FATAL ACCIDENTS

REPORT OF FATAL ACCIDENT

Name of Victim: Louis P. Earnest
Address: R.D. 1, Marianna, Pennsylvania
Name of Mine: Marianna #58
Name of Company: Bethlehem Mines Corporation
Date of Accident: February 15, 1980

A. M. Pawlosky, Mine Inspector 26th Bituminous District

DESCRIPTION OF THE ACCIDENT

On February 15, 1980, at approximately 8:20 p.m., Louis Earnest, 39 years of age, miner operator with 8 years and 9 months of experience underground, of which 4 years and 6 months were as miner operator and helper, was fatally injured when a rib roll occurred striking him on the head. At the time of the accident, the victim was operating a 12 CM miner at the 1 left off 1 right in the 3 Butt Section. After loading 5 or 6 shuttle cars of coal out of the left side of a fresh cut (the canvas side) he backed the machine out to position it to scoop coal spillage to the face. While backing up the machine, his head (according to his helper) was positioned out from under the protective canopy, watching the cable and direction of travel. As he was backing the miner away from the face a rib roll occurred, striking him on the head, and forcing the upper portion of his body toward the mine floor. The immediate witness to the accident was his helper, who immediately called for help. The rib that rolled, including the draw slate, measured 16" thick, 36" wide and 10' long.

CAUSE OF THE ACCIDENT

The accident was caused by a rib roll which was loose enough to roll over on the victim. The rib that rolled was not supported. Although four crew members stated that the particular rib looked alright, the rib was not evaluated properly; and, therefore, the unsafe condition was not corrected.

MEANS OF PREVENTING A SIMILAR ACCIDENT

Similar accidents of this nature can be prevented if more attention is given to the rib conditions in this particular section. The general rib and roof conditions in this section were bad. This is a retreat section, with very heavy cover, which was causing an additional squeeze on the coal seam. Therefore, when these conditions exist, a closer observation, evaluation, and determination of the sides should be made by the foreman and the workmen in order to get a better understanding of the side strata. And, where there is any doubt whatsoever, the ribs should be secured by bracing or posting. Also, the management should constantly remind the workmen of possible dangerous conditions, which in this case, were an undetected loose rib, and an operator running the miner with his head positioned out from under the protective canopy. Management and the workmen must strictly comply with all safety rules and especially, use good sound judgment when performing their work.

REPORT OF FATAL ACCIDENT

Name of Victim: James P. Yakubec
Address: Box 119, Ronco, Pennsylvania 15476
Name of Mine: Robena #1 Mine
Name of Company: U. S. Steel Corporation
Date of Accident: April 30, 1980

Eno Chellini, Mine Inspector 3rd Bituminous District

DESCRIPTION OF THE ACCIDENT

The section was just started in pillar work and the working place was being bolted with 6' resin bolts. Before bolting started, the victim examined the working place. He used drill steel to make the examination. The roof bolter helper operated the left side drill facing the face. The victim operated the right drill. The victim marked the bolt pattern before starting to bolt. Jacks were not checked before bolting because they were set on the previous shift. The roof bolter helper had received roof bolt training about eight months prior to the accident. Bolting was started and one bolt was placed under the coal lip. The victim bolted the right side of the place and was two bolts ahead of the pattern. The roof bolter helper started bolting on the left side and had trouble with one bolt because the impact wrench was not long enough to properly install the resin bolt. He tried the second hole after placing a block under the head of the drill with the same results. He placed wooden wedges between the plate and the roof to tighten the bolt. The roof bolter helper told the victim of the problem and they quit drilling and went for the section boss. The section foreman went to the place and told them that the holes had to be re-drilled and properly installed. He sent the roof bolter helper to the ramp to wait for a longer wrench which the section boss had sent a motorman to get from another section. The victim walked out of the working place with the section boss and the roof bolter helper. The victim stopped at the crosscut where the miner was being worked on. He assisted the mechanic to remove the oil motor. The roof bolter helper returned to the drill with the wrench and did not see the victim. He went to the other working place to find him. He could not locate him so he returned to the drill. This time he went to the left side of the drill and saw a light shining along the mine floor and upon investigating, he found the victim under the rock that had fallen. He hollered for help. Immediately the foreman and the crew came to his assistance. A lifting jack had to be used to remove the victim from under the rock. Within twenty-five minutes he was removed from under the rock and was given first aid by three employes trained in EMT. He arrived outside at approximately 7:45 p.m. at which time Dr. R. Jack pronounced him dead of multiple injuries.

