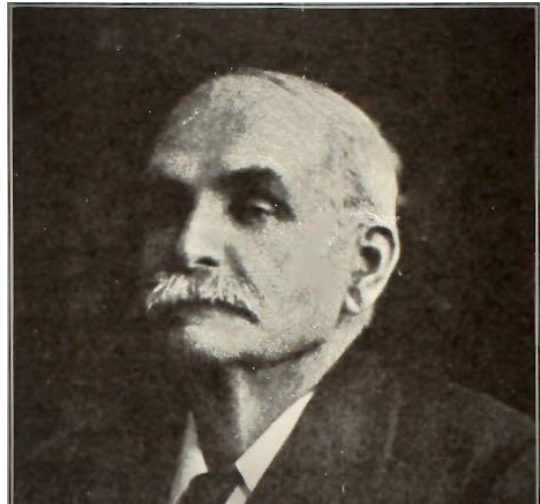


## A Mining Accident in Donnington Wood – Was anybody to blame?

John M. Smith

In this story, we examine a 1908 fatal mining accident in Donnington Wood to see what actually happened, and whether anybody was to blame. Statistics show that death and injuries in the mines were all too common in this time frame. The mine owners' view was that mining was inherently dangerous, and a mine could never be completely safe. They often regarded a miner's death as just an unfortunate accident with nobody to blame. In contrast, the miners thought that a lot of these "accidents" could have been prevented, and the mine owners should be held responsible for them.

The backdrop for our story is William Latham's testimony to the Royal Commission on Mines in 1907. William was the Shropshire Miners' Agent and spoke as the miners' representative. He had 36 years of experience working for the Lilleshall company as a miner at the Freehold Colliery in Donnington Wood. In his testimony, William advocated for improved mining regulations to increase the safety of miners. For our purposes, two of William's many proposals to the Royal Commission are noteworthy.



The first proposal concerns "overwind" accidents. These are accidents when the miners' cage is wound over onto the pit wheel, often tipping the occupants to their death down the mine shaft. To prevent overwind accidents, William proposed that "the use of a detaching hook (a safety device) be made compulsory by law".

The second proposal concerns the composition of juries for Coroners' inquests on fatal mining accidents. William felt that mine owners got off too lightly because juries lacked knowledge about mining and could not properly judge who was at fault. William proposed a requirement that "juries should include some actual miners, rather than just farmers (or similar people) with no mining experience".

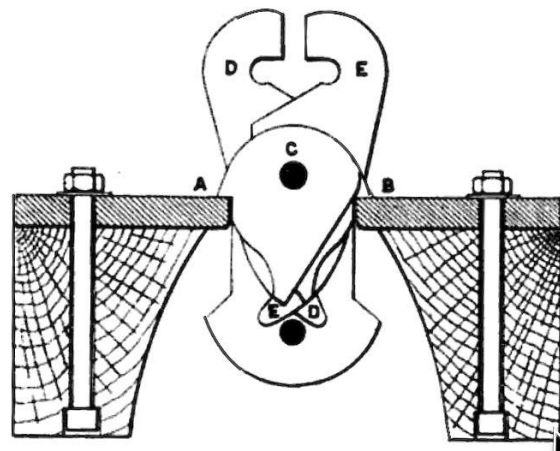
In 1908, just seven months after William's testimony to the Royal Commission, a fatal overwind accident occurred at the Waxhill Barracks Colliery – another Lilleshall Company Colliery right next to the Freehold Colliery where William had worked. This raises the question of why the Lilleshall Company did not use a detaching hook, and whether any fault was found with the Company during the inquest. There is also the question of why the mine was in use at all – the Barracks Colliery had been closed for 8 years. Here is an account of what happened.

By the 1890's, coal production at the Barracks Colliery became less and less economical. The Lilleshall Company decided to stop production in about 1900, but to continue pumping water from the mine and to maintain at least one of its two shafts. This may have been done to preserve access to the remaining coal reserves, or to help reduce water infiltration in adjacent mines. By 1908, every four to six weeks, this shaft, and one of the adjacent water tunnels, were examined and repairs carried out as necessary. It was during one of these maintenance operations that the overwind accident occurred.

Fundamentally, overwind accidents result from the small margin for error when raising the cage in the mine shaft. The movement of the cage is directly controlled by the engineman operating a steam engine. However, the engineman cannot directly observe the position and speed of the cage, and has to rely on secondary indicators such as marks made on the winding rope and signals relayed from the banksman standing at the top of the shaft. If the engineman is late in slowing the cage, or has difficulty with the braking equipment, there is very little time to avert disaster – the cage will just wind onto the pit wheel.

