

AUGUST 1983



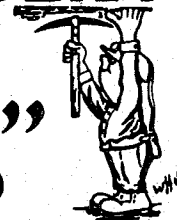
BULLETIN



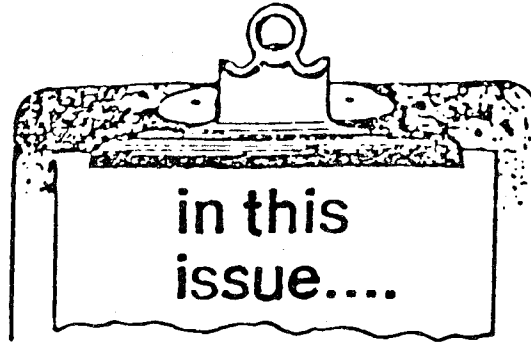
**BE ACCIDENT
FREE IN**



"83"



HOLMES SAFETY ASSOCIATION



August 1983

1. Safety Topic, "Welcome New Members"
2. Safety Topics, "I Lost An Eye"
"Human Failure In Industrial Injuries"
3. Posters, "Safety Tips, 'Your 10 Best Tools'
'Mouth To Mouth Resuscitation'
4. Graph, "Fatalities-Coal/Roof-Face-Rib--"
5. Safety Topic, "Cyanide Mill Reagents"
6. Safety Topic, "Relax In Safety"
7. Abstract, "Machinery Accident"
8. Abstract, "Electrical Accident"
Safety Topic, "It's Up To The Motorist"
9. Safety Topics, "Enthusiasm"
"Second Sight"
10. Safety Topic, "Conveyors Underground Coal"
11. Safety Topic, "Analysis of Injuries Involving Conveyors
In Underground Coal Mines"
12. Safety Topic, "Stop Accidents"
13. The Last Word
14. Meeting Report Form (Mine Chapters Only)



HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

August 1983



More Energy Inc
More Energy Coal
Paintsville, Kentucky

Big Buck Coal Co Inc
No. 1
Meta, Kentucky

Big Oaks Coal Corp
Big Oaks Coal
Richlands, Virginia

Crystal Coal Corp
Crystal Coal
Clintwood, Virginia

Cheyenne Coal Corp
Cheyenne Coal
Wolford, Virginia

Blankenship & Rife Inc
Blankenship & Rife Coal
Grundy, Virginia

Rogers Coal Co Inc
Rogers Coal
Wolford, Virginia

H J & H Coal Co Inc
H J & H Coal
Grundy, Virginia

Beckley Welding Supply Inc
Wholesale Welding Supply
Beckley, W Virginia

Dunbar Coal Co
Dunbar Coal
Dunbar, Kentucky

Cary-Watts Inc
C & C Coal
Morgantown, Kentucky

Coleman Martin Constr
CMC-Buckhorn Coal
Morgantown, Kentucky

Bon Harbor Coal Co
Bon Harbor
Morgantown, Kentucky

Riverside Dock
Riverside Coal
Morgantown, Kentucky

A & D Coal Co
A & D No. 2
Prater, Virginia

Meadows Coal Co
Meadows No. 4
Oakwood, Virginia

LBJ Coal Co Inc
No. 1
Honaker, Virginia

L & R Mining Inc
L & R No. 6 Coal
Mavisdale, Virginia

Irving Materials Inc
McCordsville Pit Sand/Gravel
Fortville, Indiana

Irving Materials Inc
McCordsville Quarry/Limestone
Fortville, Indiana

Irving Materials Inc
Pendleton Pit Sand/Gravel
Anderson, Indiana

Irving Materials Inc
Pendleton Quarry Limestone
Anderson, Indiana

Irving Materials Inc
Anderson Pit Sand/Gravel
Anderson, Indiana

Irving Materials Inc
Connersville Pit Sand/Gravel
Connersville, Indiana

Irving Materials Inc
Cambridge City Pit Sand
Cambridge City, Indiana

Irving Materials Inc
Springport Pit Sand/Gravel
Mt Summit, Indiana

A M Daniels Coal Corp
A M Daniels Coal
Majestic, Kentucky

C & B Coal Co Inc
Folk Ridge
Abingdon, Virginia

Bright Coal Co Inc
No. 3 Deep
Whitesburg, Kentucky

Elite Mining Inc
No. 1 Coal
Cumberland, Kentucky

U.S. Coal Inc
No. 5-2
Jacksboro, Tennessee

Wampler Brothers Coal Co
Wampler Brothers Coal
Mayking, Kentucky

F S Coal Company
Fred & sons
Whitesburg, Kentucky

Peabody Coal Co
Walton Creek
Centertown, Kentucky

Southwind Mining
No. 1 Coal
Beaver Dam, Kentucky

Earth Coal Co
Earth Coal
Morgantown, Kentucky

Tandem Mining Corp
Tandem Coal
Grundy, Virginia

Card Coal Corp
Card Coal
Grundy, Virginia

Potter & Dotson Coal Co
No. 5
Oakwood, Virginia

M P & M Coal Co Inc Ltd
M P & M Coal
Grundy, Virginia

Green Constr Of Indiana
Construction/Coal
Louisa, Kentucky

Portland Coal Inc
Portland
Terra Alta, W Virginia

Big Wheel Coal Co
Big Wheel No. 1
Honaker, Virginia

Kiser & Tackett Coal Co
Kiser & Tackett
Pikeville, Kentucky

Black Widow Coal Co Inc
No. 1
Vansant, Virginia

Lanham Coal Co
Lanham No. 1
Philpot, Kentucky

Derek Mining Inc
Magan No. 1 Coal
Greenville, Kentucky

Hillcrest Constr Co Inc
Construction
Morgantown, W Virginia

Four T Coal Co
No. 1
Meta, Kentucky

E H Hatfield Enterprises
E H Hatfield Coal
Phelps, Kentucky



August 1983



HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

I Lost An Eye

The following story tells how it feels to lose part of one's eyesight. It isn't a pleasant story but it's one that is badly in need of telling.

To My Coworkers:

Let me tell you how it feels to be suddenly cut down to 50 percent vision and to be very concerned that something may happen now to make me totally blind.

On August 29, I was on a routine job changing bits on a mining machine. Most of us machine operators before my accident felt that doing this job would involve no particular risk so I did not bother to put on my safety glasses.

I was about to remove the bit from the chain of the mining machine to replace it with a new bit when I hit the bit or chain with my hammer and a piece of flake of the chain flew into my left eye.

When that piece of steel penetrated my eye, I thought that I had been hit right on the eyeball by a hammer. It nearly knocked me out.

I was sent to the hospital by the first aid attendant. While riding to the hospital, I was worried sick that I had lost my eye.

I was on the operating table for almost an hour. I was conscious of what was going on around me; therefore, I was very anxious about every move that was made. The doctors had trouble removing the steel fragment. They must have thought I was out cold because I could hear them talking about my eye. You can just imagine my state of mind.

They eventually got the piece of steel out but only after another and larger incision had been made in my eye. Back in the ward, I had to lie still with bandages firmly fixed over both eyes for four days. Whenever I sneezed or coughed, I thought that my injured eye was exploding right out of its socket.

I was scared and felt alone. I could not even feed myself. The realization of how it would be for the rest of my life, if I was totally blind, was terrifying. It was very depressing to me. And believe me, I had plenty of time to think about it during those four days of blackness.

They did not remove the injured eye although I cannot see out of it. Maybe future developments in eye surgery will help me to get some vision back in my injured eye. I was told that I had better reconcile myself to working with only one eye. A person can always hope though. In the meantime, I am sure of one thing--nothing will induce me to risk injury to my good eye.

I will do everything possible in my power to ensure the protection of the sight remaining to me. Those four days of absolute blackness gave me plenty of time and cause to think. I have learned my lesson the hard way. My advice to you is--WEAR EYE PROTECTION ALL THE TIME.

Human Failure in Industrial Injuries

Much has been written about safety around machinery, and especially how it concerns you, your job, your family and your future security.

Millions of dollars have been wisely invested to safeguard mechanical equipment in an effort to reduce occupational injuries. Yet a high percentage of industrial injuries involve human failure.

This usually is caused by any one or a combination of the following: curiosity, distraction, fatigue, failure to make an effort to be safe, worry, anger, illness, and deliberate chancetaking.

Much can be said about each one but as far as you and I are concerned, it all boils down to four brief thoughts:

Watch your every move around machinery.

Know what you are doing.

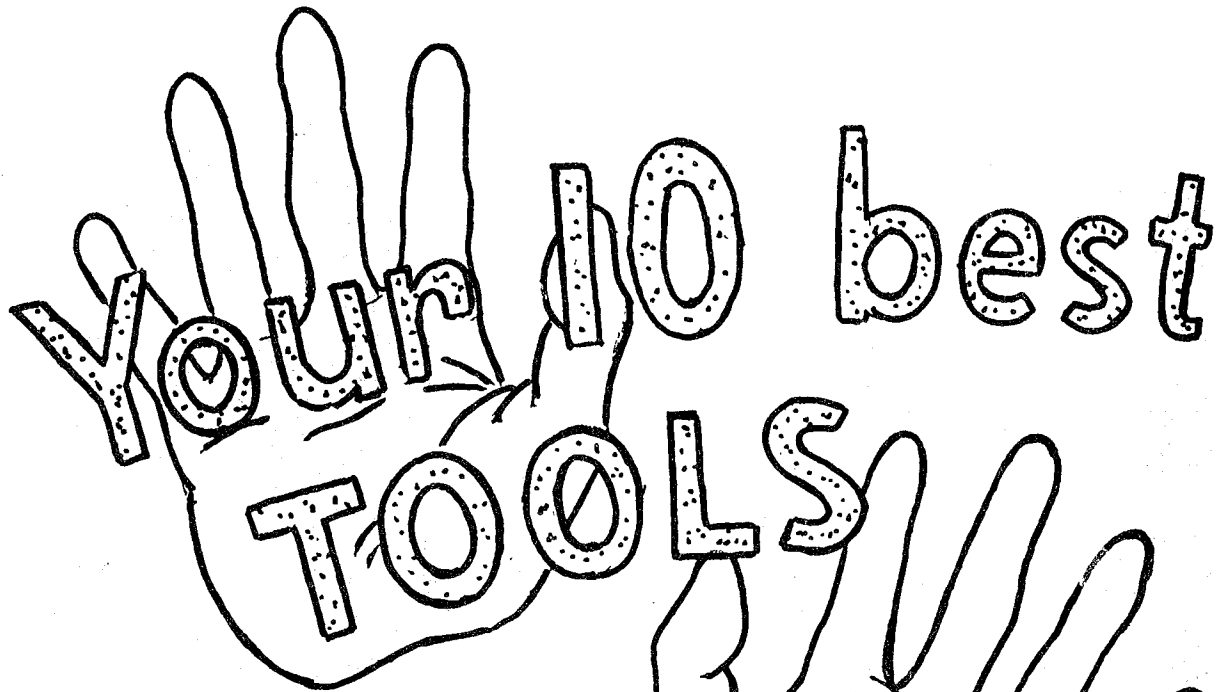
Before making repairs or adjustments, turn off machinery and make sure it will stay off.

