FATAL ACCIDENTS

Name of Victim:

Address:

Name of Mine: Name of Company: Date of Accident: Raymond E. Overly

Kunkle Strip - Canterbury Coal Co. Marquise Mining Corp. (Contractor)

3/13/95 - Armstrong County

Greensburg District Office

Bituminous - Surface Mining

DESCRIPTION OF THE ACCIDENT

On March 13, 1995, at approximately 7:30 a.m., Raymond E. Overly, age 47, was fatally injured at the Kunkle strip mine, Marquise Mining Corporation, in Armstrong County. The victim was a equipment operator, (rock truck driver).

The victim was assigned to haul mud from the access roads and parking area to the spoil pile using a Caterpillar, Model 773, 50-ton rock truck. The victim was at the south side of the spoil pile while backing to dump, he inadvertently traveled over the embankment. The truck was observed traveling over the edge of the embankment and began to roll on it's side and rolled several times before reaching a bench area. The truck struck the bench, and it began flipping end-over-end until it reached the bottom of the embankment. Near the bottom of the embankment, the victim was thrown from the vehicle to the haul road. The victim was pronounced dead at 9:30 a.m. The cause of death was given as blunt force trauma with crushing injuries.

CAUSE OF THE ACCIDENT

The accident occurred when for an unknown reason the Caterpillar 773 Rock Truck overtraveled the south edge of the spoil pile, throwing victim from the vehicle and striking the victim before it came to rest.

A contributing factor was that a means to prevent overtravel was not provided for a distance of 18 ft. on the south side of the spoil pile. The perimeter of the spoil, at the accident location, was not uniform resulting in the right rear tires being on solid ground and the left rear tires over the embankment.

MEANS OF PREVENTING A SIMILAR ACCIDENT

A beam or similar means be provided to prevent overtravel at the rock truck dump area.

Adequate inspection should be conducted on all trucks, checking braking systems for proper operation, prior to use.

Name of Victim:

Address:

Name of Mine:

Name of Company: Date of Accident:

Gregory Scumlanski Conservation Mine Inspector Joseph David Coates

SS 206-48-6241

224 N. 2nd St., Pottsville, PA Tremont #3 Strip Mine - Lincoln

SMP #54920103

Harriman Coal Corp.

3/14/95 - Schuylkill County

Surface Mining

Pottsville District Office

DESCRIPTION OF THE ACCIDENT

At approximately 8:10 a.m. on March 14, 1995, Joseph D. Coates, 23 years of age, was fatally injured at the Tremont/Lincoln No. 3 Mine, SMP #54920103, Harriman Coal Corporation, Schuylkill Copunty. The victim was a Mechanics Helper/Truck Driver with less than 3 months mining experieence.

The victim was married with one child six months old.

Death was caused by massive cervical and thoracic injuries.

The accident occurred when the victim was ascending a 17% grade haulroad, when for an undetermined reason the loaded Euclid R-50 started down the haulroad backwards. The truck traveled approximately 250 feet, struck a berm and overturned onto the drivers side. The victim was fatally injured as he attempted to exit the truck through the drivers door. As the victim jumped out of the truck cab, the truck swerved, hit a berm and fell over on top of the victim, crushing him to death.

CAUSE OF THE ACCIDENT

Brakes failed to stop the loaded truck on the 17% grade.

Failure to maintain the Euclide R-50 haulage truck in a safe operating condition (brake failure).

MEANS OF PREVENTING A SIMILAR ACCIDENT

All operators should remain inside the equipment they are operating with their seat belts fastened.

Name of Victim: Address: Name of Mine: Name of Company: Date of Accident: Charles J. Frederick 713 Scott St., Kulpmont, PA Primrose Slope Primrose Coal Co. 3/30/95 - Schuylkill County

Robert E. Whitmer, Jr. Underground Mine Inspector

Anthracite - District 5

DESCRIPTION OF THE ACCIDENT

At approximately 5:45 p.m. on March 30, 1995, Charles J. Frederick, social security number 164-52-0654, age 33, was fatally injured at the Primrose Slope, Primrose Coal Company, in Schuylkill County. The victim had thirteen years mining experience as a laborer. Victim was pronounced dead by Deputy Coroner, at 7:40 p.m. at the mine site. Cause of death was cardiac arrest from electrocution.

The victim was performing his duties loading a slope buggy in the North Wing Slope when he was electrocuted.

