FATAL ACCIDENTS

REPORT OF FATAL ACCIDENT

Name of Victim:	James Yuchem
Address:	Harleigh, PA
Name of Mine:	Rosa Breaker
Name of Company:	Jeddo Highland Coal Company
Date of Accident:	2/15/93 - Schuylkill County
Clement Thatcher & Robert Whitmer Mine Electrical Inspectors	2nd - Anthracite District

DESCRIPTION OF THE ACCIDENT

On February 15, 1993, James Yuchem was fatally injured at the Rose Breaker, Jeddo Highland Coal Company in Shanandoah, Pennsylvania. Mr. Yuchem and Mr. Steve Varylic had entered the Rosa Breaker to obtain rock salt which was located on the first floor of the breaker. In doing so, Mr. Yuchem attempted to use the hoist to lower the bags of rock salt. At this time an electrical malfunction, probably in the hand held on-off switch button, sent electrical current into Mr. Yuchem.

CAUSE OF THE ACCIDENT

Gross negligence as committed by a host of entities responsible for providing a safe work environment for the workers in the coal industry. The work environment at the accident site illustrated non-compliance to the policies and laws of both regulatory agencies as well as non-conformance to the national standard (NEC) for the installation and maintenance of equipment when using electricity. Conclusion from the subsequent chronological facts in investigating the circuit involved in the fatality from its source are as follow:

1. Area where fatality occurred - needed cap lamp for proper visibility.

2. The pendant (control station), had a hole in the cover exposing energized wires.

3. The crane (hoist) involved in the accident was using incidental contact as the grounding medium.

4. The rails for the crane (hoist) had an abundant amount of dirt and rust accumulated on them which isolated the crane from the grounding medium.

5. Improper branch circuit protection. 30 AMP fuses trying to provide protection for two #12 wire circuits.

6. The conduit runs were not continuous to provide grounding continuity.

7. The green wire within cables not being used as frame ground reference but as a current carrying conductor.

8. No lightning arrestors to provide incoming feed circuit protection. Feed circuits into plant are exposed to lighting with arrestors being approximately 100 yards away.

9. One phase of a 480 volt underground Delta system - was grounded without any knowledge to anyone on the job site.

10. Welding circuit that provided the grounded phase showed complete deterioration of the insulation on all three phase conductors.

11. Question as to what a steel worker was doing on a UMWA job site and whether he received task graining with validation.

12. Fault detection system located next to substation was not in the circuit unless a welder linestarter was activated in the outside shop.

13. Fire protection in outside substation was not checked since 1991.

14. No record of when the last time the substation ground-bed was checked.

15. Found 6 foot lamp pole in outside shop - energized when the power was activated. Fatality or accident waiting to occur.

16. No one on the job site attempted to check the fault detection system to see if a problem existed.

17. Lighting circuits energized with no frame ground connections and conduit turns.

18. An unbalanced condition on the 480 volt feed system illustrating leakage to the ground.

19. Deplorable conditions at permanent installations - looks like a pigpen with cables being run in a helter-skelter fashion.

MEANS OF PREVENTING A SIMILAR ACCIDENT

The lack in the issuance of paper may be due to direction or lack of policies or standards for law enforcement since the anthracite law does not contain regulations for surface installations.

REPORT OF FATAL ACCIDENT

Name of Victim:	Thomas E. Peska
Address:	RD 11, Box 909 Greensburg, PA
Name of Mine:	Blue Stone Quarry
Name of Company:	Latrobe Construction Co.
Date of Accident:	3/3/93 - Westmoreland Co.

Donald R. Wilkinson	Pottsville Bureau of
Metal and Non-Metal Mine Inspector	Deep Mine Safety

DESCRIPTION OF THE ACCIDENT

On March 3, 1993 at approximately 9:15 a.m., Thomas E. Peska, Water Truck Operator,age 41 with sixteen years mining experience was fatally injured at the Blue Stone Mine Quarry, Latrobe Construction Company in Westmoreland County.

The victim was single with two dependents.

Nature of Injury: Crushed head and body.