CAUSE OF THE ACCIDENT

The cause of the accident was a fall of rock. Since no one was present at the time of the accident, the investigating committee found it impossible to determine whether the rock fell on its own volition, kicking the jack out that was reportedly set, or if the victim was in the act of moving the jack.

MEANS OF PREVENTING A SIMILAR ACCIDENT

1) Roof bolters should follow the proper procedures outlined in the approved roof control plan and should not bolt one side ahead of the other.

2) Temporary jacks set in the working place should not be removed until a complete row of bolts are installed.

3) Bolting should be done only with proper tools.

4) When jacks are set in a working place from the previous shift, a check should be made on them to see if they are firmly set.

5) Making a good examination of the roof should be of continued priority with roof bolters.

REPORT OF FATAL ACCIDENT

Name of Victim: Arthur J. Hackinson
Address: 161 W. Main Street, Monongahela, Pennsylvania
Name of Mine: Mathies, Gamble Portal
Name of Company: Mathies Coal Company
Date of Accident: May 16, 1980

R. E. Fulton, Mine Inspector 6th Bituminous District

DESCRIPTION OF THE ACCIDENT

The victim quit work early. He came up on the elevator and when he got off the elevator he saw the shift foreman, to avoid being seen he opened a door which covered the stairway to the shaft. He went to the second tier, so he was on ground level, and tried to climb out. Someone apparently pushed a button that activated the elevator and it came down the shaft, caught him and dragged him against the shaft wall down to the bottom.

CAUSE OF THE ACCIDENT

The victim was trying to evade the shift foreman so that he would not get caught quitting work early.

MEANS OF PREVENTING A SIMILAR ACCIDENT

Employees must cooperate with management and obey company safety rules and policies and use the designated means of egress when getting off the elevator. Additional guards were placed on the shaft steps.

REPORT OF FATAL ACCIDENT

Name of Victim: Jesse Kiehl
Address: 29 Yohe Street, Tower City, Pennsylvania
Name of Mine: Skidmore Vein Slope
Name of Company: Bush Coal Company
Date of Accident: June 10, 1980

Richard P. Lesser, Mine Inspector 5th Anthracite District

DESCRIPTION OF THE ACCIDENT

Apparently victim was caught between second and third car of a three car trip, and forced against a prop on low side of gangway. Victim was found in a sitting position when found by tugger operator. Victim told operator to get help his hips hurt him. Operator of tugger was running loaded cars from #6 chute to bottom of slope when victim would have changed cable from loaded cars to empty cars and then sent loaded cars to surface. Operator went to investigate why victim did not give signal that cars were on slope bottom when he found the injured victim.

CAUSE OF THE ACCIDENT

Victim's failure to see loaded cars coming out of gangway.

MEANS OF PREVENTING A SIMILAR ACCIDENT

Workman to take more care in the movement of approaching cars.

REPORT OF FATAL ACCIDENT

Name of Victim: David A. Rudolph
Address: 214 S. Main Street, Homer City, Pennsylvania
Name of Mine: Lucerne #9
Name of Company: Helvetia Coal Company
Date of Accident: June 16, 1980

Felice Libertini, Mine Inspector 25th Bituminous District

DESCRIPTION OF THE ACCIDENT

Apprentice miner Rosiline Randolph was being trained to operate a shuttle car. William Petro ran the shuttle car out of #4 to #5 crosscut onto #5 room straight, which has a 7% grade, turned the power off and engaged the parking brake and got out of the operating compartment. The deceased was explaining the operation of the controls to Rosiline Randolph, when she disengaged the parking brake, causing the shuttle car to start running away. When the shuttle car started to run away, the deceased ran after the car to try to stop it and he got pinned between the rib and the canopy of the shuttle car, causing crush injuries of the head and chest.

CAUSE OF THE ACCIDENT

Failing to comply with Rule #17 and Rule #18 of the State Approved Guidelines, Rules and Regulations for training of shuttle car operators, which states as follows: Rule #17 - When leaving the cab for any reason, shut off the motor, put the lever in neutral position, set the brakes and block the wheels. Rule #18 - Where unusual grades exist, turn the shuttle car wheels into the rib before parking.