The accident occurred due to a ground fault condition in the main surface fan and a second ground fault condition in a submersible pump in the main slope. Since both ground faults were on isolated ground beds, the victim came in contact with 480 volts AC between the mine car and a pump.

CAUSE OF THE ACCIDENT

Ground detector should be maintained in working condition and shall be noted each day by the person in charge of the underground electrical system.

Ground detector was not in operation the day of the accident.

The surface ground bed and the mine ground bed were isolated from each other.

There was a ground fault condition on the main surface fan.

There was a ground fault condition on a submersible pump in the main slope.

MEANS OF PREVENTING A SIMILAR ACCIDENT

Connect all ground beds to a common grounding bus.

Have ground detector on at all times when men are at the mine, conditions noted and immediately reported to the Mine Foreman the occurrence of a ground fault.

REPORT OF A NON-COAL FATAL ACCIDENT

Name of Victim:

Gerald F. Lynch SS 163-40-5985

Address:

Accident Occurred at:

Ashville, PA Pennsylvania Clearance Project Allegheny Tunnel - Gallitzin

Cambria County

Date of Accident: Date of Death:

4/28/95 5/2/95

Ellsworth Pauley, Mine Inspector Supervisor Anthony Scarton, Underground Mine Inspector Mark Eckley, Metal Non-Metal Mine Inspector

DESCRIPTION OF THE ACCIDENT

The Allegheny Tunnel Project is an undertaking by the Consolidated Rail Corporation to heighten and widen the Southern Railway Tunnel that goes under the town of Gallitzin, Pa. The primary contractor of the project is Monterey Construction Company of Lakewood, Colorado and the design consultant Shannon and Wilson, Inc. of Seattle, Washington. The Allegheny tunnel is cut stone and brick lined, which is approximately 3600 feet in length, originally completed in 1854.

The initial reconstruction of this tunnel was started in July of 1994. There are approximately 85 men who work on this project on a three shift rotation system usually six days a week. The underground excavations and construction of this project is worked from two separate directions. One construction crew works from west to east and another crew works from east to west.

April 28, 1995, Gerald F. Lynch, 47 years of age, was fatally injured at the Allegheny Tunnel Project by a roof fall in Cambria County. The victim had 22 years of mining experience. He died May 2, 1995, at 7:21 p.m.

The victim a truck driver report for work on the 3:30 p.m. to 11:30 p.m. shift. His assignment was to haul concrete from the batch plant located on the east side of the Allegheny Tunnel Project, to the face area of the west side construction site. At approximately 5 p.m., the workers at the west side face area had finished spraying shotcrete on the roof and ribs. The operators of the drill rig, had just finished installing a partial row of roof bolts in the north side of the tunnel and drilled holes for there roof bolts when the drill rig broke down. The drill was repaired and at this point the shift foreman had just arrived from the east side of the project. The shotcrete truck was connected to the two inch discharge line used to pump concrete into an old shaft and the concrete truck was positioned at the west side, hopper end of the shotcrete truck. The victim was operating the concrete truck controls from a position outby the existing tunnel liner in an unsupported roof area.

At approximately 6:20 p.m., the co-workers $_{
m heard}$ a loud noise coming from the face of the old tunnel liner. The victim was standing at the rear of the concrete truck operating the controls and was struck by a piece of rock (approximately 2'6" x 3'4" x 5"), which fell twenty five feet from the tunnel roof. The victim was found laying on his back, partially covered by the large piece of rock on his chest and legs. The victim was transported to the Conemaugh Hospital by Life Flight Helicopter. The victim died 5/2/95.

CAUSE OF THE ACCIDENT

- Workers failed to make proper inspections of and recognize a dangerous condition of the tunnel roof.
- . Workers were permitted to work under roof that was not supported with roof bolts or any other roof support device.
- Inadequate training of supervisors, miners, and men of general work.
- . Undesirable work standards being practiced by the workers.

CONCLUSION

The operator failed to properly evaluate the tunnel roof prior to the workers being exposed to the unsupported roof area.

A staggered heading sequence was not followed, at the time of this accident, a full face mining sequence was present.

Two inches of shotcrete was not installed on the entire unsupported roof area at the west heading face.

The roof bolt installation pattern exceeded the required 4 foot to 5 foot spacings.

RECOMMENDATIONS

Inspect the tunnel's roof daily and after each blast, for loose rock and maintain a record of these inspections.

Personnel trained on the proper roof support installation procedures.

Employee shall received task and hazard training.

A record shall be kept of all employee training.

