SEPTEMBER 1980

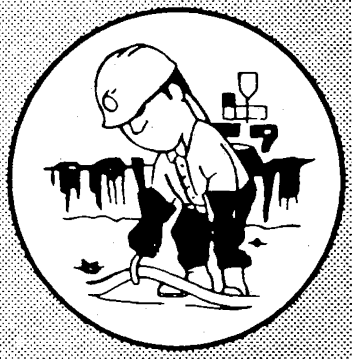
HOLMES SAFETY ASSOCIATION

E PLURIBUS UNUM

SAFETY EFFICIENCY

MINERAL INDUSTRIES

BULLETIN



United States Department of Labor

MSHA

Mine Safety and Health Administration

September 1980

CONTENTS

THE HOLMES SAFETY ASSOCIATION CREED

Our work	SAFETY EDUCATION - Goes on,
Our purpose	ACCIDENT PREVENTION - Endures,
Our hope	TOTAL SAFETY AWARENESS - Still lives, and
Our dream	AN ACCIDENT FREE ENVIRONMENT - Will never die,
SAFETY	Is and Always will be OUR FIRST CONSIDERATION!

Fatalgram

U.S Department of Labor
Mine Safety and Health Administration
Metal and Nonmetal Mine Safety and Health Activity

date July 21, 1980

SPECIAL FATALGRAM

POWERED HAULAGE: VEHICLE-OVER-EDGE ACCIDENTS

SINCE THE BEGINNING OF 1979 THERE HAVE BEEN 15 HAULAGE FATALITIES INVOLVING TRUCKS WHICH BACKED OVER THE EDGES OF DUMPS AND VEHICLES WHICH RAN OFF EDGES OF ELEVATED ROADWAYS. SHORT SUMMARIES OF THE CIRCUMSTANCES OF EACH OF THESE ACCIDENTS FOLLOW:

1. 6/12/79 VICTIM WAS BACKING HIS OWN PICKUP TRUCK UP A DISUSED RAMP WHICH WAS BARRICADED AT THE LOWER END. NEAR THE UPPER END HE STEERED BADLY AND WENT OVER THE EDGE TO A 47-FOOT FALL.
2. 6/21/79 TRUCK BACKING TO DUMP OVER A BANK INTO DREDGE POND. LARGE SECTIONS OF BANK COLLAPSED, CARRYING TRUCK AND DRIVER INTO 35-FOOT-DEEP POND.
3. 8/8/79 IN RAIN, OPERATOR LOST CONTROL OF GRADER-LOADER ON A TURN AND SKIDDED OVER AN EMBANKMENT.
4. 9/1/79 HAULAGE TRUCK VEERED TO ONE SIDE, RAN THROUGH A BERM AT SIDE OF ROAD AND ROLLED OVER AND OVER DOWN MOUNTAIN SIDE. ROAD STRAIGHT, AND NO OBVIOUS REASON FOR THE OCCURRENCE.
5. 10/2/79 22-YEAR-OLD DRIVER BACKED TRUCK OVER 34-FOOT-HIGH LEDGE WHILE PREPARING TO DUMP HE HAD 2 1/2 YEARS OF EXPERIENCE AS A TRUCK DRIVER, BUT BACKING TO DUMP OVER THE EDGE OF A WALL OR DUMP WAS A NEW PROBLEM FOR HIM.
6. 10/5/79 FRONT-END LOADER OPERATOR, STRIPPING OVERBURDEN ABOVE QUARRY, DROVE TOO NEAR EDGE OF QUARRY FACE. PIT WALL COLLAPSED UNDER LOADER.
7. 10/27/79 HAULAGE TRUCK LEFT ROADWAY AND OVERTURNED INTO SETTLING POND. ROADWAY WAS OVER A NARROW DIKE; THERE WAS SOME FOG; AND THE TRUCK LACKED WINDSHIELD WIPERS.
8. 10/29/79 TRUCK DRIVER BACKED TOO NEAR TO EDGE OF WASTE DUMP, WHICH COLLAPSED UNDER HIM.
9. 12/18/79 BACKED DOWN A GRADE TO POSITION TRUCK FOR DUMPING OVER A CLIFF. INSTRUCTIONS HAD BEEN TO DESCEND FRONTWARDS AS BRAKES WERE DESIGNED PRIMARILY FOR FRONTWARDS OPERATION. BACKING, DRIVER LOST CONTROL AND WENT OVER EDGE.
10. 1/11/80 DRIVER BACKED OVER EDGE OF DUMP AFTER FAILING TO SEE SPOTTER'S SIGNAL TO STOP.
11. 1/16/80 LABORER, IN OWN PICKUP TRUCK ON HIS WAY TO WORK, LEFT MINE ACCESS ROAD AND ROLLED DOWN STEEP EMBANKMENT. HE HAD BEEN OBSERVED BY A FOLLOWING DRIVER TRAVELLING VERY NEAR THE EDGE OF THE ROAD.
12. 1/17/80 DROVE TRUCK OFF EDGE OF STOCKPILE THROUGH INATTENTION, WHILE DRIVING SLOWLY TO CHECK AN ENGINE NOISE.
13. 5/21/80 LOADER, DESCENDING RAMP IN QUARRY, VEERED OFF EDGE. THIS LOADER HAD SEVERAL KNOWN BUT UNCORRECTED DEFECTS IN BRAKES AND STEERING MECHANISMS.
14. 1/27/80 BACKED TRUCK OVER EDGE OF BANK WHILE TRYING TO POSITION IT TO DUMP MATERIAL FOR A BERM.
15. 1/30/80 BACKED TRUCK ONTO UNSTABLE GROUND WHILE PREPARING TO DUMP IN AN UNAUTHORIZED LOCATION. BANK SLOUGHED DOWN, CARRYING TRUCK AND DRIVER INTO 35-FOOT-DEEP POND.