MEANS OF PREVENTING A SIMILAR ACCIDENT

All rules and regulations of the State Approved Guidelines for the training of shuttle car operators to be complied with.

REPORT QF FATAL ACCIDENT

Name of Victim: Clair Erdman
Address: Main Street, Gratz, Pennsylvania
Name of Mine: Middle Split Slope
Name of Company: Bush Coal Company
Date of Accident: July 16, 1980

Richard P. Lesser, Mine Inspector 5th Anthracite District

DESCRIPTION OF THE ACCIDENT

Victim was traveling slope to check valve on pump when apparently he was struck by empty cars being lowered down slope. From the point of impact, where the victim's glasses were found, to the location where the victim was found, there was an estimated distance of 127 feet. The accident happened between the seventh and eighth level.

CAUSE OF THE ACCIDENT

Struck by descending mine cars on the slope.

MEANS OF PREVENTING A SIMILAR ACCIDENT

No one shall travel the slope when cars are being lowered or hoisted.

REPORT OF FATAL ACCIDENT

Name of Victim: Wayne P. Travica
Address: 13584 St. Clair Dr., N. Huntingdon, Pennsylvania
Name of Mine: Mathies Mine
Name of Company: Mathies Coal Company
Date of Accident: July 18, 1980

R. E. Fulton, Mine Inspector 6th Bituminous District

DESCRIPTION OF THE ACCIDENT

The victim was unloading crib blocks from inside of a mine car and came in contact with the bare power wire.

CAUSE OF THE ACCIDENT

The victim was working under bare trolley wire which was not guarded or de-energized, and he came in contact with the bare trolley wire.

MEANS OF PREVENTING A SIMILAR ACCIDENT

At any time when persons are assigned by management to a work place where they could come in contact with trolley or other bare power wires, management shall ensure that the trolley or bare power wires are adequately guarded or de-energized.

REPORT OF FATAL ACCIDENT

Name of Victim: Henry R. Lewis, Sr.
Address: R.D. 1, Box 113, Blairsville, Pennsylvania
Name of Mine: Florence #1, Blacklick Portal
Name of Company: Florence Mining Company
Date of Accident: August 15, 1980

Lester D. Kimmel, Mine Inspector 16th Bituminous District

DESCRIPTION OF THE ACCIDENT

The crew of a continuous mining machine operating in 1 Right off 1 West Section, Blacklick Portal, Florence Mining Company, No. 1 Mine, had just completed a two cut lift in the face of No. 2 entry and was in the process of pulling out to begin mining on another face, when without prior warning, a piece of rock fell from the face toward the intersection and fell on the miner helper, who was standing 1-1/2 to 3 feet in by the last permanent roof support, under unsupported roof.

CAUSE OF THE ACCIDENT

Sudden fall of rock from the face of No. 2 entry toward the intersection.

MEANS OF PREVENTING A SIMILAR ACCIDENT

No person shall be permitted to advance beyond the last permanent or temporary roof support (from interrogation of crew members it could not be determined that the victim had any valid reason for being in the location he was in at the time of the accident) except for the purpose of making a working place safe, by setting either additional temporary or permanent roof supports.

REPORT OF FATAL ACCIDENT

Name of Victim: Earl L. Bender, II
Address: RD 4, Box 416, Pine Grove, Pennsylvania
Name of Mine: #2 Mammoth Slope
Name of Company: C.S.S. Coal Company
Date of Accident: September 1, 1980

Paul L. Hummel, Mine Inspector 6th Anthracite District

DESCRIPTION OF THE ACCIDENT

The investigation was conducted by James J. Shober, Jr., Director of the Bureau of Anthracite Deep Mine Safety, Michael J. Bubel, Jr., Electrical Inspector and Paul L. Hummel, Mine Inspector, 6th Anthracite District. The victim, Earl L. Bender, was tying in a series, the blasting cap leg wires to make complete circut to blast coal from the face of the slope. Inadvertantly, the shots detonated prematurely, blasting coal and rock loose from the face, covering the victim. According to the autopsy report supplied by Dr. Richard Bindie, Pottsville Hospital, Pottsville, Pa., the cause of death was reported to be internal hemorrhage due to a crushed pelvis.