A visual warning device shall be installed at all entrances to unsupported roof areas to make workers aware of their limits of travel.

Roof bolts shall be installed one row at a time, in a systematic sequence from side to side.

Name of Victim:

Address:

Name of the Mine: Name of Company:

Date of Accident:

Charles A. Colbert

1040 Hewitt Ave., Washington, PA

Mathies Mine

MonView Mining Co.

6/17/95 - Washington County

Dennis G. Gramling

Underground Mine Inspector

Bituminous - District 6

DESCRIPTION OF THE ACCIDENT

Between 10:05 p.m. to 10:15 p.m. on June 17, 1995, Charles A. Colbert, 56 years of age, was fatally injured at the Mathies Mine, MonView Mining Company, in Washington County. The victim was employed as a coal car rotary dump operator for 7 months with 19 years mining experience.

Death was attributed to asphyxiation due to mechanical compression of the neck and trunk.

The victim was working his sixth consecutive day on the 3:15 p.m. to 10:30 p.m. shift. By 10 p.m., he had placed the last loaded car trip for his shift on the dump car-haul and had gone into the yard to cut the empties for the motorman to take back into the mine.

At approximately 10:05 p.m., the victim notified, via phone, the preparation plant operator that he was dumping again. The victim proceeded to dump five additional coal cars, dumping at the rate of approximately one car per minute. At 10:15 p.m., the plant preparation plant foreman, went to the rotary dump and found the victim's body squeezed into a 3 1/2" -4" wide space between a loaded car and the dump framework.

When the last loaded fifteen-ton coal car was rotated to dump the coal, that car uncoupled from the train of loaded coal cars. Using the car-haul, the victim pulled the remaining 19 loaded cars up a slight grade away from the rotary dump. He then proceeded past a "Danger-No Clearance" sign and entered the dump to align the coupler of the recently emptied car. It was necessary for the victim to have his back toward the loaded coal cars while he was aligning the coupler. The loaded cars drifted back to the rotary dump, crushing the victim between the corner of the first loaded car and the dump framework.

FACTORS WHICH CONTRIBUTED TO THE ACCIDENT

Fatigue may have contributed by affecting the victim's awareness and/or judgment. The accident occurred during the final minutes of his sixth consecutive afternoon shift.

Substandard practices that contributed to the accident as follows:

- Job procedures effectively required dumpers to take careless actions.
- . Part of the fencing along with the danger sign was removed to gain access to a dangerous area.

- . Using defective equipment.
- Reversing car-haul to use as a braking device without any positive means to control cars.
- . Absence of positive stop blocks to control cars.
- . Dumpers were conditioned to enter the rotary dump without having secured the loads.
- . Victim was working to complete shift on time.
- Inadequate supervision, planning, work standards, training instruction, equipment, guards or barriers, and warning system.

MEANS OF PREVENTING A SIMILAR ACCIDENT

To prevent reoccurrence, the procedure to handle an uncoupling situation was revised to insure that no one enters the area without an adequate means of blocking the trip. Other safety precautions and devices were also installed.

Name of Victim: Allen John Deeter SS 165-48-5173

Address: 235 Second St., Joliett, PA

Name of Victim: Shawn P. Kelly SS 208-48-5471

Address: 1801 Center St., Ashland, PA

Name of the Mine: No. 4 Vein Slope
Name of Company: L V Coal Co.

Date of Accident: 7/25/95 - Schuylkill County

Raymond Glosek

Underground Mine Inspector Anthracite - District 6

DESCRIPTION OF THE ACCIDENT

At approximately 11:00 a.m. on July 25, 1995, Allen John Deeter, 38 years of age, was fatally injured at the No. 4 Vein Slope, L V Coal Company, Schuylkill County. The victim was the owner, operator, superintendent and mine foreman. The victim had 20 years of mining experience and eight month experience at installing chute spout.

The victim was married with three dependents.

The second victim Shawn P. Kelly, 25 years of age was a miner and had 7 years mining experience.

Death was from suffocation due to entrapment under loose, fine coal.

