING-continued.

Name of Person kil	led.	Date of Accident.	Mine or Claim.	Cause of Accident, and Remarks.
Alfred Stone		31/3/15	Talisman Mine (quartz)	Deceased, and his mate, Leslie Kirk, were driving the face of the S drive, No. 15 level. After spitting and firing in one section cleven holes (in contravention to Regulation 94 (9), six holes being the maximum under those conditions), it is alleged that eleven reports were counted, they returned to the place to work down loose ground; they subsequently erected the rock-drill. After striking a few blows with the drill an explosion occurred killing deceased and injuring Kirk's eyes. The Coroner delivered a verdict that the injuries were received owing to the drill coming into contact with unexploded gelignite, which he believed had fallen from some previous charge into a crevice, and he recommended that faces should be hosed down before firing, and a search made for unexploded cartridges. The Inspector of Explosives drew attention in his evidence to the necessity of keeping all gelignite perfectly dry and the advisability of using detonators of No. 7 size in preference to No. 6. The recommendation of the
Frederick Paton		25/4/15	Talisman Mine (quartz)	Coroner is now incorporated in the new Mining Regulations, 94 (9). Deceased, a pumpman, with two others, was engaged repairing a sinking-pump near the bottom of the Talisman inclined (63°) shaft, when he slipped from a ladder and fell to the sump below, receiving concussion of the brain when falling. The Coroner returned a verdict
Peter Antwis	••	2/5/15	Waihi Grand Junction Mine (quartz)	of accidental death. This fatality occurred in a stope worked on the shrinkage system on the Royal lode above No. 6 level. The deceased with his mate, together with the assistant manager and shift boss, were debating where to start cribbing a double pass when a large piece of quartz fell from the back of the stope, killing deceased instantaneously. Although the highest point of the stope did not exceed 5 ft. a proper examination of the back had not been made that morning before the commencement of work. The Coroner returned a verdict of accidental death, with a rider that the attention of miners should be drawn to the importance of a thorough examination of each stope before commencing work each shift; obviously
Max Oertmann	••	28/8/15	Ross Minc (deep alluvial)	sound advice. Deceased, a competent miner, was working with his mate in one of the blocking-faces above the No. 7 level. The ground was worked on the false-set system, the roof being compact gravel. The timber was temporarily held together by two short and two long timber dogs, which were removed and refixed as further sets were erceted. Deceased having stood a main set, stepped back to remove the dog from the last set to the main set next to the trucking road, his mate holding one end of the dog while he knocked out the other end. Directly he had done so one set sprung and fell to the face, pushing over the false set and the main set; deceased, who was standing so as to keep the set in position, was buried under a fall of ten or fifteen tons of coarse gravel and wash. An inquest was held and a verdict of acci-
John Matthew		1/10/15	Waihi Mine (quartz)	dental death was returned by the jury. The deceased, a Maori, was standing on the quartz at the top of an uncovered pass in a stope about 50 ft. above No. 10 level when the quartz, which had become blocked, suddenly collapsed, precipitating him down the pass and burying him; an hour later when his body was uncovered life was extinct. The Coroner returned a verdict of accidental death, with a rider drawing attention to the clause in stoping contracts providing that all passes shall be securely covered with strong poles, and that when a pass is in use no space exceeding 12 in. wide shall be left open for quartz or filling material. Deceased was mining on contract, and in charge of the
Jam∈s Lanini		15/11/15	Bell Hill (sluicing-claim)	stope wherein he was killed. At the time of this accident deceased was working in an open channel about 45 ft. deep. The channel connects a tail-race tunnel with a sluicing-paddeck, and is constructed through fine gravel and silt. It was without adequate batter or timber support, having only been completed a few days. A fall suddenly occurred during rain, burying deceased. When extricated about three hours later he was dead. A verdict of accidental death was returned by the Coroner at the inquest which followed.