Keep machine guards in place--don't tamper with them.

Observe these precautions and your safety in machine operations is practically assured.

HOLMES SAFETY ASSOCIATION

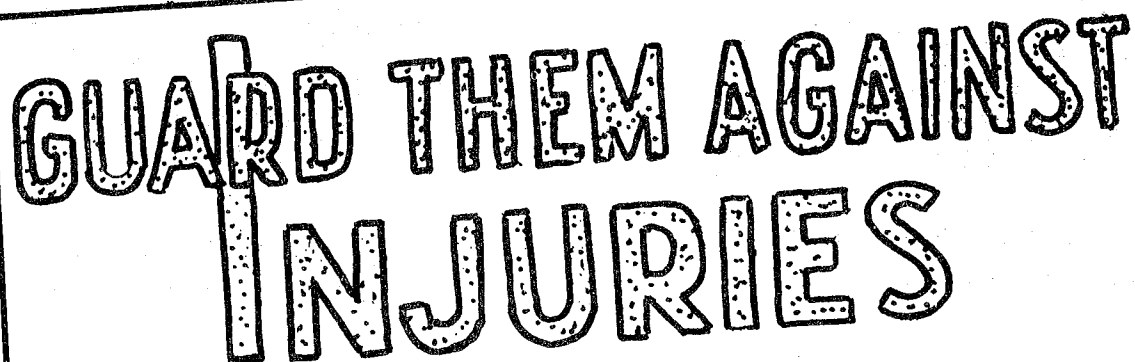
SAFETY TIPS



Your 10 best
TOOLS



... NO EXTRAS
IN STOCK!