80-032

DEATH TOLL Period covered: January through May

Year	Underground	Surface	Mills	Total
1979	7	18	13	38
1980	6	20	10	36

DO YOUR PART TO KEEP THE TOLL DOWN!
SAFETY IS EVERYBODY'S BUSINESS

☆ U.S. Government Printing Office: 1980—677-158/5

September 1980

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

Excerpts from Code of Federal Regulations

Mandatory Safety Standards--Underground Coal Mines

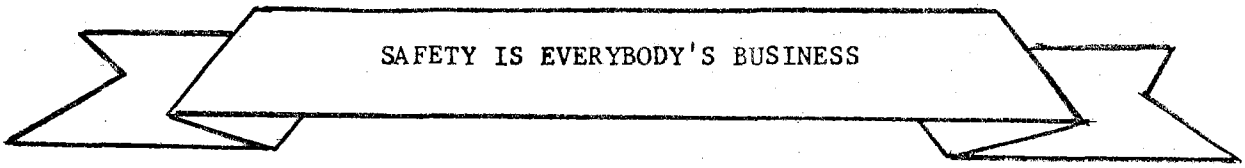
Part 75.321--Stoppage of Fans, Plans

Each operator shall adopt a plan which shall provide that when any mine fan stops, immediate action shall be taken by the operator or his agent (a) to withdraw all persons from the working the working sections, (b) to cut off the power in the mine in a timely manner, (c) to provide for restoration of power and resumption of work if ventilation is restored within a reasonable period as set forth in the plan after the working places and other active workings where methane is likely to accumulate are reexamined by a certified person to determine if methane in amounts of 1.0 volume per centum or more exists therein, and (d) to provide for withdrawal of all persons from the mine if ventilation cannot be restored within such reasonable time. The plan and revisions thereof approved by the Secretary shall be set out in printed form and a copy shall be furnished to the Secretary or his authorized representive.

Part 75.321-1--Reasonable period

Unless a different period of time is approved by the Coal Mine Safety District Manager, "reasonable period" referred to in section 75.321 means a time lapse of not more than 15 minutes.

(For use in all underground coal mines)



September 1980

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

Gumming Up the Works!

When chewing gum, keep in mind that careless working habits can gum up the works in many ways. We don't need to tell you that carelessness is an invitation to accidents. We just want to remind you that an accident not only gums things up for you, it gums things up for your family as well -- from moments of worry to heartbreak, hardship, and more, depending on how seriously you are hurt.

Carelessness on your part gums things up for your fellow employees, too. Often they are endangered and always they are upset when there is an accident. A worried, upset person has a difficult time keeping their mind on their job.

Here are a couple of suggestions for you to "chew over":

1. Keep your wits about you!
2. Live up to the letter of the safety rules that have been set up for your protection and for the protection of your fellow workers -- not only during the summer, but throughout the whole year.

WORK SAFELY -- DON'T BE THE ONE WHO GUMS THE WORKS

(For use in all mining operations)

September 1980

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

HAND INJURIES

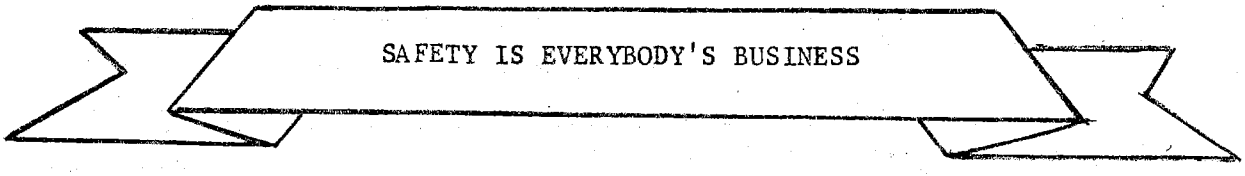
Did you ever try to button your shirt or tie your neck tie with a sore finger? It is difficult to do. Suppose you had a thumb or finger missing. You may have to have someone to do these things for you. What I am saying is that we should protect our hands. It is true that practically all of our work is done with our hands and, therefore, are exposed more than any other part of our body. If we know that our hands are more liable to injuries and are the most important part of our body, shouldn't we take every possible precaution to protect them?

