FATAL ACCIDENTS

REPORT OF FATAL ACCIDENT

Name of Victim:	Robert K. Brenner
Address:	5493 Wilkens Avenue, Pittsburgh, PA
Name of Mine:	Renton - Allegheny County
Name of Company:	Consolidation Coal Company
Date of Accident:	March 27, 1983 - died March 29, 1983

Robert J. Monaghan, Mine Inspector — 5th Bituminous District

DESCRIPTION OF THE ACCIDENT

Robert Brenner, Assistant Mine Foreman, was found unconscious at 5:15 P.M. on March 27, 1983, by Foreman Stephen Hatbob, at the bottom of Renton Mine Supply Shaft, Consolidation Coal Company. Victim never regained consciousness.

At approximately 4:00 P.M., Brenner called to the surface and talked to the Section Foreman, stating that he was going to change out the aultman (stem) pump at the bottom of the Renton shaft, and also stating not to operate the cage. The Section Foreman after not hearing from Brenner, at approximately 4:40 P.M. tried to contact him on the mine phone. Repeated calling at 5 minute intervals until 5:00 P.M. At this time the Foreman proceeded down the shaft with the cage in the automatic position and using the emergency stop switch to stop within about 15 feet above the bottom landing. He then observed Brenner on the counterweight side of the shaft in the sitting position against the steel grating, with the aultman pump on his lap. Mr. Brenner did not respond to his call.

CAUSE OF THE ACCIDENT

The cause of the death was attributed to a cranio-cerebral trauma.

MEANS OF PREVENTING A SIMILAR ACCIDENT

No upright pump shall sit on either side of sump. They shall be installed away from the sump area with the suction line running to sump then to the pump scene. At no time will men be working in the sump to repair sump unless cage is down and blocked.

REPORT OF FATAL ACCIDENT

Name of Victim:	Joseph Cyga
Address:	Not available
Name of Mine:	Shade No. 2 - Mine Drainage Permit Number 4173SM6
Name of Company:	Shade Mining Company
Date of Accident:	April 25, 1983 - Hillsboro Township-Somerset County

Joseph Kaufman
Surface Mine Conservation Inspector — Ebensburg District Office

DESCRIPTION OF THE ACCIDENT

Victim Joseph Cyga climbed ladder and entered the storage silo at the top. His helper was climbing the ladder and could no longer see the victim when he reached the top of the silo. The victim had either slipped off the ladder on the inside of silo, or stepped onto the crust that had formed on the top of the ammonium nitrate and fell through a cavity in the nitrate and was completely covered with approximately 6 feet of ammonium nitrate. The helper immediately called for assistance from the welder and telephoned the fire company for assistance. The helper then opened the loading chute to empty the storage bin and the victim's feet fell through the loading chute. Three holes were cut in the silo and the victim was removed and pronounced dead at approximately 9:45 a.m.

CAUSE OF THE ACCIDENT

The victim either slipped or used poor judgement in entering an unsafe area on the curst of the ammonium nitrate without a safety harness.

MEANS OF PREVENTING A SIMILAR ACCIDENT

1. Use of a safety line or harness when working inside the silo.
2. Installation of a vibrator to vibrate the sides of the silo to loosen material.
3. Coating of inside of storage silo with Teflon to prevent sticking.

RESPONSIBILITY FOR THIS ACCIDENT

It is nearly impossible to determine responsibility for this accident as no one knew exactly what happened to the victim once he entered the silo.

REPORT OF FATAL ACCIDENT

Name of Victim:	Nathan L. Klingensmith
Address:	R.D. 1, Box 662-A, Uniontown, PA
Name of Mine:	Maple Creek No. 1
Name of Company:	United States Steel Mining Co., Inc.
Date of Accident:	May 23, 1983 - Bentleyville, PA - Washington Co.
Robert Fulton/Raoul Vicinelly Mine Inspector	7th Bituminous District

DESCRIPTION OF THE ACCIDENT

On Monday, May 23, 1983, at approximately 9:30 AM a roof fall accident occurred in the Maple Creek No. 1 Mine, Spinner Shaft, United States Steel Mining Co., Inc., in 1 Main, 7 Flat Right Section, 6 Room No. 20 Split Intersection, causing a double fatality to occur. The accident resulted in the death of Nathan L. Klingensmith, age 59, Assistant Underground Plans Coordinator. Victim had thirty four years of experience on the job with United States Steel Company. The victim went under unsupported roof to install drive points, when the roof collapsed covering him.