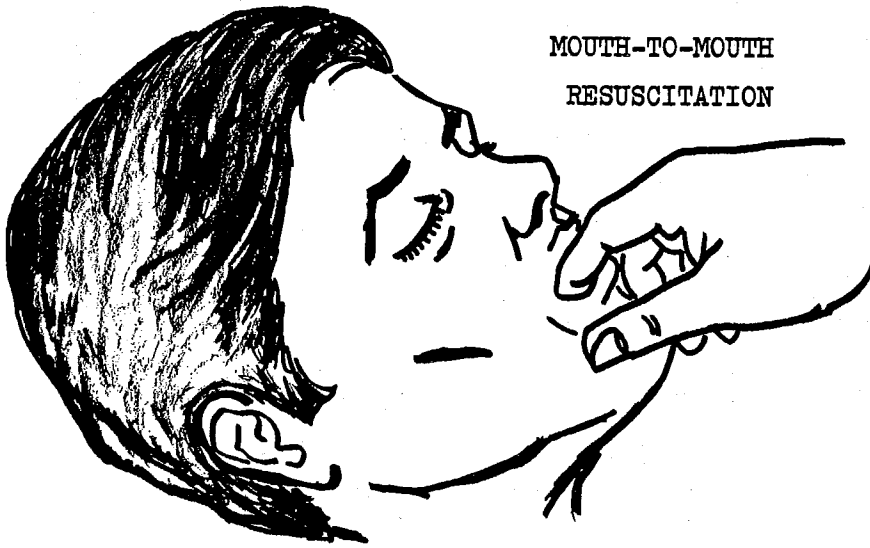


GUARD THEM AGAINST
INJURIES

HOLMES SAFETY ASSOCIATION

SAFETY TIPS

MOUTH-TO-MOUTH RESUSCITATION



1. CLEAR THE AIR PASSAGE.



2. LIFT UP UNDER NECK
(EXTEND CHIN) AND PINCH
THE NOSTRILS TOGETHER.



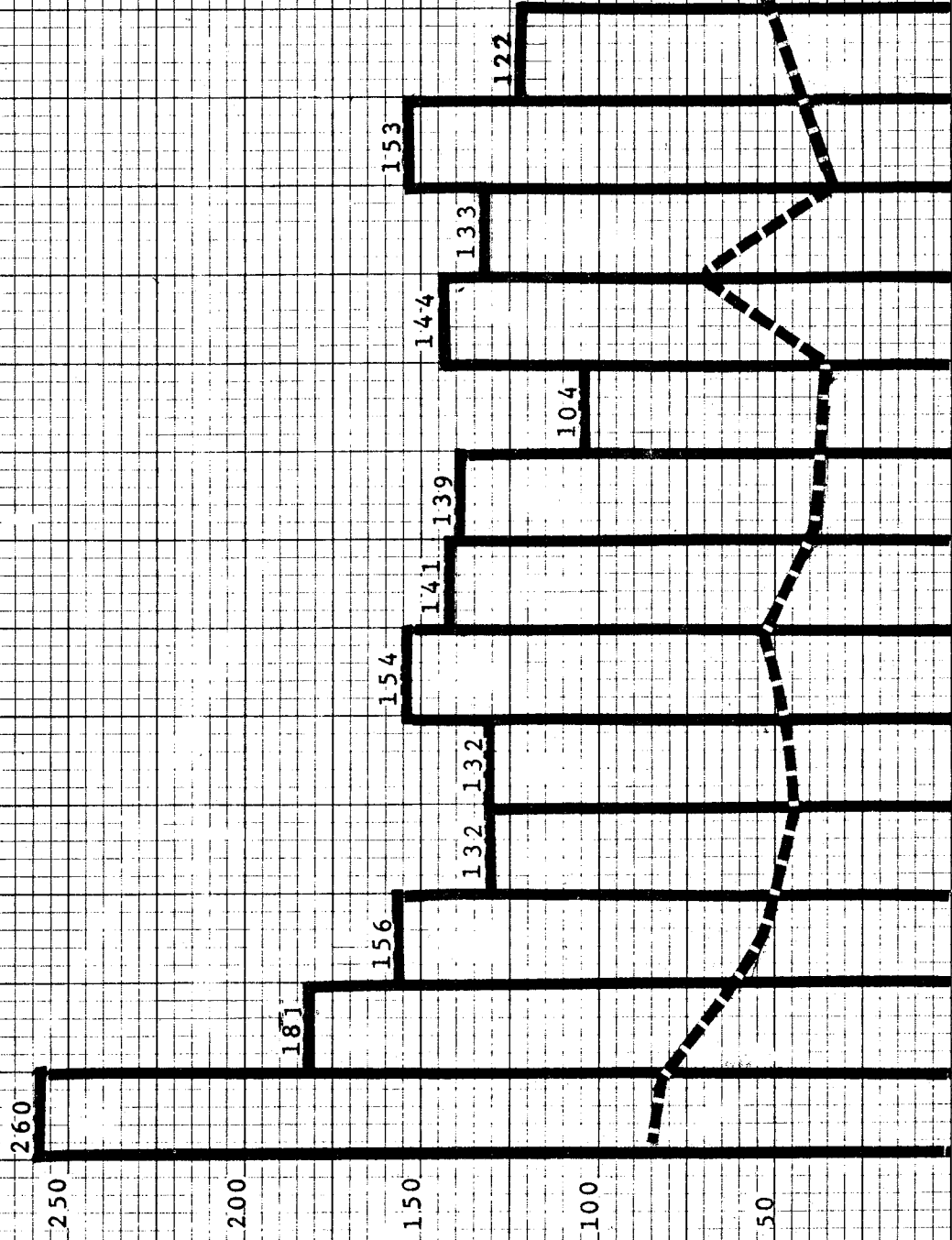
3. INHALE DEEPLY. BREATHE
INTO VICTIM'S MOUTH.



4. REMOVE MOUTH, LISTEN
FOR RETURN FLOW OF AIR.

FATALITIES--COAL

ROOF--FACE--RIB



1970 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85



August 1983



HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

Cyanide Mill Reagents

Work Practice Guidelines. U.S. Dept. of Labor, Mine Safety and Health Administration.

Introduction

There are two major mining processes in which cyanide chemicals are used. The first is a hydrometallurgical process in which a solution of cyanide in water is used to dissolve gold and silver from their ores. This milling process uses cyanide in quantity and cyanide solutions are generally present in the entire mill flow circuit. A modification of this process is heap leaching, in which a cyanide solution is sprayed over an ore pile, and the solution containing the dissolved precious metals is collected in a storage pond or tank. Most of the heap-leach operation is accomplished outdoors without the need for buildings or leach tanks.

Another modification of the hydrometallurgical process is in situ leaching, in which cyanide solutions are percolated through an ore zone and collected in an underground sump. This process may require workers to be located underground. The precious metal values in all these hydrometallurgical processes are generally recovered by either zinc precipitation or electrowinning. In addition to gold and silver, the cyanide solutions used in these processes will also dissolve and form complex ions with many other associated metals that are found in mineralized rock. These complex ions are of varying degrees of toxicity and are usually disposed to tailings, where they can form toxic molecular hydrogen cyanide.

The second major mining use of cyanide is in the flotation process, where cyanide is used to treat the surface of mineral particles for processing in flotation machines. In general, cyanide is used as a depressing agent for pyrite and sphalerite and occasionally for copper sulfides. The cyanide circuit in the flotation process constitutes only a small portion of the total process. Cyanide exists in toxic concentrations from the point of preparation of the reagent solution to its addition into the actual milling process. This addition point can be a conditioning tank, ball or rod mill, thickener, or the rougher circuit of the mill. At this point the cyanide is reacted and diluted to low concentrations.