CAUSE OF THE ACCIDENT

The victim was pumping water at face in room 12 right. Drillers were in the room when the victim started to pump. The drillers moved out of the room before victim was finished. The drill was moved up to 11 D section. Then the drillers came back to 12 right to move their water truck. They went over to the victims water truck and could not locate him, but noticed his hard hat under the edge of fallen stone. The drillers then went to the surface office and said the roof fell in 12 right and that Thomas Peksa was in there. The victim was buried under 2-3 feet of rock, body was completely covered by stone

MEANS OF PREVENTING A SIMILAR ACCIDENT

Scaling of roof in working sections to be done by mechanical scaling machines.

Closer examination of roof by mine officials and miner.

Scaling of roof not to be preceded by more than 24 hours before men are allowed to work in face area.

RESPONSIBILITY FOR THIS ACCIDENT

No violation of the law contributed to this accident.

REPORT OF FATAL ACCIDENT

Name of Victim:	Roger Miller
Address:	R.D. 1 Box 130, Mill Run, PA
Name of Mine:	Springfield Pike Quarry
Name of Company:	Commercial Stone Co., Inc.
Date of Accident:	4/26/93- Fayette County

Donald R. Wilkinson	Pottsville Bureau of
Metal and Non-Metal Mine Inspector	Deep Mine Safety

DESCRIPTION OF THE ACCIDENT

On April 26, 1993 at approximately 10 a.m., Roger Miller, age 38 with four year and four weeks experience as a welder was fatally injured at the Springfield Pike Quarry in Fayette.

The victim was married and had three dependents.

Nature of Injury: Blunt force trauma to the head and body.

CAUSE OF THE ACCIDENT

The victim was air arc welding on the bucket of a front-end loader underground. He was cutting with an oxygen and acetylene torch several minutes before the explosion. Mr. Miller shut off the torch and placed it in the tank compartment of the maintenance truck. Acetylene gas leaked from the torch into the tank compartment. Victim was on his third welding rod when the compartment of the truck exploded, caused when a combustible mixture of acetylene and air was allowed to build up in a partially confined storage cabinet used to store welding and cutting equipment. The mixture was ignited by sparks or hot molten particles from an air arcing operation being conducted in close proximity. The ensuing explosion blew off both doors, one of which struck the victim, killing him instantly.

MEANS OF PREVENTING A SIMILAR ACCIDENT

Increase the vent area of the bottle compartment and maintain distance between the working area and bottle compartment such that any sparks created would not enter the compartment. Be sure that when task is complete the bottle valves are shut off.

RESPONSIBILITY FOR THIS ACCIDENT

No violation of the law contributed to this accident. Results of both underground and laboratory investigations suggests a probable scenario for the accident.

REPORT OF FATAL ACCIDENT

Name of Victim:	Donald R. Blough, Jr.
Address:	Davidsville, PA
Name of Mine:	Quemahoning No. 1
Name of Company	Quemahoning Collieries, Inc.
Date of Accident:	7/19/93 - Somerset County

Lynn Jamison	District 17
Underground Mine Inspector	Bituminous Region

DESCRIPTION OF THE ACCIDENT

On July 19, 1993, between 3:30 a.m. and 5:45 a.m., Donald R. Blough, Jr., Mechanic, age 40 with 13 1/2 years mining experience was fatally injured on the North Mains 003 working section at the Quemahoning No. 1 Mine, Quemahoning Collieries, Inc. in Somerset County

The victim was married with three dependents.

CAUSE OF THE ACCIDENT

The investigators concluded that the victim, while performing maintenance work on the Simmons Rand SR500 continuous-mining machine in the crosscut between Nos. 3 and 4 entries in the 3 North working section, was crushed between the right cutting drum of the machine and coal rib. Although there were no eyewitnesses to the accident, the investigators concluded that the victim placed himself in a vulnerable position between the machine and coal rib.

The Armed Forces Institute of Pathology is a collected group of experienced pathologists world renowned in their professional capabilities. Their opinion was that the cause of death was from crushing injuries.

Detailed investigation and testing of the mine power system, continuous miner and all section equipment did not reveal any evidence to substantiate an electrocution.