There are many ways you can protect your hands from injuries. Suppose we consider the following reminders:

1. Always coordinate work movement with co-workers.
2. Keep tools in good condition.
3. Do not improvise tools.
4. Wear gloves for hand protection only where they would not be a hazard.
5. Keep shirt and jacket sleeves buttoned, and do not allow them to become frayed or ragged.
6. Use holders for chisels and punches where provided.
7. Do not place hand tools near moving machinery.
8. Be sure electrical testers are well insulated.

There are other causes of hand injuries, but by analyzing your job and preparing yourselves by becoming aware of the hazards, you can do the job safely.

(For use in all mining operations)



September 1980

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

Man and Material Hoists

With the increased number of longwall mining units being installed and the manufacture of larger, heavier mining equipment that must be transported into and out of a mine via hoisting installations, it is necessary to examine the capabilities of existing hoisting facilities.

The following should be determined:

The capability of the braking system in relation to the loads being transported;

The breaking strength of the wire rope, including the recommended factor of safety in relation to the maximum load;

The quality of inspection of the hoisting installation, especially the wire rope for broken wires, reduction in diameter, and the wire rope terminations.

These factors need to be determined as a result of numerous recent problems that have occurred to hoisting installations because heavier equipment is being hoisted and the required inspections appear to be only cursory.

(For use in underground coal mines)

SAFETY IS EVERYBODY'S BUSINESS

September 1980

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

DON'T LET LIGHTNING 'LIGHT UP' YOUR BLAST

Electrical storms are phenomenons of nature that we are not able to control. The lightning strokes associated with these storms are, in effect, static discharges of gigantic proportions. The extremely large amounts of electrical energy released by and the powerful electric and magnetic fields associated with lightning represent a hazard to any material that is inflammable or detonable.

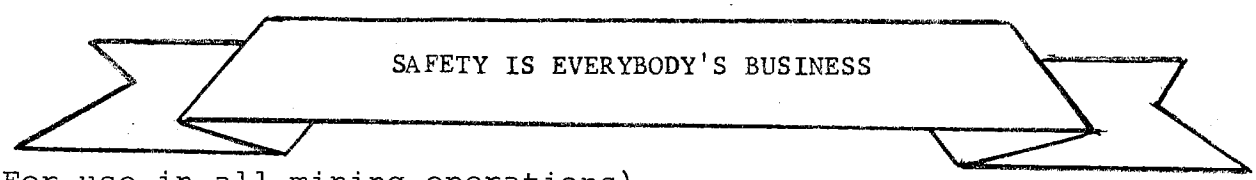
There is a warning in every case of explosives to keep away from all explosive products during the approach and progress of an electrical storm. This, of course, is irrespective of the type of explosives or initiating device in use.

One should not be lulled into any false sense of security should non-electric systems be in use. Direct lightning strikes may be apt to initiate these types of systems. This is so stated in the literature.

Because of this, all explosives loading operations should be discontinued and all personnel in and around the blast area should retreat to a position of safety until the storm has passed over.

Lightning storms tend to occur most often during summer months and in certain geographical areas called "Thunderstorm Belts." All operations, and especially those that are prone to electrical storms, should have established rules for evacuating blast areas when necessary. The following recommendations, which include precautions for minimizing the hazard to EB caps, could form the basis for an established procedure:

1. Obtain advance warning of the approach or buildup at a blast area of an electrical storm so that there is adequate time to evacuate the site. Such warning may also preclude unnecessary shutdowns if a storm is only passing by at a safe distance. There are three methods for doing this. The best method is to use a thunderstorm warning device that monitors two characteristics of electrical storms - sferics activity for long distance warning and atmospheric potential gradient for close in warning. If either or both these criteria exceed prescibed levels, it can be concluded that a storm is imminent and appropriate action can be taken. Thunderstorm warning devices are commercially available. Second, and less reliable, is to utilize the services of a nearby weather station who can warn you when weather conditions are such that



(For use in all mining operations)

electrical storms might occur. Many times they use radar to track electrical storms, and, thus can detect their approach to a blast area. The third, and least reliable method, is to assign some individual the responsibility to monitor the atmosphere for visual indications of the buildup or approach of a storm. Although this method is better than none at all, it cannot be relied on to give adequate warning for several reasons.