CAUSE OF THE ACCIDENT

The victim proceeded under bad unsupported roof after being warned of the dangerous roof. He also violated the Roof Control Plan, by proceeding beyond supported roof.

MEANS OF PREVENTING A SIMILAR ACCIDENT

Strict compliance of the approved Roof Control Plans, and good communication between supervisors and employees.

REPORT OF FATAL ACCIDENT

Name of Victim:	Glenn D. Ward
Address:	Box 303-A, Grindstone, PA
Name of Mine:	Maple Creek No. 1
Name of Company:	United States Steel Mining Co., Inc.
Date of Accident:	May 23, 1983 - Bentleyville, PA-Washington Co.
Robert Fulton/Raoul Vicinelly Mine Inspector	7th Bituminous District

DESCRIPTION OF THE ACCIDENT

On Monday, May 23, 1983, at approximately 9:30 AM a roof fall accident occurred in the Maple Creek No. 1 Mine, Spinner Shaft, United States Steel Mining Co., Inc., in 1 Main, 7 Flat Right Section, 6 Room No. 20 Split Intersection, causing a double fatality to occur. The accident resulted in the death of Glenn D. Ward, age 43, Underground Plans Coordinator (Transit Man). Victim had nine years of experience on the job and thirteen years underground. The victim went under unsupported roof to install drive points, when the roof collapsed covering him.

CAUSE OF THE ACCIDENT

The victim proceeded under bad unsupported roof after being warned of the dangerous roof. He also violated the Roof Control Plan, by proceeding beyond supported roof.

MEANS OF PREVENTING A SIMILAR ACCIDENT

Strict compliance of the approved Roof Control Plans, and good communication between supervisors and employees.

REPORT OF FATAL ACCIDENT

Name of Victim:	Arthur Okeson
Address:	Wampam, PA
Name of Mine:	Mine Drainage Permit No. 2566BSM37
Name of Company:	Medusa Cement Company
Date of Accident:	June 24, 1983 - Wampam, Pa. - Lawrence County

Stephen Amsler
Surface Mine Conservation Inspector — Knox District Office

DESCRIPTION OF THE ACCIDENT

At the time of this accident, the deceased was in training as a dragline operator for the Medusa Cement Co. of Wampam, PA. The deceased had approximately seven weeks experience on this machine and was working with an operator of several years experience. The experienced operator had been running the machine and at approximately 2:20 a.m. turned the machine over to the deceased and left the machine to get something from his pick-up truck, which was parked about 150 ft. away. As this man was walking toward his truck, he turned to look at the drag and saw that it was flipped-over and the operator was pinned in the cab beneath. He immediately drove to another dragline to call for help. The company supervisors, fire department, and rescue squad arrived shortly thereafter. The operator was pronounced dead at approximately 3:30 a.m., however, was not removed from the machine until about 6:00 a.m. MSHA officials were on the scene before the man was removed from the machine. The machine involved was a 4600 Manitowoc with a 7 yard bucket and 120 ft. of boom. The machine was working at reclaming the outslope of the long cut on the south side of the 2566BSM37 permit.

CAUSE OF THE ACCIDENT

The exact cause of this accident is unknown. MSHA officials conducted a thorough investigation of the incident and found no evidence of equipment failure or company negligence. The machine was sitting approximately 20-24 feet from the edge of the bench, therefore, bench failure is not a possibility.

It is only speculation, however, the accident may have been caused if the operator had dropped a loaded bucket and then spiked the brakes, causing the machine to be jerked over.

MEANS OF PREVENTING A SIMILAR ACCIDENT

Unknown.

RESPONSIBILITY FOR THIS ACCIDENT

Unknown.

REPORT OF FATAL ACCIDENT

Name of Victim:	Sylvester Lee Mitsko
Address:	Box 241, Homer City, PA
Name of Mine:	Homer City
Name of Company:	Helen Mining Company
Date of Accident:	July 3, 1983 - Homer City - Indiana County

William Cherry, Mine Inspector — 25th Bituminous District

DESCRIPTION OF THE ACCIDENT

While making a fire run on a battery operated jeep (fan was not operating) entered an area of an explosive mixture of methane. It is assumed that the controller of the jeep ignited an explosive mixture of methane and gas. The accident resulted in the death of Sylvester Lee Mitsko, age 38, Assistant Mine Foreman. The victim had eight years experience at this occupation and thirteen years underground. Cause of death was inhalation of super heated air and poisonous gas.