CAUSE OF THE ACCIDENT

Upon completion of the investigation of said accident, a meeting was held by Director James J. Shober, Jr., Michael Bubel, Paul L. Hummel, and Thomas Conway, Superintendent of C.S.S. Coal Company. It is believed that current from an unknown source charged the blast prematurely. It is also believed that evidence could have been removed during and/or after the accident occurred prior to our arrival on the scene.

MEANS OF PREVENTING A SIMILAR ACCIDENT

Firing lines must be attached securely to timber or props with sufficient breaks in trunk line, and firing lines are to remain shunted until immediately before the blast.

REPORT OF FATAL ACCIDENT

Name of Victim: Edward W. Shrader
Address: 313 S. Vine Street, Carmichaels, Pennsylvania
Name of Mine: Nemacolin
Name of Company: Nemacolin Mines Corporation
Date of Accident: September 26, 1980

Eno Chellini, Mine Inspector 3rd Bituminous District

DESCRIPTION OF THE ACCIDENT

In 9 Road, 1 Left, 16 Crosscut, between two room and one room the first pass was completed in the box cut. After cleaning this side up and loose rock was trimmed, the miner was positioned to take the second pass. (slab cut on right side). Only two (2) jacks were set and two 10' pieces of tubing were placed for ventilation. While the right side was being mined, the operator saw the section foreman across from him in the mined out area. He stopped mining and went over to talk to the foreman who was in by the permanent roof supports near the temporary roof support (jack). When the operator turned to go out of the place, he heard rock fall and he said he (the continuous miner operator) scrambled to safety. He looked back and saw the rock on the victim.

CAUSE OF THE ACCIDENT

A large piece of sand rock fell on the victim in under unsupported roof area and crushed the victim.

MEANS OF PREVENTING A SIMILAR ACCIDENT

1. Management must enforce the roof control plans for this mine.

2. Employees and management must all be instructed to follow the plan for roof protection for all employees to the fullest extent.

3. A true and honest evaluation must be made of the roof and ribs when making examinations and before performing the assigned duties of all of the employees.

4. No employee or foreman is to advance beyond the last permanent roof support or temporary support while coal is being mined.

5. The mine foreman is responsible to see that the roof control plans are provided for all employees. The mine foreman is responsible to see that the roof control plans are implemented. If, at any time, anyone is in violation of the roof control plan the mine foreman must take appropriate action.

REPORT OF FATAL ACCIDENT

Name of Victim: Edward S. Helfer
Address: 104 Oakmanor Drive, Natrona Heights, Pennsylvania
Name of Mine: Loyal Creek #3
Name of Company: Loyal Creek Coal Company
Date of Accident: September 29, 1980

Walter Christopher, Mine Inspector 11th Bituminous District

DESCRIPTION OF THE ACCIDENT

The victim proceeded in by permanent roof supports 7' x 2" for the purpose to see where next roof bolts were to be installed.

CAUSE OF THE ACCIDENT

Victim was struck by a piece of Sand Rock 13' long x 3' wide and 9" thick while observing lip of fall area.

MEANS OF PREVENTING A SIMILAR ACCIDENT

This accident could have been prevented had temporary Roof Supports been installed on 4' Centers and no persons permitted under unsupported roof, only for the purpose of installing temporary Roof Supports.

REPORT OF FATAL ACCIDENT

Name of Victim:	Edward J. Negro
Address:	Box 96, Lowber, Pennsylvania
Name of Mine:	Mathies
Name of Company:	Mathies Coal Company
Date of Accident:	October 2, 1980

Robert E. Fulton, Mine Inspector 6th Bituminous District

REPORT OF FATAL ACCIDENT

The victim and his fellow workman were assigned to work in the immediate area of the scene of the fatality for the purpose of recovering and installing new cantenary wire (messenger cable) which is used to support high voltage A.C. cable. At the time of the accident, the assignment had been completed. Since there were no eyewitnesses to this accident, an accurate description cannot be determined; however, from our investigation, it is assumed for some unknown reason that the victim placed himself in a position to come in contact with energized and unguarded trolley wire thereby receiving a fatal electric shock.