A rib fall occurred at the L V Coal Company, No. 4 Vein Slope, resulting in deaths of two victims. Mr. Allen Deeter, owner arrived at the mine at approximately 9:00 a.m., powered up all necessary surface equipment, entered the mine making the pre-shift examination, returned to the surface and made record of this examination. At approximately 10 a.m.. Mr. Deeter and Shawn Kelly, other victim, entered the mine to resume work to develop an air connection chute in the No. 3 East heading. The two men shipped three cars of coal to the surface. Mr. Deeter then asked to the hoist engineer for an accommodation to a point approximately 100 ft. up the slope to retrieve a hatchet. He then returned to the No. 3 East heading via the slope car. Immediately upon getting off the slope car he directed the hoist engineer to lower the slope car a few more feet to the loading point giving no indications of any hazardous conditions existing at the work face. Within a period of less then one minute, the hoist engineer heard calls for help from the victim on the intercom. The hoist engineer made several attempts to return communications with no success. He then went for help contacting emergency response personnel.

CAUSE OF THE ACCIDENT

Failure to install additional timbers such as punch props and spraggs.

Substandard conditions that contributed to this accident was the nature of the coal seam being loose, friable and fine.

Information gathered from interviews indicates that the operator experienced a minor rib fall prior to the accident in the same immediate area. Had the operator reported this condition to the District Inspector, additional recommendations for securing the area could have been made.

CONCLUSION

Investigation revealed that the operator experienced a minor rib fall approximately two weeks prior to the accident. This area was

secured with cribbing before further advancement, however, operator failed to install additional timbers such as punch props and spraggs to further secure the area.

The operator then began development of a chute approximately 20' inby this affected area which caused a further weakening of the rib between these two points. This and the fact that the coal seam is of a very friable nature were contributing factors which resulted in a major rib fall covering both victims.

RECOMMENDATIONS

When the operator encountered the first rib fall, all necessary precautions should have been taken to insure no further sloughing of the rib would occur in this immediate area. Due to the friable nature of the coal seam, a face battery should have been installed prior to cribbing this area. Also additional timber such as relief sets, punch props, and spraggs should have been installed to secure the area.

Name of Victim: Name of Mine: Name of Company: Date of Accident: Date of Death: James Balsley Purco Strip Purco Coal, Inc. 7/25/95 - Fayette County 8/14/95

William D. Sparvieri Coal Mine Safety & Health Federal Inspector

Bituminous Region

DESCRIPTION OF THE ACCIDENT

On Tuesday, July 25, 1995, a machinery accident occurred at the 001 pit of Purco Coal, Inc's Purco Strip. James Balsley, age 60, equipment operator/laborer, began his shift at 7:00 a.m.. The victim along with bulldozer operator, and a front-end loader operator, were assigned the duties of removing logs from an area that was scheduled for mining. The logs were trees that had previously been cut and the limbs removed.

At approximately 7:10 a.m., the front-end loader operator connected one end of a 5/8 inch chain, 25 feet in length, to the first log to be moved. Then connected the other end of the chain to the blade tilt jack of the bulldozer. The bulldozer operator was instructed to raise the bulldozer blade and pull the log. As the bulldozer started to move in reverse, the victim walked to the area where the logs were to be placed and disconnect the chain from each log that was moved. The log had been moved approximately 40 feet when the end closest to the bulldozer abutted a tree stump, causing the log to swing to the left side of the bulldozer striking the victim. The victim's injuries were a broken left collar bone and five broken ribs. The victim had 23 years mining experience with 18 years experience at this activity.

PHYSICAL FACTORS INVOLVED

The investigation revealed the following factors relevant to the occurrence:

- 1. The accident occurred on 7/25/95. The investigation did not start until July 31, 1995; therefore the accident scene was mined and the log was removed prior to the start of the investigation. Since all physical evidence was removed all measurements are approximate and based on eyewitness accounts of the accident.
- 2. The procedure for cleaning future mining sites by mine employees at this mine includes felling the trees and removing the limbs of the trees. The resultant logs, which are sold to a local lumber mill, are then moved with a bulldozer to a location along the roadway for pickup.
- 3. The log involved in the accident was approximately 25 feet long, with a diameter of 18 inches at one end and tapering to 10 inches diameter at the other end.
- 4. The log was connected to the blade tilt jack of a Caterpillar D9G bulldozer using a 5/8 inch chain, 25 feet long.
- 5. The tree stump was approximately 18 inches in diameter and protruded 2 feet above the ground level.