To prevent overwinds, a detaching hook can be used. A detaching hook is fitted between the winding rope and the top of the cage, and a special plate is mounted in the headframe. If the cage is raised near to the pit wheel, two things happen automatically: the winding rope is released, and the cage is securely anchored on the plate in the headframe. The occupants of the cage can then be rescued. Detaching hooks were introduced in 1865, but their adoption by the mining industry was very slow. Even by 1908, they were not in use in some collieries.

The diagram shows a detaching hook after it has passed through the bracket and released the winding rope. The cage hangs from the bottom of the detaching hook and is not shown.



In his testimony to the Royal Commission, William mentioned that the colliery where he worked had installed detaching hooks and that one or two overwind accidents had been prevented. So in 1908, the Freehold Colliery (and probably other Lilleshall Company collieries) had detaching hooks, but the Barracks Colliery did not.

The most likely reason is that the Barracks Colliery was in maintenance mode, rather than full production. The Lilleshall Company likely viewed the installation of a detaching hook, solely for maintenance, as an unnecessary expense. The risk of serious accident may have seemed small when compared to the risk during normal production. William Latham's view was different. He felt that a detaching hook was justified for any shaft where miners (as opposed to tubs of coal) were raised in the cage. He would not have been shy in sharing this viewpoint with the Lilleshall Company managers.

Maintenance operations were usually performed by specially skilled miners called "sinkers". A sinker's primary skill was to excavate new shafts and to stabilize their walls as needed with linings and support framing. This work was very dangerous. Sinkers were exposed to objects falling from the walls, and from baskets going up or down the shaft containing spoils or construction materials. Sinkers were also called upon for the inspection and repair of old shafts.

On Wednesday July 8th, 1908, there was a maintenance operation at the Barracks Colliery. The sinker was Thomas Jones and the engineman was William Evans.

Thomas Jones lived on West Street, St. Georges, with his wife and four young children. He started life as a collier at a young age, became a pit sinker in his early 20's and was later appointed foreman sinker. By the time of the accident, Thomas was age 33 and likely had over 10 years of experience as a sinker. William Evans also lived in St. Georges. He started out as a horse driver before working on steam engines. By the time of the accident, William was 71 years old and had a long accident-free history as an engineman.

Thomas Jones arrived at the pit with an assistant. William Evans lowered them both in the cage and Thomas started the assistant on performing some repairs to the water tunnel. William then raised Thomas alone in the cage.

With the cage about 50 yards from the top, William Evans shut off steam to the engine and then tried to apply the flywheel brake but it appeared to get stuck. He then applied the drum brake but it did not slow the cage sufficiently. With the cage now approaching the top of the shaft the situation became critical. The only option remaining was to use the engine as a brake. This is a tricky operation in which steam is directed against the motion of the piston by manual control of the slide valve. In the heat of the moment, William was unable to perform this operation successfully, and he actually increased the speed of the cage. The cage wound onto the pit wheel, tilted over to one side and tipped Thomas out and down the shaft. He suffered severe injuries and was found dead at the shaft bottom.

A Coroner's inquest on the death of Thomas Jones was conducted a few days later. It was attended by Mr. Beech for the Lilleshall Company, Mr. Johnstone as H.M. Inspector of Mines, and William Latham representing the Miners' Association and the deceased's family. After hearing details of the accident, the jury exonerated William Evans from any blame. Indeed, he had followed all the established procedures in operating the engine, and had done his best to stop the cage. No fault was found with the Lilleshall Company, presumably because a detaching hook was not a legal requirement at the time. The jury returned a verdict of "Accidental Death".

In his official report on the Barracks accident, the Inspector of Mines included the statement: "The accident would probably have been prevented if a detaching hook had been in use". For William Latham this, at least, was a small step in the right direction. The Inspector's dispassionate statement put the Lilleshall Company on notice that they could have done more to prevent the death of a man in the prime of his life, and to avoid a lasting tragedy for his wife Clara and their young children. (Subsequently, Clara worked from home as a seamstress while raising the children alone.)

The sites of the Barracks Colliery and the Freehold Colliery can be visited today at the Granville Country Park. Michael Ward, the secretary at the time of writing, was kind enough to provide this writer with articles from the Wellington Journal and Shrewsbury News concerning the Coroner's Inquest.