CAUSE OF THE ACCIDENT

Before the victim went to work or pass under the trolley wire, he should have either de-energized or guarded the wire. Also, according to the coroner's report, the victim's shoes, socks and feet were wet which contributed directly to his death.

MEANS OF PREVENTING A SIMILAR ACCIDENT

All persons who work in or around the mines shall strictly adhere to Section 328 of the Bituminous Coal Mining Laws of Pennsylvania. Workmen shall also use safety equipment that is provided and shall be aware of the hazards of wet and/or defective wearing apparel around energized electrical equipment.

REPORT OF FATAL ACCIDENT

Name of Victim: Joseph Shultz
Address: Box 192, St. Benedict, Pennsylvania
Name of Mine: No. 2, South Portal
Name of Company: Greenwich Collieries Company
Date of Accident: October 6, 1980

William Garay, Mine Inspector 19th Bituminous District

DESCRIPTION OF THE ACCIDENT

On Monday October 6, 1980, at approximately 5:30 a.m., Joseph Shultz, a certified miner and machine runner, with approximately twelve (12) years mining experience received fatal injuries from a rock fall accident which occurred while working as a continuous miner helper in the belt entry of the M-1 right side section at the Greenwich Collieries Co.'s No. 2 mine located near Cookport, RD, Green Township, Indiana County. Due to repairs needed on the continuous miner, the victim and his fellow worker were assigned to roof bolt the face of the R-1 entry at the beginning of the shift (12:01 - 8:00 AM). At approximately 4:15 AM the victim and fellow worker stopped to have lunch. After lunch was over, the miner operator and the victim were told that the continuous miner had been repaired and were directed by the foreman to mine coal at the face of the belt entry. (Approximately 4:40 AM) Based on information received from the miner operator, eyewitness, he said after reaching the working place he made the necessary examinations and began to mine the left side of the working place. The right side had been mined on Friday, October 3, 1980. After mining out the left side he trammed the continuous miner back beneath permanent overhead support and locked out the controls. As he was returning to place support on the left side with the victim, for some unknown reason, the victim was assumed to be in process of removing or repositioning a temporary support which had been placed on Friday evening, October 3 when a sudden collapse of massive rock fell pinning the victim to the mine floor which resulted in crushing his chest and breaking his back, causing instant death.

CAUSE OF THE ACCIDENT

This accident was caused by the victim attempting to remove or reposition a temporary support which had been placed to secure a massive slick-sided soap stone piece of rock.

MEANS OF PREVENTING A SIMILAR ACCIDENT

An accident of this nature can be prevented by requiring all workmen to work with roof support, properly examine the roof and place adequate additional support prior to removing or repositioning any previously placed temporary support.

REPORT OF FATAL ACCIDENT

Name of Victim: William D. Harris
Address: R. D. 1, Nanty Glo, Pennsylvania 15943
Name of Mine: Cambria Slope #33-B Mine
Name of Company: Bethlehem Mines Corporation
Date of Accident: November 4, 1980

A. E. Valeri, Mine Inspector 24th Bituminous District

DESCRIPTION OF THE ACCIDENT

On Tuesday, November 4, 1980 at approximately 4:50 a.m. William D. Harris, a certified miner with about two years and eight months mining experience, received fatal injuries when pinned between the coal rib and a continuous Lee Norse mining machine boom while working as a continuous miner helper in the #1 Entry of F-West 15-Right Section at the Bethlehem Mines Corporation's Cambria Slope #33-B Mine located near Ebensburg, Cambria County, Pennsylvania. Being that the regular miner helper was off on floating days the victim was assigned the job as helper for the last two days on the 12:01 to 8:00 a.m. shift. The victim and miner operator had finished loading on the canvas (air) side of the #1 Entry, and with the help of the shuttle car operator, timbered and extended the line canvas to within five feet of the face. They then shoveled coal spillage after which it was time to go to dinner but they agreed to finish squaring the place off in that there were about three shuttle cars of coal yet to mine. The shuttle car came out under the boom load which went to the belt, and the other shuttle car was on the way in when the victim went over to the canvas side where the operator spoke to him. Then while the operator was loading, the victim came out around the shuttle car and up to the end of the boom near the front of the car and the shuttle car operator rang the bell indicating the car was loaded. The operator shut the boom conveyor off and began raking the top of the roof where the shuttle car was on the way out. When the operator shut the machine off, he went to say something to his buddy whereupon he saw him pinned between the boom and the rib. The operator was not aware of the victim being on that side since when he last saw him on the opposite side he was sure he would stay there.