Commercially available cyanide mill reagents are generally the solid cyanide salts of sodium (NaCN) and, less commonly, calcium ($\text{Ca}(\text{CN})_2$) and potassium (KCN). Hydrogen cyanide gas (HCN) can be generated from reaction of these salts with either moisture or acidic substances. Acetylene gas (C_2H_2) can be generated during reactions with water if the salt contains calcium carbide (CaC_2).

Cyanide use creates many potential problems for the mine operator because of the variety of its physical and chemical forms. The commercially available salts are used in either briquet or flake form, and can generate airborne dust when improperly handled. Improper mixing of the alkaline cyanides can result in the formation of toxic hydrogen cyanide gas. Both the cyanide salt dust and hydrogen cyanide gas are respiratory hazards. If the cyanide solution is controlled at the proper pH, the resulting liquid is highly alkaline and as such is more corrosive to human tissues than most acids.

The greatest health hazard from exposure to alkaline materials is a splash into the unprotected eye. In addition, both hydrogen cyanide gas and the cyanide ion (CN^-), present in cyanide solutions, can be absorbed through the skin as well as through the respiratory system, thus increasing the hazard potential.

Cyanide compounds are highly toxic. Average lethal doses of the salt reportedly range from 50 to 250 milligrams when taken orally, depending upon individual tolerances and life-saving action. This amount is less than half the weight of a standard paper clip and could easily be contained under a long fingernail. A fatal dose of a 0.5 percent NaCN solution (10 pounds of solid salt per ton of water) is about 0.7 fluid ounces, which is less than a full shot glass. Inhalation of hydrogen cyanide gas concentrations of about 135 parts per million (ppm) or more for 1 to 30 minutes can be fatal, especially if first aid is not given.

Cyanide salts and HCN have the same mechanism of toxic action: inhibition of enzymes necessary for cellular use of oxygen. Cyanide bonds to metallic enzyme molecules and disturbs the cell's ability to use oxygen, causing chemical asphyxiation. Although hydrogen cyanide gas exerts its toxic action more rapidly than the salt, both forms are equally hazardous when proper work practices are not followed.

Current metal and nonmetal mining regulations enforced by the Mine Safety and Health Administration limit 8-hour occupational exposures to 5 mg/m^3 for cyanide salts and 10 ppm for hydrogen cyanide (American Conference of Governmental Industrial Hygienists, Threshold Limit Values for 1973). Additionally, HCN exposures for 30 minutes must not exceed 20 ppm (short-term limit, Pennsylvania Department of Health regulations, 1968). The concentration of airborne particulate cyanide salts can be determined by sampling with a personal sampling pump and appropriate membrane filter. The sampling instrument of choice for gas detection is NIOSH-approved colorimetric detector tubes. Continuous direct-read area monitors and personal gas detection alarms are also commercially available.

-MORE-

Cyanide salt and gas levels are best controlled by engineering techniques and safe work practices. Ventilation should be provided in work areas where cyanide dust or gas might be released, and the ventilation system must be effective enough to keep airborne cyanide concentrations below the MSHA exposure limit values. Local exhaust ventilation at the point of contaminant emission is the most acceptable method for minimizing employee exposures. Safe work practices include administrative controls, proper storage, good housekeeping and intelligent handling of cyanide compounds.

Appropriate personal protective equipment is required when handling cyanide compounds. Dust and gas respirators, eye protection, gloves and protective clothing should be worn, maintained and cleaned on a regular basis.

Although few injuries or deaths have been attributed to cyanide exposures in the mining industry, the potential for illness and injury is such a constant threat that continued good work practices are necessary for maintaining a safe work environment.

(Next month, Work Practice Guidelines, Storage).



August 1983



HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

Relax In Safety

It is a fact that accident rates are two times as great in and around the home than on the job. Home accidents result almost wholly from ignoring common everyday hazards--the sort of things that are easily seen and easy to take care of.

The descriptions of home accidents almost always points to the same thing; the failure of parents to keep a lookout for the common everyday kind of hazards--and do something about them. Instead, the average person just goes home and relaxes in safety. But homes can be full of the kind of hazards that can injure a family.

What should we do? First of all, we should take safety mindedness home with us and use it. We should apply the safety know-how we gain at the mine as far as it will fit. Most of all, we should use our heads. We should inspect our homes from attic to basement, inside and out, the yard--everything!

Why not make a thorough inspection of your home this weekend? It's really an interesting job.

Falls lead the list of home accidents. They happen on stairs, slippery floors, loose rugs and steps. Tumbles occur from stools and things we stand on to hang curtains or clean high shelves. Falls result from tripping over playthings or other loose objects on floors or stairs.

There are many chances for burns to occur. Pot and pan handles sticking out from the stove top are open invitations to little toddlers to grab or for adults to brush against. Heedless handling of hot pans and kettles, hot irons, even the Sunday roast bring a share of burns. Overheated grease used for cooking does much damage. Smoking in bed kills its share of people every year.

Then there are electrical hazards, tool hazards, poisons, fires, and others. All can be easily found and taken care of. Inspect, correct and teach safety at home. Then you can relax in safety.

