The following is a brief description of fatal accidents in connection with metalliferous mining operations during 1917 :—

Date.	Name and Situation of Mine.	Name, Age, and Occupation of Person killed.	Cause of Accident, Nature of Injuries, and Remarks.
22 Feb. ..	Waihi Grand Junction Mine, Waihi ..	William Evan Crompton (40), shift boss..	With the chamberman he assisted a miner, C. Naylor, who had been slightly injured, into the cage at No. 6 level. The cage had no gate, but had a hinged bar at each end 4 ft. from the floor; but there is no evidence that such bars were put up. Also it was provided with chains attached to its interior sides, which could be clasped round the waists of persons travelling. There was no evidence to show if deceased made use of such chains on this occasion. The chamberman entered the cage and signalled to ascend. During the ascent, for no accountable reason the deceased fell out of the cage and was instantaneously killed. The chamberman was subsequently prosecuted by Mr. M. Paul, Inspector of Mines, for a breach of Regulation 94 (12) under the Mining Act, which specifies that every cage shall be provided with suitable gates or other approved barriers when persons are riding, the chamberman having, under section 8 (*c*) of the Mining Amendment Act, 1914, control of the chamber and the regulation of the descent and ascent of persons in the shaft. The charge was dismissed, no direct evidence being obtainable as to whether deceased had used the safety chains. The Warden, however, ruled that the braceman and chamberman were jointly in control of the shaft and signalling, and were responsible for the use of safety appliances in connection with cages. The Inspector has since notified all mine-managers that all cages used for raising or lowering men shall have fixed gates opening only inwards.
18 April ..	Bull's Battery, Thames	William John Ward (44), part-owner of battery	With his two partners he had repaired a berdan driving-belt, after which he ascended to a platform parallel to the driving-shaft, where he sat down, his legs hanging below the platform. One of the partners below had just finished coupling the belt when it went out of his hands and caught around the foot of deceased, causing him to be revolved round the driving-shaft for about five minutes before the machinery was stopped. It is believed that the accident was due to the belt catching on a bolt-end standing out from the pulley, and being wound up round the shaft. The injuries received by deceased, and from which he died about three hours later, consisted of a very bad crush of the left leg, necessitating amputation, with consequent loss of blood and shock.
4 July ..	Rise-and-Shine Gold-dredge, Cromwell ..	William John Ritchie (46), dredgemaster..	To disconnect a chain of buckets on a ladder, a wire rope was led to a pulley attached by a shackle to a $\frac{3}{4}$ in. eyebolt in the deck 29 ft. in front of the winch, and then on to the surge-drum of the winch. He was standing by that drum to take in the slack rope as the strain came on, when the eyebolt broke, the pulley-shackle and part of the bolt flew back and struck deceased, fracturing his skull. He died three days later. It was found that the eyebolt had a bad flaw. The deceased was responsible for the quality of the plant used, and controlled the operations.
13 July ..	Waihi Grand Junction Mine, Waihi ..	James McConnell (33), miner	With his mate James Stubbing he was sinking a winze below No. 7 level on the Royal lode; a depth of 22 ft. had been attained, six holes had been drilled which deceased charged with gelignite, having fuses 5 ft. in length attached. Stubbing then pulled the bucket containing unused gelignite up to the brace of the winze; deceased then spitted the holes with gelignite and lighted them with a candle, after which he ascended the ladder to the collar of the winze, when the first hole went off, severely injuring him. Stubbing reached down and caught deceased by the hands and raised him to the level, along which he carried him to a place of safety. At the subsequent inquest the jury found that a premature explosion occurred owing, they believed, to defective fuse, and recommended electric firing in winzes and rises in future. They highly commended James Stubbing for his bravery in risking his life to rescue deceased. Subsequent tests of that consignment of fuse were made by Inspector of Mines M. Paul, who found it to be in good condition. Some of the gelignite, however, he found to be defective; and if such had been used for spitting, deceased may have been delayed and may unconsciously have spent more time than he was aware of endeavouring to light the gelignite-spitting. The Inspector has since notified mine-managers that to avoid similar accidents, until stocks of reliable time-fuses can be procured, instructions be given to men working in rises and winzes that all fuses be cut at least 6 ft. in length, and that instead of spitting with gelignite a small piece of candle should be placed under the fuse and allowed to burn through.