CAUSE OF THE ACCIDENT

This accident was caused by the victim coming around the front end of the shuttle car and up to the back end of the miner next to the boom while the miner operator was backing up and cutting roof rock. The victim placed himself in a precarious location so that the conveyor tail (boom) of the miner caught him between the conveyor boom and the coal rib.

MEANS OF PREVENTING A SIMILAR ACCIDENT

Communication should be established among co-workers so that unsafe work procedures of this kind are corrected immediately. No person should be permitted around a machine without the knowledge of the operator. Miner helpers should position themselves out-by in safe locations beyond the tail of the machine and should not allow themselves to be caught in tight pinch points near machinery. No person should approach operating machinery without the operator being fully aware of their presence and location and the machine should be stopped when anticipating a maneuver that might endanger the miner helpers. The stopping of the machine should be done in order to make the miner helpers aware of the anticipated maneuvering. Supervisors should instruct all employes on job hazards of this kind and they should be made aware of the details of this fatal accident. The boom operating lever should be made or marked in such a way that it is readily distinguishable from other operating controls. The miner helper (s) shall not move around machinery without the operator being made aware of his location.

REPORT OF FATAL ACCIDENT

Name of Victim: Clair Kline Jr.
Address: RD 1, Central City, Pennsylvania
Name of Mine: Eureka No. 40
Name of Company: Jandy Coal Company
Date of Accident: November 20, 1980

Theodore Britten, Jr., Mine Inspector 21st Bituminous District

DESCRIPTION OF THE ACCIDENT

On Thursday, November 20, 1980, Clair Kline Jr. a certified miner, suffered severe injuries which later resulted in his death, when he ran his locomotive into the rear of a supply trip. Two motormen were taking supplies into the mine. John Gaudlip was on the lead motor and Clair Kline Jr. was behind, not coupled. Guadlip proceeded onto 28 Dip and continued slowly down the hill with the controller off. When he hit the bottom of the hill, he put the controller on six points to climb the opposite hill. When nearly to the top of the hill, the motor quit pulling and was spinning. The trip started going backwards, at which point, Clair Kline Jr. ran his motor into the truck of bars at the rear of the trip and was severely injured.

CAUSE OF THE ACCIDENT

The crash occurred because Clair Kline Jr. had gone through the signal light at 19R and ran into the back of the runaway trip of supply cars.

MEANS OF PREVENTING A SIMILAR ACCIDENT

Reinstruction of men on use of signal lights, trolley phones and pagers. Supplies shall not be loaded higher than the sides of cars. Follow locomotives shall be coupled to the trip. The company is considering installing wrap-around protection on the locomotives.

REPORT OF FATAL ACCIDENT

Name of Victim: William Prandi
Address: R. D. 2, Cherry Tree, Pennsylvania 15724
Name of Mine: Greenwich No. 2
Name of Company: Greenwich Collieries
Date of Accident: December 12, 1980

Theodore Britten, Mine Inspector 19th Bituminous District

DESCRIPTION OF THE ACCIDENT

On Friday, December 12, 1980, William Prandi, a longwall foreman, was working with his crew on P-14 longwall at Greenwich Collieries' South Mine. He and his crew were straightening up the pan line, taking off short passes at the head gate. While they were moving up the chocks, a rock from the roof came down and killed the victim. The accident occurred while the victim, working with the snaker Richard A. Shankle, were in the process of lowering #80 chock to get rock off top of it. The victim had his head and arms above the chock while attempting to remove the rock.

CAUSE OF THE ACCIDENT

The victim placed his body in a precarious position above the chock and was exposed to bad roof which came down on him.

MEANS OF PREVENTING A SIMILAR ACCIDENT

A man should not expose any part of his body above chocks to get rock off them. This is to be done with shovels. Also, the company had made scrapers to use on removing rock off top of chocks. These will be placed along chock line in longwall. If it is necessary to get above chocks to clean away rocks, temporary supports must be set.