ABSTRACT FROM FATAL ACCIDENT

August 1983

HOLMES SAFETY ASSOCIATION
MONTHLY SAFETY TOPIC



Machinery Accident

Description of Accident: A machinery accident occurred in a longwall face resulting in the death of the shear operator. The victim had six years experience as a shear operator.

The accident occurred when the victim positioned himself across the shearer haulage unit frame to contact the head operator to move the longwall conveyor line. The victim remained in the stated position while the conveyor line was moving. A piece of rock in the moving conveyor line lodged under the guide of the shearer, raising the shearer haulage unit up into the canopy, crushing the victim.

The victim evidently did not recognize the hazard involved by positioning himself in such a manner.



Legend:

1. Victim caught between chocks and frame of shearer.
2. Paging system used by victim to talk with headgate operator.

ABSTRACT FROM FATAL ACCIDENT

August 1983

HOLMES SAFETY ASSOCIATION
MONTHLY SAFETY TOPIC



Electrical Accident

General Information: The quarry was an open-pit single-bench limestone operation. Limestone was mined by the single-bench method with drilling and blasting accomplished by conventional means.

A 60- x 80-foot sump was used to catch the water drainage from the quarry. A pump was installed in the sump to drain the collected water out of the quarry. Normal procedure for starting the pump was to connect the power cable from the junction box to the power cable from the pump. Since the cable ran across the haulage roadway, the pump was only operated during the night when the quarry was not operating. At the beginning of the workday, the two cables were disconnected. Power was shut off at the magnetic starter switch where no means of locking were provided due to the nature of the switch.

Description of Accident: The victim disconnected the twist lock four-prong receptacle which supplied electrical power to operate the sump pump in the quarry, and removed the 230- and 370-foot electric cables from the haulage roadway. Work proceeded normally until the victim and a coworker repositioned the cable. The victim made the first twist lock four-prong electrical connection without incident. While he was attempting to make the second connection, which made the circuit complete, the men observed an electrical arc. The coworker told the victim to let go of the cables, which he did. The coworker then went back to the magnetic starter and shut off the power. Upon returning from the magnetic starter, about 600 feet away, the coworker did not see the victim until he reached the top of the roadway where the victim had attempted to make the electrical connection. The coworker stated that the victim was lying in a prone position.

Cause and Recommendations: The direct cause of the accident was the victim making the electrical connections without first checking to make sure the power cable was de-energized.

A contributing cause of the accident was the magnetic starter; an employee could not detect by visual observation whether the circuit was energized or de-energized.

Part 56.12-7 MANDATORY Trailing cables and power-cable connections to junction boxes shall not be made or broken under load.

The company should re-instruct all employees in the hazards and use of electricity.

A manual disconnect switch should be installed ahead of the magnetic starter in the quarry so an employee could tell by visual observation whether a circuit was energized or de-energized.

It's Up To The Motorist

To always slow down in school zones.

To drive with extra caution, prepared to stop when there are children around.

To remember to slow down in residential districts, even away from school zones, during the hours when children are on their way to and from school.

To expect the unexpected and regard every child near the curb as a human caution sign.

To form the habit of walking behind the car before backing out of a driveway and then back only when certain that no children are around.

To allow plenty of room for bicycles.

To stop for all school buses loading or unloading children. To remember that drivers, overtaking the bus from the rear or approaching the bus from the front, are required to stop and wait until the school bus moves on.

To drive as though every child ahead were her/his own and as she/he wishes others to drive.

To remember that an empty seat in a school room just because a child forgot or because some motorist couldn't stop in time is hard to explain and impossible to forget.



August 1983



HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

Enthusiasm

That certain something that makes us great--that pulls us out of the mediocre and commonplace--that builds us up. It glows and shines--it lights up our faces. Enthusiasm--the keynote that makes us sing and makes others sing with us.

Enthusiasm--the maker of friends--the maker of smiles--the producer of confidence. It cries to the world--"I've got what it takes."

Enthusiasm--the inspiration that makes us wake up and live. It puts spring in our step--spring in our hearts--a twinkle in our eyes and gives us confidence in ourselves.

Enthusiasm--it changes a lackadaisical worker into a producer--a pessimist to an optimist--a free-loader to a go-getter.

Enthusiasm--if we have it, we should be thankful. If we don't have it, we should cultivate it.

Upon the plains of hesitation, bleached the bones of countless millions who, on the threshold of victory, sat down to wait, and waiting, they died.

Second Sight

How much do you really see? Only what your eyes look at, or do you also see with your imagination, knowledge and experience?

Suppose you are about to sharpen a tool on a grinding wheel. You see that the protective eye shield on the grinder has loosened and is out of place. Is that all you see? If you're looking with your mind's eye, then you'll also see:

**The possibility of a tiny chip striking your eye, or the next person being blinded.

**Or the need for wearing safety goggles as well as having the shield fixed.

**Or an image of yourself with a black patch over one eye.

**Or the difficulty of working or driving your car when one eye is sightless.

When you're tempted to risk your future, take a second look into the twilight zone of what could happen. Let that second sight make a decision.