CAUSE OF THE ACCIDENT

Still under investigation.

MEANS OF PREVENTING A SIMILAR ACCIDENT

Still under investigation.

REPORT OF FATAL ACCIDENT

Name of Victim:	Louis Sinclair, Jr.
Address:	R.D. 6, Somerset, PA
Name of Mine:	Grove No. 1
Name of Company:	G. M. & W. Coal Co.
Date of Accident:	July 11, 1983 - Jennerstown, PA - Somerset Co.
Andrew P. Kentula, Mine Inspector	23rd Bituminous District

DESCRIPTION OF THE ACCIDENT

The continous miner machine was located in No. 5 entry loading the standard shuttle car which was in the X cut 4 entry to 5 entry. The shuttle car was partially loaded and the car operator wanted the end of the car loaded, so he turned his seat around to get ready to pull up, when he moved out under power, he pinned the miner helper against the rib (opposite the shuttle car operator) severing both legs at the crotch.

The shuttle car operator said he did not see anyone in the X cut when he prepared to move the car. He saw the victim after he started to tram the car and could not stop the car, he said he did not remember if he had his foot on the brake pedal, but remembers hitting the panic bar several times. The accident resulted in the death of Louis Sinclair, Jr., age 56, Utility man and Miner helper. The victim had five years-ten months experience at this occupation.

CAUSE OF THE ACCIDENT

It is the opinion of this investigation committee that the location of the miner helper was not known to the shuttle car operator.

Lack of communication between the shuttle car operator and miner helper.

Miner placed himself on the blind side of the shuttle car operator.

MEANS OF PREVENTING A SIMILAR ACCIDENT

Closer supervision on the conduct of crew and their habits in the working section. To follow Task Training Program set up by management. This involves the Foreman, Safety Department and Labor.

At no time shall persons or person travel on the blind side (opposite side of machine operator). All equipment shall be De-energized when person or persons are on the opposite side of equipment operators, all equipment shall not be energized till person or persons are in the clear of the equipment, warning device shall be sounded.

Extra caution to operators of equipment if equipment of same manufacture differ in control operation or location.

REPORT OF FATAL ACCIDENT

Name of Victim:	Frank S. Sorbin
Address:	833 High Street, Saltsburg, PA
Name of Mine:	Lucerne No. 8
Name of Company:	Helvetia Coal Company
Date of Accident:	August 2, 1983 - Clarksburg, PA - Indiana Co.
William Cherry, Mine Inspector	25th Bituminous District

DESCRIPTION OF THE ACCIDENT

On August 2, 1983, at approximately 10:30 PM the victim was setting temporary supports (jacks) in a completed cut. A slab of rock fell from the roof and forced the victim to the mine bottom. The rock that fell covered him from the arm pits all the way down to his feet. The accident resulted in the death of Frank S. Sorbin, age 57, Roof Bolter, on August 4, 1983. The victim had seven years-six months experience at this occupation and thirteen years underground. Cause of death was massive blunt trauma to chest - abdomen and pelvis.

CAUSE OF THE ACCIDENT

Roof fall.

MEANS OF PREVENTING A SIMILAR ACCIDENT

Test the roof and areas around where persons are going to perform work. All places must be examined and roof and ribs tested before any work is performed by and person.

REPORT OF FATAL ACCIDENT

Name of Victim:	Norman F. Anderson
Address:	R.D. 1, Marion Center, PA
Name of Mine:	Emilie No. 4
Name of Company:	Keystone Coal Mining Corporation
Date of Accident:	August 11, 1983 - Elderton, PA - Armstrong Co.

Gerald E. Brosius, Electrical Inspector
Robert J. Monaghan, Mine Inspector — 10th Bituminous District

DESCRIPTION OF THE ACCIDENT

On August 11, 1983, the victim was caught between the rib and the front end of a shuttle car at an intersection while the shuttle car was making a turn. The accident resulted in the death of Norman F. Anderson, age 46, Assistant Mine Foreman, on August 11, 1983. The victim had five years experience at this occupation. Cause of death was crushing injuries, (chest, extremeties).

