FATAL ACCIDENTS

REPORT OF FATAL ACCIDENT

Name of Victim:	Michael Noss
Address:	Gratz, PA
Name of Mine:	Tracy Slope
Name of Company:	Jeff Coal Co.
Date of Accident:	2/11/94 - Schuylkill County

Robert Whitmer, Jr.,
Raymond Glosek, Underground Mine Inspectors
Michael Bubel, Underground Mine
Electrical Inspector 5th - Anthracite District

DESCRIPTION OF THE ACCIDENT

On February 11, 1994, Michael Noss, Laborer, age 31 with seven years mining experience and employed by the Jeff Coal Company was fatally injured at the Tracy Slope Mine.

The victim was in the process of installing relief timbers in the affected area when the rib inadvertently run off and covered the victim. After firing the first miner heading west into the #15 Breast, the victim and co-worker were working the area returned and installed a rib length. They then noticed the timbers taking weight. The victim was instructed to install additional relief timbers. They began pulling down coal from the previous cut which fired through from the miner heading down #15 Breast. The victim installed one relief timber and had dug two additional hitches and had measured to cut another timber. As the victim turned to walk toward the timber pile, outby #14 Breast, the rib gave way completely covering the victim. Cause of death has been determined to be asphyxiation.

It appeared that after firing the first miner heading through to the #15 Breast, the rib timbers took weight from the high rib. Because of the additional weight, a piece of middle stone which was timbered on, slipped out, and allowed timber to come with it. One inadequate timber was found in the immediate area.

CAUSE OF THE ACCIDENT

The substandard conditions that contributed to this accident:

- One inadequate timber/rib support
- Faulty middle stone rock slip
- Sloughing off of material from high rib
- Friable coal
- Irregular formation of middle stone

What violations of law influenced this accident:

- Section 257 - Roof Support to be placed promptly as soon as room available

MEANS OF PREVENTING A SIMILAR ACCIDENT

All timbers shall be of adequate size and strength. After picking hitch, install timber as soon as possible prior to picking additional hitch.

Should you encounter irregular conditions, install single timbers, post and bar sets, double timbers, fore poles, cribbing, or cogs, etc. as warranted.

REPORT OF FATAL ACCIDENT

Name of Victim:	John Hershey
Address:	5 Glenola Drive, Leola,PA
Name of Mine:	Weaverland Quarry
Name of Company:	Martin Limestone, Inc.
Date of Accident:	6/3/94 - Lancaster
Thomas Rooff Conservation Mine Inspector	Non-Coal Pottsville Surface Office

DESCRIPTION OF THE ACCIDENT

On June 3, 1994 at approximately 3 a.m., John Hershey, age 35 with 5 1/2 years mining experience was fatally injured at the Weaverland Quarry in Lancaster County

The victim was married and had three children.

Nature of Injury: Victim appears to have died from oxygen depravation due to being buried by a large amount of limestone dust.

CAUSE OF THE ACCIDENT

The victim and assistant, initially attempted to set up a bucket truck at the limestone dust stockpile area to grease and service the stacker conveyor. However, there was too much material, stone and dust near the area, and the victim and assistant decided to wait until some of the pile was removed by the independent contract truck driver.

The victim and assistant returned to the stockpile area at about 2:50 a.m., and decided to grease and service the stacker conveyor; as a large amount of the stockpile had been removed by the independent contract truck driver. The removal activities created an almost vertical face on the remaining stockpile area and the victim leveled the area with a loader for the bucket truck to set up. The men then backed the bucket truck into the area for servicing the stacker conveyor.

The assistant then left the area to assist a truck driver at the bagging area near the stockpile. When the assistant returned to the bucket truck about 2 minutes later, he found the dust pile had shafted and buried the victim beneath the shifted dust pile. Local ambulance, police and rescue personnel were summoned. The victim was extricated at approximately 4:40 a.m. and was pronounced dead at the scene by the county corner.

CAUSE OF THE ACCIDENT

The victim placed himself between an unstable pile of material and machinery. The unstable pile was not trimmed to prevent hazards to persons, and the pile collapsed and covered the victim.