August 1983



HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

CONVEYORS UNDERGROUND COAL



January 1, 1978 - December 31, 1980

<u>1978</u>	<u>1979</u>	<u>1980</u>
355	580	840
Injuries	Injuries	Injuries

Conveyor Injuries Have Increased 137 Percent
In The Past Two Years



August 1983



HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

ANALYSIS OF INJURIES INVOLVING CONVEYORS IN UNDERGROUND COAL MINES

There were 1,775 conveyor related injuries in coal mines from 1978-1980; four of these were fatalities. Installing or removing a portion of the conveyor system, cleaning spillage next to or under moving belts and riding, crossing, entering or leaving a moving belt were the primary activities the miners were engaged in at the time of injury.

Data for this study were obtained from the accident reports on file at the Health and Safety Analysis Center, Denver, Colorado. The accident reports for all underground conveyor systems, including those which were part of continuous-mining machines, longwalls, feeders, etc., were analyzed.

ANALYSIS

Over 25 percent (450 injuries) of the conveyor accidents during the three-year period occurred while setting up or moving the conveyor system (Table 1). Within this category the most common accident (176 injuries) resulted when the miner was pulling on the belt.

Cleaning spillage from around moving conveyor belts accounted for 440 injuries. The movement of the belt caused shovels, bars and other tools to be forced at or from the miner inflicting various injuries. The greatest number of injuries related to this accident category occurred when miners were pulled into the rotating components of the conveyor.

Routine maintenance work accounted for 417 injuries. These injuries occurred when miners were greasing rollers, cleaning or picking waste and training belts.

Crossing conveyor belts accounted for 154 injuries. A hidden danger in crossing a stationary belt is that it may be started unexpectedly. This occurrence accounted for 45 injuries.

Loading and unloading moving belts accounted for 126 conveyor injuries. Miners incurred these injuries while loading and unloading bolts and timbers while the belt was running.

Riding, entering or leaving a moving belt accounted for 115 conveyor injuries. In general, these injuries resulted from the miners being thrown about or striking the roof or timbers while mounting, riding or dismounting the belt.

-MORE-

There were four fatal conveyor injuries during this three-year period. Three of these injuries occurred in 1979. One miner was crushed between the tailpiece of the continuous-mining machine and the rib. In a similar accident a miner was crushed between the tailpiece of a continuous-mining machine and a roof jack. The third fatal accident in 1979 occurred while a miner was riding the mantrip belt and struck his head on the roof. The fourth conveyor-type fatality occurred in 1980 when a miner became entangled in the belt drive and was crushed.

RECOMMENDATIONS

Injuries during the belt move-up could be reduced by closer supervision and proper lifting techniques, i.e., back straight and knees bent or with the use of mechanical aids.

Accidents that occurred while miners were cleaning up spillage would have been reduced by not allowing this work while the belt is moving or by guarding pinch points between belts and rollers at the point where spillage most frequently occurs.

The installation of extended grease fittings, effective belt cleaners, proper pinch point guarding and insuring that the belt is properly locked-out during maintenance activities will reduce the number of injuries occurring during routine maintenance.

Riding, working on and crossing over a belt has resulted in numerous injuries to miners. Proper crossover points and locking out the belt during maintenance activities could have prevented most of these injuries. Injuries resulting from getting on or off the belt during regularly scheduled mantrips are the result of making the attempt while the belt is moving. Most of these injuries will be avoided if the belt is stopped during the time employees are boarding or getting off the belt.

Manual cleaning of pulleys, rollers and other parts necessitated by build-up should be undertaken only with the conveyor at rest and the power supply switch locked-out.

Removing waste or other material from moving conveyor belts by hand should only be permitted where designated stations for this activity are provided. Where such stations are provided, they should include safeguards such as additional guarding of the belt where materials are unloaded.

Table 1. Underground Conveyor Accidents, Coal
1978 - 1980 by Activity

	<u>1978</u>	<u>1979</u>	<u>1980</u>	<u>Percent</u>
<u>Setting Up or Moving</u> <u>Conveyor System</u>				
Pulling on Belt	35	58	83	9.8
Lifting Belt	20	32	47	5.6
Carrying Roller	18	29	42	5.0
Moving Conveyor Stand	10	16	24	2.8
Not Stated	7	12	17	2.0
	<u>90</u>	<u>147</u>	<u>213</u>	<u>25.2</u>
<u>Cleaning or Shoveling</u>				
Pulled into Idler/Roller	28	47	66	7.9
Struck by Material from Belt	19	31	44	5.3
Struck by Rebounding Shovel, Bar, etc.	17	28	40	4.9
Fell Onto Belt	6	10	14	1.7
Struck by Moving Belt	5	8	8	1.2
Belt Started Unexpectedly	2	3	5(1F)	0.6
Not Stated	12	19	28	3.3
	<u>89</u>	<u>146</u>	<u>205</u>	<u>24.9</u>
<u>Lubricating or Maintenance</u>				
Pulled into Idler/Roller/Tail- pulley	23	39	55	6.5
Struck by Maintenance Material (Wrench, Grease Gun, etc.)	21	34	50	5.9
Struck by Material from Belt	13	21	31	3.7
Belt Started Unexpectedly	10	13	24	2.6
Crushed by Swinging Tailpiece	2	3(2F)	4	0.6
Not Stated	15	24	35	4.2
	<u>84</u>	<u>134</u>	<u>199</u>	<u>23.5</u>
<u>Crossing Belt</u>				
Belt Stationary	12	19	28	3.3
Belt Moving	10	16	24	2.8
Belt Started Unexpectedly	9	15	21	2.5
	<u>31</u>	<u>50</u>	<u>73</u>	<u>8.6</u>