CAUSE OF ACCIDENT

Unknown.

MEANS OF PREVENTING A SIMILAR ACCIDENT

Re-instruction of workmen. Re-evaluation of Safety Program.

REPORT OF FATAL ACCIDENT

Name of Victim:	Donald C. Spencer, Jr.
Address:	Unknown
Name of Mine:	Mine Drainage Permit No. 17800119
Name of Company:	Central Pennsylvania Coal Co. (Formerly Simca Mining Company)
Date of Accident:	August 31, 1983 - Lawrence Township, Clearfield County

Gary J. Byron
Inspector Supervisor
Bureau of Mining and Reclamation — Philipsburg District Office

DESCRIPTION OF THE ACCIDENT

On Wednesday, August 31, 1983, at approximately 2:45 A.M., a powered haulage accident occurred on the above-referenced site resulting in the death of Donald C. Spencer, Jr. Mr. Spencer was operating a Caterpillar 988A front-end loader. He had approximately nine years total mining experience. He had only minimal experience as a loader operator. He had been employed by Central Pennsylvania Coal Company for six weeks.

The accident occurred along the edge of a partially mined-out unstable roadway leading from an upper "D" rider coal pit down 20 ft. into a lower "D" coal pit. This make-shift road was narrow, only ten to twelve feet wide and soft from rain. The outside wheel measurement of the 988A loader was ten feet The outer edge of the roadway collapsed under the weight of the 988A loader. The loader rolled off the roadway and came to rest in the lower "D" coal pit on the machine's cab. The cab collapsed, crushing Mr. Spencer. Clearfield County Deputy Corner Charles Stone attributed death to multiple blunt force trauma and crushing injuries to the chest cavity.

CAUSE OF THE ACCIDENT

Management's failure to provide an adequate safety barrier to prohibit access to the partially mined-out unstable roadway where the accident occurred. It must be noted that testimony given does not preclude the possibility that the victim, constructed a barrier at the beginning of the shift and then removed it shortly before the accident occurred. There was no barrier of any kind in place at the time of the accident.

The victim's failure to heed a verbal warning given to the entire crew at the midnight lunch period by the night shift work leader.

MEANS OF PREVENTING A SIMILAR ACCIDENT

The caterpillar 988A front-end loader did not have the MSHA required rollover protection and seat belt. It is the opinion of the investigative team that had the rollover protection been provided and a seat belt been utilized at the time of the accident; the chances of this accident resulting in a fatality would have been nearly eliminated.

RESPONSIBILITY FOR THIS ACCIDENT

Unknown.

REPORT OF FATAL ACCIDENT

Name of Victim:	Eugene D. Capone
Address:	635 E. Center St., Mahanoy City, PA
Name of Mine:	Transformer Station, Pine Knob Minersville, PA
Name of Company:	Reading Anthracite Coal Co.
Date of Accident:	September 15, 1983 - Schuylkill County

Donald J. Sandherr
Surface Mine Electrical Inspector — Pottsville District Office

DESCRIPTION OF THE ACCIDENT

On September 15, 1983, Mine Electrical Inspector, Donald J. Sandherr was notified of a fatal accident, by electrocution, at Reading Anthracite Coal Co., Pine Knob transformer station, at approximately 2:10 p.m.. Investigation and testing was started on September 16, 1983 to determine what happened when the victim (Eugene D. Capone, age 31, with seven years experience and his associate electrician Mark Fawler) when the accident occurred. They were in the final stage of re-connecting a 4500 KVA transformer station, with three branch circuits, from 66,000/2,300 Volts delta to 66,000/4, 160 Volts Wye System for the operation of a shovel. At the time of the accident, a "safety zone" was established by having visual disconnect switches, on the line side of No. 3 breaker, open in order to connect a 1/0 SHD cable to the load side of 7,500 Volt 600 AMP General Electric circuit breaker. The connection point had external bushings located on the roof of the cubicle. When the phase conductors were connected, to complete job, it was necessary to connect the grounding conductors of the cable to a current transformer, (that is used in conjunction with limiting resistor), that was located on the opposite side of resistor from where the victim was located. In order to make this connection, it was necessary for the victim's helper to get additional cable, to extend the leads from the truck located outside transformer station fence. The movements of the victim while changing positions after making the phase connections, cannot be accurately determined. The helper and Master Electrician, Clare Yarnell, who was in the yard, were not watching at the time. The victim was next seen on the front of the cubicle roof making erratic motions with his body and arms before he fell to the ground.