MEANS OF PREVENTING A SIMILAR ACCIDENT

1. Prohibit personnel from placing themselves between any piles of material and machinery.

2. Set up a routine safety program on stockpile safety and related area.

3. Require that all stockpiles or piles of material are trimmed to prevent hazards to persons.

REPORT OF FATAL ACCIDENT

Name of Victim:	Wilbur E. Shaffer
Address:	R D 4, Berlin, PA
Name of Mine:	Hauger/Permit No. 56823008
Name of Company:	Croner, Inc.
Date of Accident:	7/5/94 - Somerset County
Richard Lamkie	Conservation Mine Inspector

DESCRIPTION OF THE ACCIDENT

At approximately 7:50 a.m. on July 5, 1994, Wilbur E. Shaffer, 54 years of age, a mechanic with 17 years experience was fatally injured at the Croner, Inc's Hauger Mine SMP4 56823008. His injuries, a crushed pelvis and massive internal injuries were the result of a 3000 lb. tire/wheel assembly, which he was installing on a scraper, falling on him. A brake repair job had been done and the tire wheel assembly was to be picked up by a hydraulic boom on a mechanic's truck and placed on the hub of the scraper. The tire wheel assembly was attached by means of two 3/8 inch chains which were placed around the circumference of the tire at the approximate center of the tread face. When the victim and another employee, Terry Hayman, attempted to place the assembly on the hub, the cable of the boom and/or the chains which were hooked to the tire, and had approximately 12" of slack, struck an overhanging fender preventing the installation. The victim then attempted to push the tire-wheel assembly into place by hand and the tire fell, striking him on the shoulder, and landing on his lower back forcing him to the ground in a kneeling position. First aid was administered promptly and emergency personnel were on site within seventeen minutes. The victim died of his injuries at 11:35 p.m. on July 5, 1994.

CAUSE OF THE ACCIDENT

The tire, a 33.5-39 which standards 93" tall, and wheel assembly was not secured properly by the method of using chains wrapped around its circumference. A secondary cause was that the fender of the scraper should have been removed, a simple unbolting procedure, so that the hub could be more easily accessed.

MEANS OF PREVENTING A SIMILAR ACCIDENT

By using a method of lifting large tires which provides safeguards against the tire falling from the securing mechanism.

RESPONSIBILITY FOR THIS ACCIDENT

The responsibility for this accident largely lies with the victim for conducting the tire wheel assembly installation in an unsafe manner. However, the employer also must share some of the re-sonsibility in that a safe procedure for this task was not provided. It bears mentioning that using a chain wrapped around the circumference of the tread face is a commonly used practice as evidenced by our interviews with the service managers of Beckwith Machinery, Somerset Branch and Walters Tire Service of Somerset. A similar accident on 6/30/94 in Kentucky which also resulted in a fatality indicates that a safer method is necessary.

REPORT OF FATAL ACCIDENT

Name of Victim:	Beryl T. Smouse
Address:	Ringgold, PA
Name of Mine:	Dora No. 6
Name of Company:	Doverspike Bros. Coal Co.
Date of Accident:	7/20/94 - Jefferson County
Date of Death:	7/25/94
R. Duane Morgan Underground Mine Inspector	Bituminous - 13 District

DESCRIPTION OF THE ACCIDENT

At approximately 7:00 a.m. on July 20, 1994, Beryl T. Smouse, 55 years of age, a general laborer was fatally injured at the Dora No. 6 Mine, Doverspike Bros. Coal Co., in Jefferson County. The victim died July 25, 1994.

The victim was towing a disabled P-242 Kersey Tractor out of the mine with his P-242 Kersey Tractor. Approximately 100 feet from the surface, while towing the disabled tractor, the wire rope used to pull it came loose from the clamps while going up the slope entry. The victim stopped his tractor to make another hook-up.

CAUSE OF THE ACCIDENT

Apparently, the victim did not properly set the brake on his vehicle causing his tractor to drift back and pinned him against the parked disabled P-242 tractor.

MEANS OF PREVENTING A SIMILAR ACCIDENT

When towing equipment or supplies, substantial draw bars and suitable pins shall be used. When exiting transportation equipment braking systems shall be properly sent and equipment blocked.

REPORT OF FATAL ACCIDENT

Name of Victim:	Vincent C. Lucas
Address:	Mt. Carmel Township
Name of Mine:	Harmony Mine
Name of Company:	UAE Coal Corp. Assoc./W. Point Mng.
Date of Accident:	9/27/94 - Columbia County
Edward T. Shingara Underground Mine Inspector	Anthracite - District 2

DESCRIPTION OF THE ACCIDENT

At approximately 2:15 a.m. on September 27, 1994, Vincent C. Lucas, was fatally injured at the Harmony Mine, UAE Coal Corp. Associates, Columbia County. The victim had a total of 6 years, 3 months of mining experience and 4 1/2 months as a supervisor.

