

DEPARTMENT OF MINERALS AND ENERGY WESTERN AUSTRALIA

SIGNIFICANT INCIDENT REPORT NO. 58

REMOVAL OF A RISE LADDER - FATAL ACCIDENT

INCIDENT

A longhole stope miner received fatal injuries when he fell 40m into an open stope whilst removing a ladder in a stope rise. The method of mining required working from a 3 deck stage suspended in the rise. The ladder was part of a continuous emergency ladderway installed on the footwall of the rise and the stoping method dictated that the ladderway was removed progressively as the stope was advanced upwards by firing horizontal longholes drilled from the rise.

While a colleague was on the middle deck of the stage preparing a sling to anchor the ladder, the deceased went down the stage access ladder below the middle deck to unbolt the lowest section of the rise footwall ladder. The rise ladder connection was not accessible from the stage due to the excessive gap between the bottom deck and the footwall. In the process of removing the ladder the deceased fell (together with a section of the ladder) into the open stope and sustained fatal injuries.

CAUSE

- 1. The method of work involved removing sections of the ladder from within the rise, rather than hauling up the entire ladder and removing sections from the level above.
- 2. The ladder's joints were not approachable from the stage, requiring work either from the ladder itself or from the footwall of the rise. The system of work was less than satisfactory.
- 3. The deceased miner did not use a fall arrester, though such equipment was available at the job site.

PREVENTATIVE ACTION

A written procedure for installing and removing continuous ladderways in steeply inclined openings should be developed. This should involve work from the level above, rather than work in the rise.

Where any work is required in steeply inclined openings, a safe approach and firm footing must be provided and the use of fall arrest equipment and overhead protection is mandatory.

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