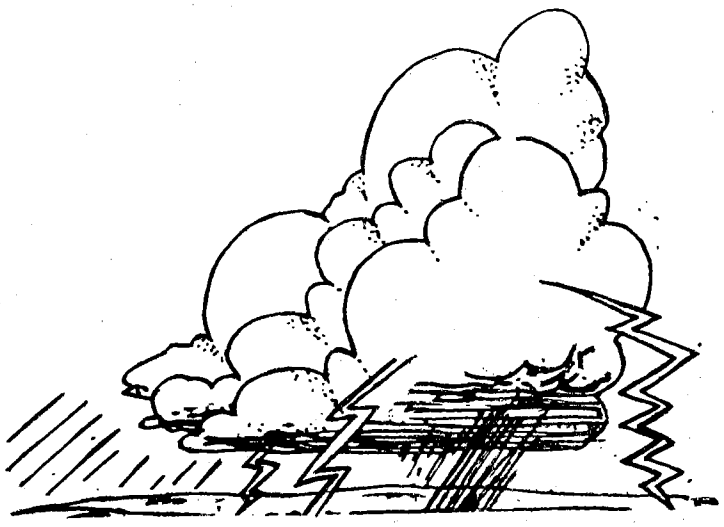
2. Once it has been ascertained that a storm is imminent, evacuate all personnel away from the blast area to a position of safety.

3. When leaving the blast site, leave individually shunted EB caps, whether or not they are in a loaded borehole, undisturbed and open all shunts and closed wire loops in the blasting circuit being careful to keep all bare wire insulated from earth.

4. After the storm has passed over, replace all shunts immediately on return to the blast area.

5. Lightning gaps should be installed in all permanent firing line systems. The gap should consist of a 15-foot physical separation of two sections of the duplex firing line.

Information that has been collected on lightning-caused premature detonations indicates that in most instances, the extraneous electricity was introduced into the blasting circuit by inductive coupling. Inductive coupling is the process by which electrical energy is transferred from the primary to the secondary windings in a transformer. Opening all closed wire loops in the blasting circuit prevents inductive coupling to the blasting circuit.



ABSTRACT FROM FATAL ACCIDENT

September 1980

HOLMES SAFETY ASSOCIATION
MONTHLY SAFETY TOPIC

FATAL FALL-OF-GROUND ACCIDENT

General Information: A miner was fatally injured when he was struck and pinned by several slabs of rock which fell out of the back in a development stope drift. The miner was employed at this mine for 2-1/2 years. He had no known previous mining experience.

The mine was an underground uranium mining operation which was operated three 8-hour shifts, 5 days a week. The mine was opened by a 12.5-foot diameter, three-compartment steel and concrete vertical shaft 840 feet in depth. The mine was connected from the 1-4 level to the adjacent mine and there were six cased boreholes to the surface. Mining of the ore-bearing sandstone was by a modified room and pillar method. Haulageways were driven below the ore bodies.

Description of Accident: On the day of the accident, the victim proceeded to his working place in the 0504 development stope on the 1-4 level. The breakthrough round had been blasted a week before and at that time it was determined by supervision that the stope was in good condition and that roof support was not necessary. The stope was posted against entry at this time.

On the previous day, the stope was visited by the mine foreman and the shift boss. Both supervisors agreed that ground conditions in the stope were bad and the ground must be supported. Instructions at this time were to clean out the muck and install roof bolts and wire mesh. The shift boss briefed the victim on the activities of the previous shift and instructed him to continue supporting the roof and ribs of 0504 stope with roof bolts and wire mesh.

Apparently, the victim installed the roof jacks about 6 feet past the roof bolts and wire mesh near the intersection. He then proceeded to drill five rows of roof-bolt holes. Sixteen holes had been drilled to a depth of 6 feet without incident. The final hole was drilled 12 feet past the permanent support and was about 14-inches deep when the roof fall occurred.

When a coworker came into the stope, he found the drill running, but did not see the victim. Knowing something was wrong, he left the area and met the shift boss who was on his way to the stope. They returned and found the victim almost completely covered by roof fall. They determined that some of the slabs were too large

(For use in underground metal and nonmetal mining operations)

for the two men to remove and the shift boss went for help. The victim was removed from under the slabs and efforts were made to revive him. He was transported to the hospital where he was pronounced dead.

Cause of Accident: The direct cause of the accident was the victim working under a section of the back where no permanent ground support was provided. Contributing causes were: failure of supervision and the miner to properly evaluate the ground conditions and follow adequate ground control procedures; failure of supervision to frequently check an area of known "bad ground"; and failure of supervision to observe the work habits of personnel working in such areas.

Recommendations: Miners should be trained in the proper methods of testing for, taking down, and supporting loose ground.

When needed, rock bolts should be installed as soon as possible after an area is exposed.

ABSTRACT FROM FATAL ACCIDENT

September 1980

HOLMES SAFETY ASSOCIATION
MONTHLY SAFETY TOPIC

FATAL FALL-OF-MATERIAL ACCIDENT

General Information: A fall-of-material accident occurred in a strip mine pit resulting in the death of a groundman. The victim had about 40 years experience, the last 12-1/2 years as a groundman. He had positioned his bulldozer between the stripping shovel and the highwall. A rock fell from the highwall and struck the victim resulting in his death.

Description of Accident: Normal coal preparation activities of removing overburden from the coalbed had been delayed because loose material had fallen onto the coalbed from the highwall and the highwall had to be scaled. The stripping shovel was utilized for the scaling operation and a bulldozer was used to push the scaled material away from the highwall to an area where the stripping shovel could reach the material.

The bulldozer, operated by the victim, was operating between the stripping shovel and the highwall. When the shovel operator was ready to dump a bucket of material on the spoil bank he notified the groundman, who in turn notified the dozer operator (victim) to observe whether the rear rotating housing of the stripping shovel would clear the highwall. The bulldozer was normally positioned in back of the right rear crawler of the stripping shovel when the victim was observing whether there was adequate clearance. The groundman was observing the operation from a platform on a stripping shovel where a telephone was located to provide communication between persons near ground level and the operator of the shovel. The victim would signal the groundman if clearance space was adequate and in turn the groundman would relay that information to the stripping shovel operator. This work continued for about 6 moves, a linear distance of about 26 to 32 feet, without incident.

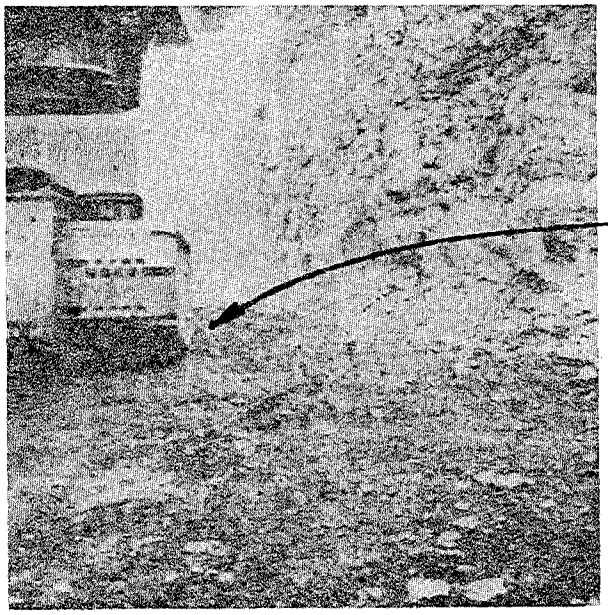
While the victim was observing whether or not there was clearance between the rear portion of the revolving housing of the stripping shovel and the highwall; the bulldozer was parked near the front of the rear crawler of the stripping shovel between the shovel and the highwall. The groundman observed the victim lean forward and a moment later saw the left cab door window shatter. The groundman immediately notified the stripping-shovel operator of the occurrence and proceeded to the bulldozer to see if the victim was injured. When he arrived at the bulldozer he found the victim slumped over in the right front corner of the cab. He immediately called for

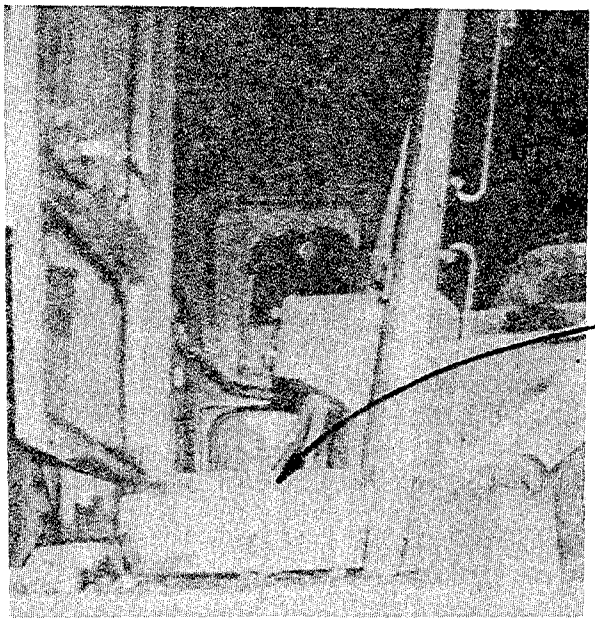
assistance to move the victim to a safe location. He was transported to the hospital where he was pronounced dead.

Cause of Accident: The accident and resultant fatality occurred because loose hazardous material was not removed from the highwall and the loose, unconsolidated material was not sloped to the angle of repose, or barriers, baffle boards, screens or other devices were not provided to afford protection. The following factors contributed to the seriousness of the accident:

1. The bulldozer was not parked in a safe location.

2. The victim opened the cab door facing the highwall.





View of the cab through which the rock traveled

September 1980

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

FIRST AID BLEEDING

In case of an accident, after you have made certain that the victim you are aiding does not have a breathing problem, your next concern is to control any bleeding that may be present. If a person is bleeding severely and the bleeding is not stopped, death may occur. This can happen more quickly than most people realize.

Oxygen enters the blood system in the lungs. The oxygen is carried by the blood stream to the heart where it is pumped out into an extremely large artery. This artery then branches out into smaller arteries carrying the blood to all parts of the body. These smaller arteries continue to branch out until they become very small.

At this point the small arteries connect with capillaries, the smallest of all blood vessels. It is within the capillaries that the oxygen is passed from the blood to each cell in the body.

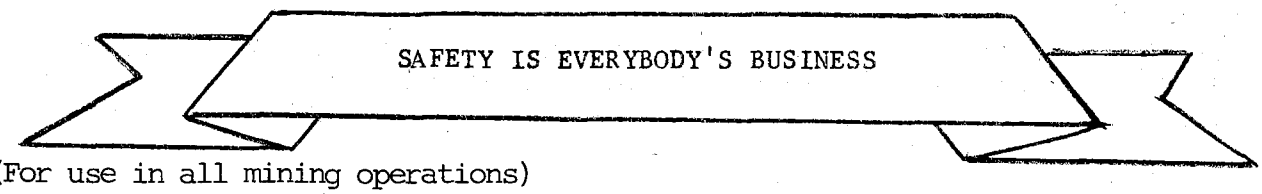
The capillaries pick up waste materials (such as the gas--carbon dioxide) from the cells and carry them in the blood to the veins. The veins at this point are very small. Each of these veins then merge with other small veins making larger veins, and eventually all meet into one large vein going back into the heart.

From the heart, the blood is carried to the lungs again, where the waste materials are deposited so they can be breathed out when you exhale. At this point, the cycle repeats itself again and again and again, continuously, 24 hours a day, 7 days a week.

Bleeding will occur any time there is a break in a blood vessel. There are certain signs that let you know which type of blood vessel (artery, vein, or capillary) the blood is coming from.

ARTERY BLEEDING--Bleeding from an artery will usually spurt and gush. This is because the arteries are the closest to the pumping action of the heart. The color of blood which is coming from an artery will usually be bright red because the oxygen gives it that color. Therefore, bright red blood gushing or spurting out is coming from an artery.

VEIN BLEEDING--Bleeding from a vein will usually flow smoothly in a steady stream because the pressure from the heart's pumping action has slowed down somewhat by the time it reaches the veins. The color of blood which is coming from a vein will usually be dark bluish-red, because it lacks oxygen. Therefore, if you see dark bluish-red blood flowing smoothly in a steady stream from a cut, you should assume it is coming from a vein.



(For use in all mining operations)

CAPILLARY BLEEDING--Bleeding from a capillary will just barely ooze out because the capillaries are so small. Usually bleeding from a capillary is not serious.

HOW MUCH IS FATAL? Bleeding from either an artery or a vein can be serious or even fatal. You have approximately 12 pints of blood in your circulatory system. If you loose 1-½ to 2 pints, it is considered serious. If you loose 3 pints you can die.

EXTERNAL BLEEDING--Minor external bleeding will usually stop by itself. This is done by the body's normal defense mechanism against bleeding. When the blood vessels and skin are damaged, and the damage only covers a small area, the body's defense mechanism sends a message to the involved blood vessels to close up. This, in conjunction with another body defense mechanism which causes blood to clot and stop flowing, usually stops the bleeding by itself. This will only occur, however, if the damage is minor and the bleeding is not severe.

There are three methods used to control severe external bleeding. The methods should be used in order. Always use method one first. If this doesn't work, go on an try method two. Only as a last effort to save life or limb should method three be used since it is extremely dangerous and can cause many problems.

The first method, and usually the most effective method, of controlling external bleeding is direct pressure.

Direct pressure means applying pressure over a wound. This is usually done by applying a sterile (clean) dressing or bandage directly over the bleeding site and applying pressure over it. If you don't have a sterile dressing, any clean object, such as a handkerchief, a cloth, or even a bare hand or fingers must be used. Maintain the pressure until the bleeding stops or until the patient can be treated by professional medical personnel. If blood soaks through the dressing without clotting, do not remove it, but add additional layers and continue direct pressure more firmly. It is also helpful to elevate the portion of the body which is bleeding, if possible.

The second method is called pressure-point control or digital pressure. It should be used only if direct pressure does not stop the bleeding.

The pressure-point control method will temporarily block the main artery which is supplying blood to the affected limb (an arm or leg), and thus stop the bleeding. This method can only be used if the severe bleeding is coming from a limb.

Pressure-point control is accomplished by applying pressure to the main artery supplying affected limb. If the bleeding is coming from either arm, firm pressure must be applied to the brachial artery on that arm. If the bleeding is coming from either leg, firm pressure must be applied to the femoral artery on that leg.

The third method of controlling severe bleeding is the use of a tourniquet. This method should only be used as a last resort, if all other methods fail. Use of this method can result in damage to nerves and blood vessels, and may

result in loss of the affected limb. So remember, only use a tourniquet when all other methods of controlling severe bleeding have been tried and failed.

To apply the tourniquet, you will need a triangular bandage, or a piece of cloth, or a long handkerchief, or a rubber tube--the item to be used must be 2 to 4 inches wide. You will also need a short, strong stick, or similar object that will not break. Then, follow these steps to apply the tourniquet.

1. Place the tourniquet just above the wound; do not allow it to touch the wound edges. If the wound is in a joint area or just below, place the tourniquet immediately above the joint.

2. Wrap the tourniquet band tightly around the limb twice and tie a half knot.

3. Place the short, strong stick on the overhand knot and tie two additional overhand knots on top of the stick.

4. Twist the stick to tighten the tourniquet until bleeding stops.

5. Secure the stick in place with the loose ends of the tourniquet, a strip of cloth, or other improved material.

6. Make a written note of the location of the tourniquet and the time it was applied and attach the note to the victim's clothing.

   CAUTION: ONCE A TOURNIQUET IS APPLIED, IT SHOULD NEVER BE LOOSENED OR REMOVED EXCEPT BY A PHYSICIAN.

Since internal bleeding occurs totally inside the body, it is not visible to us and, therefore, rather difficult to recognize. Internal bleeding can occur as a result of injuries sustained, such as internal bleeding from a closed fracture (closed fracture meaning a broken bone that has not ripped through the skin); an internal organ such as the liver or spleen which has ruptured due to severe blow to that area; or a closed wound (a wound inside the body due to a blow or fall). Internal bleeding can also be due to certain diseases or conditions such as ulcers or severe infections. And, as we said previously, internal bleeding may result from a nosebleed--with blood running down the throat into the stomach.

The symptoms of severe internal bleeding are the same as some of the symptoms of physical shock. The reason the symptoms are similar is because the victim suffering from severe internal bleeding is in physical shock.

The following is a list of symptoms to help you recognize internal bleeding:

1. Skin is cold or clammy.
2. Eyes are dull.
3. Pupils are extremely large.
4. May be anxious and possibly thirsty.
5. May be nauseated and feel faint and may possibly vomit.
6. May feel pain in the affected area.

If a victim has most of these symptoms and there is a possibility that he is bleeding internally (for example, he tells you he has ulcers, or, he received a blow to the chest or stomach, or, he has a broken hip or leg), you should treat him for internal bleeding.

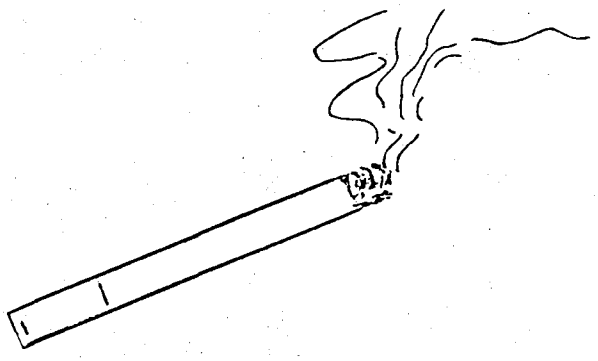
The treatment is as follows:

1. Keep victim lying down comfortably; loosen his clothing.
2. Maintain temperature (if victim is getting cold, add blankets; if victim is getting warm, remove blankets).
3. Elevate victim's feet about 6 inches, if possible.
4. Anticipate that victim may vomit and give <u>no</u> food or drink and most importantly:
5. Get professional medical help as quickly and safely as possible.

September 1980

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

COFFIN NAILS



You know, cigarettes are often jokingly called coffin nails. We remind you of this because we are going to tell you about six common beliefs that really are coffin nails and we hope you will remember them everytime you light a smoke.

They are:

1. "It always happens to the other person"
   (Maybe so, but he's thinking the same thing and you are the other person to him.)

2. "Your number's up"
   (The only time your number's up is when you invite an accident by a careless act.)

3. "Law of averages"
   (The only way the law of averages can catch up with you is for you to forget yourself and do something foolish. Be alert, work safely and you will be safe.)

4. "The price of progress"
   (There was a time when everyone believed a job cost one human life for every million dollars spent - commonsense safety practice has proved this to be false. Today, jobs running into millions of dollars are completed without a serious accident.)

5. "Spirit of '76" or "safety is sissy stuff"!
   (Even if you are a brave person and not afraid of anything, think of your loved ones and work safely. There is no reason for them to pay for your bravery.)

6. "Act of God" or "Fate"
   (If you really believed in the Act of God or Fate theory, you wouldn't hesitate to walk in front of an express train. You and everyone else would call that suicide. Carelessness in work habits is just as suicidal. Work safely.)

There they are - six killers. Don't let them get you! Live, work, drive and play safely the year 'round and the odds on your living to a ripe old age will go sky high.

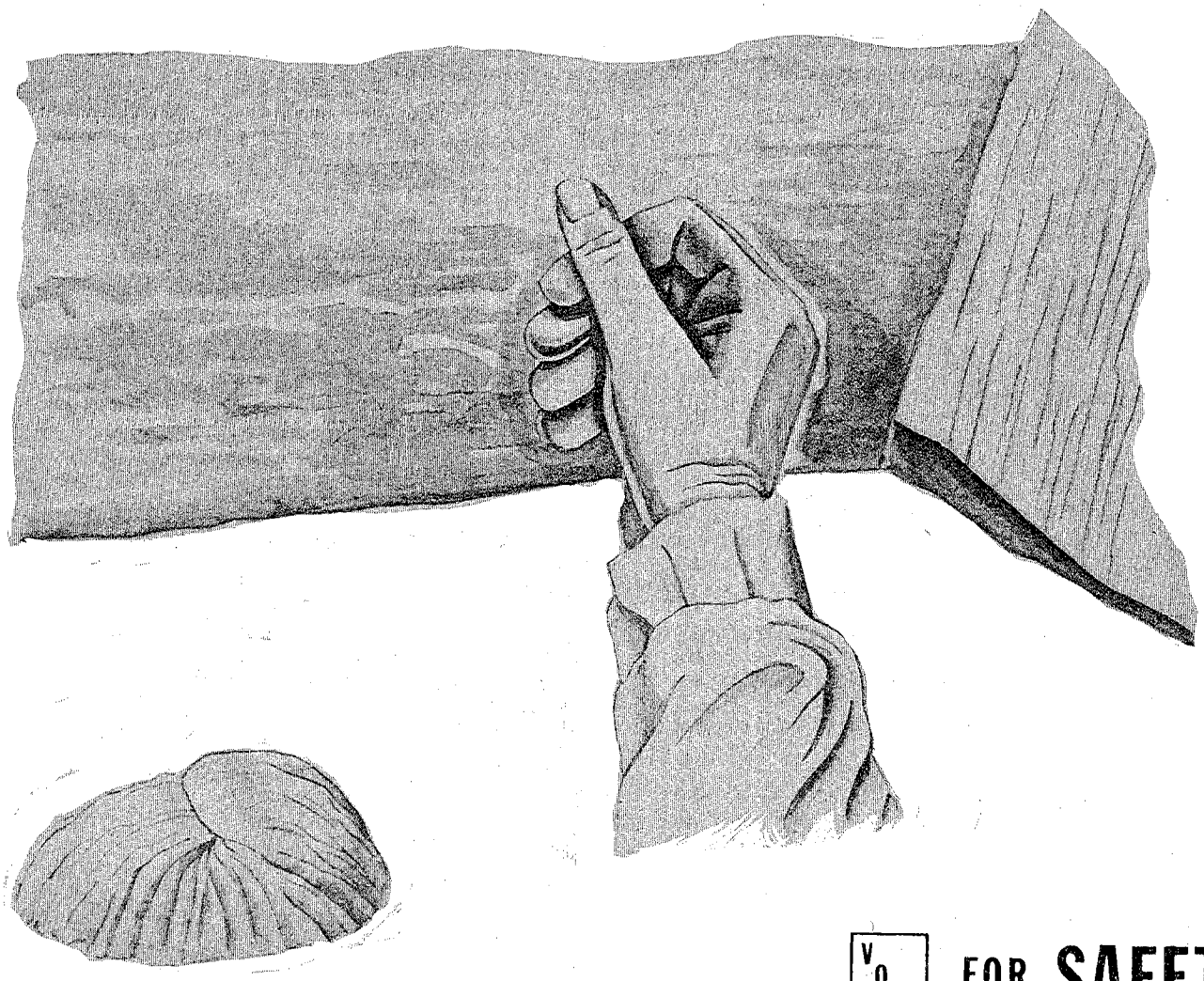
WORK SAFELY - AND YOU WON'T NEED ANY COFFIN NAILS

SAFETY IS EVERYBODY'S BUSINESS

(For use in all mining operations)

HOLMES SAFETY ASSOCIATION

Although the sand was bridged, it was not rigid. A Safety Belt and Line here could have saved a life.



VOTE

FOR SAFETY IN 1980

MSHA

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MSHA, Holmes Safety Association
Education and Training
P.O. Box 25367
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