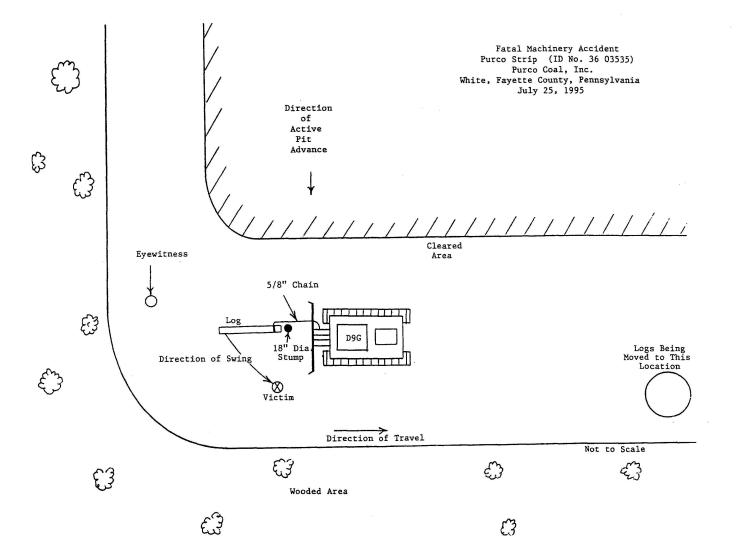
- 6. The total distance the log had to be moved was 120 feet. The log was moved 40 feet from it's original location when the accident occurred.
- 7. The method used for moving the log was the normal process used at the mine and the three miners involved were experienced at this task.
- 8. At the time of the accident the mine operator did not consider the injuries life threatening, and based on his understanding of 30 CFR, 40.2 and 50.10, did not notify MSHA immediately. On July 31, 1995, the mine operator was informed by family members of the condition of the victim and notified MSHA of the occurrence.

CONCLUSION

The accident occurred when a log, being pulled along the ground by a bulldozer, became caught against a tree stump. This caused the log to be raised off the ground, and swing to the left side of the bulldozer, striking the victim, James Balsley, in the back and on the left side of his body.

VIOLATIONS

There were no violations of 30CFR observed during the investigation.



Name of Victim:

Address:

Name of Mine:

Name of Company: Date of Accident:

Permit No. 17910114

River Hill Coal Co., Inc. 10/18/95 - Clearfield County

Steve Starner

Hawk Run -Bituminous Surface

DESCRIPTION OF THE ACCIDENT

Information unavailable at the Harrisburg Deep Mine Safety Office - To-date 3/20/96,nothing received from the Hawk Run Office.

ANTHRACITE AND BITUMINOUS FATAL ACCIDENT VICTIMS

1995

Deep District No. or Surface County Code No.		Name of Victim	Victims Address	Company	County	Date of Accident	Cause of Accident
030	Bituminous (Surface)	Raymond E. Overly	Not available	Canterbury Coal Co. (Contractor Marguise Mining Corp. Kunkle/03900112	: Armstrong	3/13/95	Equipment Rock Truck Overtravel South Edge of Spoil Pile
540	Anthracite (Surface)	Joseph Coates, Sr.	224 N 2nd St. Pottsville, PA	Harriman Coal Co. Lincon/54920103	Schuylkill	3/14/95	Haul Truck Inadequate Brakes
5	Anthracite (Deep)	Charles J. Frederick	713 Scott St. Kulpmont, PA	Primose Coal Co. N. West Slope	Schuylkill	3/30/95	Electrocution Loading a Slope Buggy
110	Industrial C Minerals (Deep)) Gerald Lynch	λshville, Pλ	Consolidated Rail Co Pa. Clearance Project Allegheny Tunnel Gallitzin		4/28/95 5/2/95 died	Roof Fall
6	Bituminous (Deep)	Charles A. Colbert	1040 S. Hewitt Ave. Washington, PA	MonView Mining Co Mathies Mine	Washington	6/17/95	Machinery - Uncoupling of Mine Cars
6	Anthracite (Deep)	Allen Deeter	235 Second St. Joliett, PA	L V Coal Co. No. 4 Vein Slope	Schuylkill	7/25/95	Entrapment Rib Fall
6	Anthracite (Deep)	Shawn P. Kelly	1801 Center St. Ashland, PA	L V Coal Co. No. 4 Vein Slope	Schuylkill	7/25/95	Entrapment Rib Fall
2	Bituminous 6C (Surface)	James Balsley	Not avialable	Purco Coal, Inc. Purco/26703078	Fayette	7/25/95 8/14/95 died	Machinery
1	Bituminous 7C (Surface)	Not available *	Not available	River Hill Coal Co. 17910114	Clearfield	10/18/95	Equipment related

Note: * Received this information per telephone call from the Hawk Run District Mining Office, Steve Starner called 2/7/96, no official report received to-date 3/4/96.