From a verbal report by Dr. Richard Bindie, the victim had pinpoint blisters horizontally across the tips of his finger and at the base of his fingers where they join the palm, also a burn the size of a nickel, about a quarter inch deep in the center of the back bone, 2 inches down from the neck which was made through two layers of clothing.

CAUSE OF THE ACCIDENT

The cause of the accident cannot be determined as to where the point of contact was made because of the below listed reasons:

(a) Unknown movement of victim while changing position was not under constant surveillance.

(b) Location of burn marks on victim's body in relation to possible points of contact on structure or equipment.

(c) No visual evidence of residue on structure or equipment that could establish point of contact.

(d) The voltage and current constraints found while making tests in area of accident.

MEANS OF PREVENTING A SIMILAR ACCIDENT

None. No reccomendations being made since all standard safety regulations were being compiled with.

RESPONSIBILITY FOR THIS ACCIDENT

Cannot be determined. Results of the investigation are not conclusive.

REPORT OF FATAL ACCIDENT

Name of Victim:	George A. Palmer
Address:	Box 258, Jerome, PA
Name of Mine:	Hritz No. 2
Name of Company:	Trent Coal Company, Inc.
Date of Accident:	November 14, 1983 - Hooversville, PA Somerset County

Frank Pohopin/John A. Swick, Mine Inspectors
Mike Anderson, Mine Electrical Inspector 22nd Bituminous District

DESCRIPTION OF THE ACCIDENT

On November 14, 1983, at approximately 1PM at intersection of the 2nd lift to the left fender of the stump located between No. 3 and No. 4 entires off of No. 11 room in the 1st right section, while taking X amount of coal out, roof flaked and the boss told machine operator to pull out. The victim was sitting along right rib at the corner, while loading coal. Machine was pulled out and apparently the victim went in to set timber, when a large rock fell out of the roof measuring 14' long x 63" wide x 53" thick, pinning him to the mine floor. The accident resulted in the death of George A. Palmer, age 53, Roof Bolter, on November 14, 1983. The victim had eighteen months experience as a Setting Timber and approximately thirty years underground. Cause of death was severe and extreme chest, abdominal and pelvic injuries.

CAUSE OF THE ACCIDENT

Rock Fall.

MEANS OF PREVENTING A SIMILAR ACCIDENT

Better evaluation of roof condition, (especially after warning has been given), by all persons.

When roof is working, especially in pillars, all should be pulled out of immediate area. Once warning has been given stay out of area until roof condition is re-evaluated.

REPORT OF FATAL ACCIDENT

Name of Victim:	Andrew P. Leskovich
Address:	R.D. 1, Friedens, PA
Name of Mine:	Hritz No. 2
Name of Company:	Trent Coal Company, Inc.
Date of Accident:	November 14, 1983 - Hooversville, PA Somerset County

Frank Pohopin/John A. Swick, Mine Inspectors
Mike Anderson, Mine Electrical Inspector 22nd Bituminous District

DESCRIPTION OF THE ACCIDENT

On November 14, 1983, at approximately 1PM at intersection of the 2nd lift to the left fender of the stump located between No. 3 and No. 4 entires off of No. 11 room in the 1st right section, while taking X amount of coal out, roof flaked and the boss told machine operator to pull out. The victim was sitting along right rib at the corner, while loading coal. Machine was pulled out and apparently the victim went in to set timber, when a large rock fell out of the roof measuring 14' long x 63" wide x 53" thick, pinning him to the mine floor. The accident resulted in the death of Andrew P. Leskovich, age 24, Roof Bolter Helper, on November 14, 1983. The victim had 11 months experience as a Setting Timber and one year - eight months underground. Cause of death was severe and extreme chest, abdominal and pelvic injuries.

CAUSE OF THE ACCIDENT

Rock Fall.

MEANS OF PREVENTING A SIMILAR ACCIDENT

Better evaluation of roof condition, (especially after warning has been given), by all persons.

When roof is working, especially in pillars, all should be pulled out of immediate area. Once warning has been given stay out of area until roof condition is re-evaluated.