FACTORS WHICH CONTRIBUTED TO THE ACCIDENT

The victim appeared to have been in the process of installing new cutting bits on the cutterhead. Based on the fact that the cutterhead motors were locked out to prevent starting, the only alternative would be to roll the head on the floor to gain access to additional bit holders.

The victim was operating the radio remote control transmitter from a location in front of the machine, thus all control functions would have been 180 degrees from the normal operation.

The machine was maneuvered in close proximity to the coal rib. This placed the trailing cable under the cutterhead and gathering pan, and near crawler tracks and the coal rib. The victim may have been in the process of trying to free the cable to prevent damage.

It was determined the "link up" between the transmitter and antennas was critical to location; therefore, the victim may have been trying to position himself to direct the radio signal to the real antenna.

REPORT OF FATAL ACCIDENT

Name of Victim:	Richard C. Pospisil
Address:	R.D., Box 102A, Acme, PA
Name of Mine:	Whitney Mine
Name of Company:	Davison Sand and Gravel Company
Date of Accident:	8/11/93 - Westmoreland County

Donald R. Wilkinson and Mark E. Eckley Metal and Non-Metal Mine Inspectors	Pottsville Bureau of Deep Mine Safety

DESCRIPTION OF THE ACCIDENT

On August 11, 1993, at approximately 5:30 p.m., Richard C. Pospisil, age 44 with two and one-half years mining experience as a Front-End Loader/Truck Driver was fatally injured at the Whitney Mine, Davison Sand and Gravel Company in Westmoreland County.

Nature of Injury: Multiple trauma to entire body - crushing.

CAUSE OF THE ACCIDENT

The victim was operating a cat 988B #518 Front-End Loader, area M3/W-21 of Whitney Mine on the 4:00 p.m. to 2:00 a.m. shift. The victim was loading shot rock from the M3/W-21 intersection which was part of a double face shot. While loading shot rock by the W-21 face he apparently noticed a potential misfire in the W-21 face. It appeared that the victim began to load shot rock at approximately a 45 degree angle to the W-21 face. The last truck load of rock was at this angle. There was shot rock dumped to the left of the loader in M-3 entry. He parked the loader with a loaded bucket setting on the muck pile at the W-21 face under the apparent misfire. It is believed that the victim then exited the loader and climbed onto the muck pile/loaded bucket exposing himself to loose and unscaled rib and roof. As he apparently reached up to pull the nonel tube and explosive paper from the hole a piece of rib rock four feet nine inches long, twenty-one inches wide, twelve inches thick fell striking the victim on the back. When the victim was found by truck drivers and drill operator he still had a piece of explosive paper in his hand.

There were no eye witnesses to this accident.

MEANS OF PREVENTING A SIMILAR ACCIDENT

1. Train personal in proper procedure for handling apparent misfire holes.

2. Nobody should expose themselves to loose roof or rib.

3. Establish a JSA Program.

RESPONSIBILITY FOR THIS ACCIDENT

The victim apparently attempted to determine if a face hole misfired. This is a violation of state mining law which states all apparent misfires must be reported to and handled by a certified blaster. The victim was not a certified blaster. This action was also contrary to company policy, which is when apparent misfires are observed, mine management is to be notified immediately.

To reach the apparent misfire the victim placed himself under unscaled loose roof and rib which is contrary to state mining law and company policy.

REPORT OF FATAL ACCIDENT

Name of Victim: George L. Brandt
Address: Palmyra, PA

Name of Mine: Millard Quarry
Name of Company: Wimpey Minerals USA, Inc.
Date of Accident: 10/24/93 - Lebanon County

Thomas Rooff Pottsville Office
Conservation Mine Inspector

DESCRIPTION OF THE ACCIDENT

On October 24, 1993, George L. Brandt, age 61, was fatally injured sometime between 4:30 p.m. on October 24 and 12:45 a.m. on October 25, 1993, when he fell through a floor opening in the primary crusher building and landed 4.19 (13 feet 9 inches) below on a concrete floor. The fatal occurred at the Millard Quarry, Wimpey Minerals USA, Inc. located in North Annville Township, Lebanon County, Pennsylvania.

The victim occupation was a electrician with 41 1/2 years at this occupation.

Nature of Injury: Victim died of a subdural hemtoma with a basilar fracture of the skull.

The victim was an electrician working on the primary crusher metal detector system box in the lower level of the primary crusher building, at the time of the accident. No witnesses to the accident, and therefore, it is believed the victim began walking towards the metal detector box across an improperly seated metal grate floor which flipped towards the metal detector box across an improperly seated metal grate floor which flipped off of its' rests when the victim stepped on the one end of the grate. The grate then slid down to the basement floor, and the victim slid down with the grate and struck his head on the floor. However, since there were no eyewitnesses, the victim's activity at the time of the fall could not be determined. Therefore, the victim could also have been attempting to properly seat a floor grate when he fell.

CAUSE OF THE ACCIDENT

Improperly secured, seated or installed removable metal grate flooring in walkway area. It appears that a stone, dirt/and or other debris were present in the beam support cradle for the walkway support beam, and this caused the support beam and metal grate to wobble. The metal grate

was also warped, and this warpage and the support beam wobble allowed the metal grate to slip off its' support and fall onto the basement floor. The main cause of the accident was the failure top provide safe access to the work area at the lower level of the primary crusher building.

MEANS OF PREVENTING A SIMILAR ACCIDENT

Set up a safety inspection schedule for all floor grating areas, and insure that all areas are inspected prior to utilization for any purpose.

Set up a routine maintenance and replacement program to insure all supports, grates, and related areas are cleaned and/or replaced as necessary for safe working conditions.

RESPONSIBILITY FOR THIS ACCIDENT

The operator or mining company is responsible for the accident, as they failed to properly maintain the walkway floor grates and the related support structures.

REPORT OF FATAL ACCIDENT

Name of Victim:	Robert Lynn Stevenson
Address:	Charleroi, PA
Name of Mine:	Fitzwater Strip Mine-63860106R
Name of Company:	Boyle Land & Fuel Co.
Date of Accident:	10/28/93- Washington County
Patrick J. Brazzon Conservation Mine Inspector	Greensburg District Office Surface Mining

DESCRIPTION OF THE ACCIDENT

On October 28, 1993, at approximately 12:25 p.m., Robert Lynn Stevenson, age 39 with 15 years mining experience was fatally injured at the Fitzwater Strip Mine Site, No. 63860106R, Boyle Land and Fuel Company in Deemston Borough, Washington County, Pennsylvania.

The victim was married with two children under 18.

The accident occurred as the victim was repositioning a drill rig on a bench area at the top of a 35 foot highwall. The drill rig was being positioned to begin drilling the last row of a three row blasting pattern on the highwall bench.

The victim backed the drill rig up three times, each time getting progressively closer to the edge of the highwall bench. The victim apparently lost sight of a small pile of topsoil, that he was using to mark the position of the shot hole he was to drill, closest to the edge of the highwall.

The victim was ejected from the cab of the drill rig, as the drill rig went down over the highwall. The victim landed on the pit floor, with the drill rig cab falling on top of the victim. The victim suffered fatal crushing injuries.

CAUSE OF THE ACCIDENT

As a result of the investigation and interviews, the Department has concluded that the accident occurred as a result of operator error.

The direct cause of the accident was the drill rig being backed over the highwall, with the operator ejected from the cab, falling onto the pit floor, and being crushed by the drill rig cab.

The indirect cause of the accident was the drill rig operator losing sight of a blasting shot hole marker on the highwall bench, and backing the drill rig over the highwall.

The early cause of the accident was the operator using a small pile of topsoil as a marker for a blasting shot hole on the highwall bench, instead of a red flag, other visible marker, or having another person act as a spotter as drill rig was backed up on the highwall bench.

Contributing factors in the accident were, the operator being left alone to back up the drill rig on the highwall bench without a spotter, and the operator's relative inexperience as a drill rig operator.

MEANS OF PREVENTING A SIMILAR ACCIDENT

The Department should consider amending it's Safety Regulations to require a safety berm, spotter, or standardized visible marker, when any equipment is backed up on a highwall bench. In addition, if drilling or loading shot holes closer then ten (10) feet to the edge of the highwall, a safety berm should also be required by the Regulations.

RESPONSIBILITY FOR THIS ACCIDENT

No violation of the law contributed to this accident.

REPORT OF FATAL ACCIDENT

Name of Victim:	Philip E. Kirkland
Address:	R.D. 1, Clymer, PA
Name of Mine:	Penn Run Mine-ID #360874
Name of Company:	Mears Enterprises, Inc.
Date of Accident:	11/5/93 - Indiana County
Joseph J. Ardini Underground Mine Inspector	District 14 Bituminous Region

DESCRIPTION OF THE ACCIDENT

On November 5, 1993, at approximately 7:30 a.m., Philip E. Kirkland, Chief Mine Electrician, age 40 with 14 years mining experience was fatally injured at the Penn Run Mine, Mears Enterprises, Inc. in Indiana County.

The victim was married with three dependents.

Nature of Injury: Massive multiple blunt force trauma to head and neck.

CAUSE OF THE ACCIDENT

The victim with another employe were servicing the continuous mining machine. The victim crawled up under the head to grease the coal chain foot shaft when the other employee inadvertently started the cutting bits, causing the victim to be caught under the auger from the waist up. The victim was pulled from under the auger,had a carotid pulse for approximately one minute. He was transported to the surface where he was pronounced dead by Thomas Streams, Indiana County Coroner.

FACTORS WHICH CONTRIBUTED TO THE ACCIDENT

1. Victim failed to acknowledge repeated warning given by co-workers in reference to servicing equipment while energized.

2. Servicing equipment while energized and failure to lock cutting devices securely to prevent accidental start up. Cleaning and lubricating pendent box control switches

while energized.

RESPONSIBILITY FOR THIS ACCIDENT

The accident occurred due to the victim and co-worker failing to follow safe job procedures when servicing the Jeffrey 101MC Continuous Mining Machine. (Machine was energized with pump and conveyor motors operating). Also the co-worker failed to lock the cutting devices by the mechanical means provided on the pendent box of the mining machine. Co-worker failed to establish proper communications and locate all workers prior to starting the mining machine.

REPORT OF FATAL ACCIDENT

Name of Victim	Robert Mensick
Address:	105 N. Jardin St., Shenandoah, PA
Name of Mine:	Hamond Strip Mine
Name of Company:	Sunray Coal Co., Inc.
Date of Accident:	11/22/93 - Schuylkill County
Thomas Flannery Conservation Mine Inspector	Pottsville Surface Mining Office Anthracite Region

DESCRIPTION OF THE ACCIDENT

On November 22, 1993, at approximately 1:00 p.m., Robert Mensick, age 39 with three years and six months experience was fatally injured at the Hamond Strip Mine Site, Sunray Coal Co., Inc. in Butler/West Mahanoy Townships, Schuylkill County, Pennsylvania.

The victim was married with two children.

Victim's Injuries: Area of body affected, heart
Described injuries: Electrocution

The victim was screwing down an outrigger on a P & H Crane. The crane was situated next to the garage with the boom facing east. The crane was being stabilized in order to lift a screen. According to eyewitness, the boom cable touched all three power lines. Witness then saw the victim lying on the ground. CPR was administered to the victim until the ambulance arrived. He died shortly after arriving at the Ashland Medical Center.

CAUSE OF THE ACCIDENT

The crane boom was too close to the power lines. The boom cable coming in contact with the power lines caused the victim to be electrocuted.

MEANS OF PREVENTING A SIMILAR ACCIDENT

When machinery is being operated or being moved under power lines, an interval of fifteen (15) feet shall be maintained between the farthest reaching point of such equipment and said power lines, or as much more as deemed necessary as recommended by the mine conservation inspector or utility company. This requirement is found in Chapter 209.

The operator should begin more safety training courses

for their employees.

RESPONSIBILITY FOR THIS ACCIDENT

The victim and crane operator are responsible. Both should have known to stay clear of the power lines.