UAE Coal Corp. entered into a contract that took effect on May 23, 1994, with West Point Mining. Under the terms of this agreement, West Point Mining, with 27 employees, including company officials, superintendent, supervisor, operated and supervised the underground portion of the mine, while UAE Coal Corp. Assoc., with 10 employes operated the surface facilities and maintained control of the entire operation. West Point Mining does not have a separate legal identity.

The miners were attempting to place roof supports in crosscut No. 17 and No. 18 south headings, approximately 50 feet inby spad No. 351.

The victim started to drill the roof-bolt hole on the left side using the 2-foot starter steel. Another miner was positioned behind, and to the right of the victim, noticed the roof "dribbling" and tapped the victim on the arm to have him shut the hammer off. The hammer was turned-off when without further warning, a piece of roof coal, ranging from approximately 4 1/2 feet to 1-foot in width, 17-feet in length, and from 0-20 inches in thickness, fell, striking both miners.

Robert Taylor, miner was covered in coal from the knees down and had leg injury. The miner managed to free himself and attempted to uncover the victim. Due to his injuries and the size of the coal lumps, he was only able to uncover the head and face area of the victim.

The victim was conscious, complained of chest pain, difficulty in breathing when taken to the hospital. The victim succumbed to his injuries at the Geisinger Medical Center in Danville, Pa at approximately 12:40 p.m., on September 27, 1994.

CAUSE OF THE ACCIDENT

The immediate roof is massive sandstone with similar bottom conditions. Due to variations in the vein thickness and pitch, undulations in the roof frequently occur. In attempting to minimize the cutting of roof rock with the continuous miner, top coal, of unknown thickness, is left unmined. At the accident site, the top coal was approximately 17 feet in length (rib to rib), 1 to 4-1/2 feet wide, and 0 to 20-inches thick. Roof bolts were in process of being installed when the top coal fell.

SUMMARY AND CONCLUSION

The accident and resulting fatality occurred because of the following conditions or combination thereof:

Coal that had been left against the mine roof during the normal mining operation was not taken down or supported prior to the victims working inby permanent roof support.

Temporary roof supports were available, but were not used.

Roof bolts were not systematically installed after the roof-bolt holes were drilled.

REPORT OF FATAL ACCIDENT

Name of Victim:	John J. Washlack, Jr.
Address:	Ellsworth, PA
Name of Mine:	Eighty Four Mine
Name of Company:	Eighty Four Mining Co.
Date of Accident:	11/16/94 - Washington County
Date of Death:	11/16/94
Stephen Strange Underground Mine Inspector	Bituminous - 5 District

DESCRIPTION OF THE ACCIDENT

At approximately 2:35 p.m. on November 16, 1994, John J. Washlack, Jr., 45 years of age, was fatally injured at the Eighty Four Mine, Eighty Four Mining Company, in Washington County. The victim had a total of 18 years, 11 weeks mining experience, all for Eighty Four Mining Co., of which eight years, three weeks was as a continuous mining machine operator. The victim was pronounced dead at 4:20 p.m. at the Washington Hospital. Cause of death was multiple blunt force trauma.

The victim was performing the duties of a continuous mining machine helper and had been standing adjacent to the continuous mining machine. He was standing approximately five feet from the operator's compartment along the right side rib when he was struck in the back and legs by portion of rib that measured approximately 19' x 4.5' x 3.5' which had dislodged from the top right hand corner of the #3 to #4 crosscut. This portion of the mine wall was a stratified composition of coal, rock and slickenside.

CAUSE OF THE ACCIDENT

Additional roof pressure and rib stress caused by the unsupported roof in crosscut #4 to #5 and in the face area of #4 entry may have combined to aggravate the abnormal rib condition and thereby could have contributed to the fatality.

MEANS OF PREVENTING A SIMILAR ACCIDENT

Heightened awareness must be given to the examination and testing of ribs in all work areas.

It is imperative that this operation establish and adhere to more stringent rib control standards. All adverse or questionable ribs must be safely pulled down, fenced off, or supported by means of rib posts, roof straps, or rib bolts.

All miners need to be retrained in proper roof and rib testing and control.

All supervisors and workers must strictly adhere to the requirements of the approved roof control and deep cut mining plans.

All affected supervisors and workers need to be retrained on the requirements of the extended cut mining plan.