Load/Unload Material from Belt

Belt Stationary	13	21	31	3.7	
Belt Moving	5	8	12	1.4	
Belt Started Unexpectedly	1	2	3	0.3	
Not Stated	6	10	14	1.7	
	SUBTOTAL	<u>25</u>	<u>41</u>	<u>60</u>	<u>7.1</u>

Riding Mantrip

Getting On/Off	12	19	28	3.3	
Struck Conveyor or Structure	7	12	17	2.0	
Struck Roof	2	3(1F)	5	0.6	
Struck Overcast, Header, Bolt, etc.	2	3	5	0.6	
	SUBTOTAL	<u>23</u>	<u>37</u>	<u>55</u>	<u>6.5</u>
Not Classified	13	25	35	4.2	
	TOTAL	<u>355</u>	<u>580</u>	<u>840</u>	<u>100.0</u>

(F) = Fatalities



August 1983



HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

Stop Accidents

A sudden disaster stirs the whole nation to sympathy and regret. People rush from all directions to give aid and comfort where there is need. Most of us have sincere sympathy and a helping hand for someone in trouble. This is good will in action--a fine human trait. But it would be even more wonderful if more people would wake up to the need for interest in other people's welfare before dire things happen.

When you hear or read of a tragic accident or when you see an accident happen, perhaps you think that it could have been prevented. But do you see things to do to help other people before they get hurt or killed?

Of course you can't be expected to spend all your time acting as a guardian for all the people you know, work with or meet. But just a little extra courtesy and common kindness and foresight help prevent accidents.

AT WORK...Help watch for hazards, point them out and help get rid of them. Give full and ungrudging support to the company safety program. Set a good example of safe work for new employees. Help any worker if you see or sense the need.

AT HOME...Make your sense of sight and your safety sense work together to keep hazards out of your home. Train the children, by advice and by example, to play safely and live safely. Talk safety in the home.

IN YOUR CAR...Remember the Golden Rule.

WHEN WALKING...Be fair and use care. You'll be helping yourself as well as motorists if you avoid thoughtless or reckless acts.

IN YOUR COMMUNITY...Participate in safety campaigns. Support safety organizations. Seek laws that offer greater safety for you and other citizens. Obey these laws.

WITH SAFETY, THE MORE YOU SHARE, THE MORE YOU HAVE!

THE LAST WORD

On Blindness

Please sit down for a moment
and let's play a game.
Now please close your eyes
and then I'll do the same.
Wouldn't blindness be awful
if this were for real?
That, in order to see, you
find you must feel?
Do you think you could reach up
and touch the blue sky?
No. Of course you can't do it,
and neither could I.
Do you think you'd enjoy
nature's dress when it's green?
Since you can't sense color
unless it is seen?
Now just keep your eyes closed
while you walk all around.
Can you tell where I stand
judging only by sound?
Tell me how you could know
if it's night time or day?
Could you find the path home
after losing the way?
You would bump into tables
and trip over chairs,
And find it not so easy
to go up the stairs.
Though your eyes are designed
to require little space,
Surely they are the most vital
part gracing your face.

Poison: Antifreeze stored in bottles for the summer can be especially attractive to children because of its red or blue color. What's more, permanent type antifreeze often has a sweet taste resembling honey. Antifreeze is highly toxic and as little as one cup can be lethal. It should be stored out of reach of children and should be labeled so that it cannot be mistaken for something else.

Ouch!

Hands and fingers were victims of roughly one fourth of all occupational injuries to the different parts of the body last year. That is why gloves and other hand protection is so important.

Of All People!

A safety director was walking away from a shop after giving it a thorough inspection. He was looking over the notes he had made when he tripped and broke his arm. Lesson to be learned--reading and walking don't go together.

Life is an everlasting struggle
to keep money coming in and
teeth and hair from coming
out.

What some people don't know
about driving fills the
hospitals.

Be dissatisfied enough to
improve but satisfied enough to
be happy.

One thing worse than being on
the wrong side of an argument
is to be in the middle of it.

Helpful Hint: When all else
fails, read the instructions.

Those who criticize the younger
generation seem to forget who
raised it.

There's a significant
difference between stupidity
and genius. That is, genius
has its limits.

Times haven't changed much. It
took Noah 40 days to find a
parking space.

POSTAGE AND FEES PAID
U.S. Department of Labor

LAB 441

MSHA, Office of Holmes
Safety Association
Educational Policy & Development
P.O. Box 25367
Denver, Colorado 80225

5000-22
(Rev. 12-78)



HOLMES SAFETY ASSOCIATION
MEETING REPORT FORM

For the month of _____

TOTAL meetings held this month _____

TOTAL attendance this month _____

Chapter Number _____ (See address label, if incorrect, please indicate change.)

(Telephone No.)

(Signature)

(Title)

FILL OUT - FOLD AND STAPLE - FREE MAIL-IN

NOTE: BE SURE OUR ADDRESS SHOWS

For uninterrupted delivery, please include any change of address below: