APRIL 1986

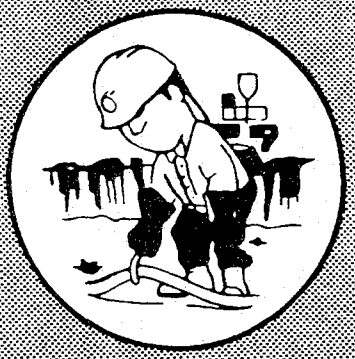
HOLMES SAFETY ASSOCIATION

E PLURIBUS UNUM

SAFETY EFFICIENCY

MINERAL INDUSTRIES

BULLETIN



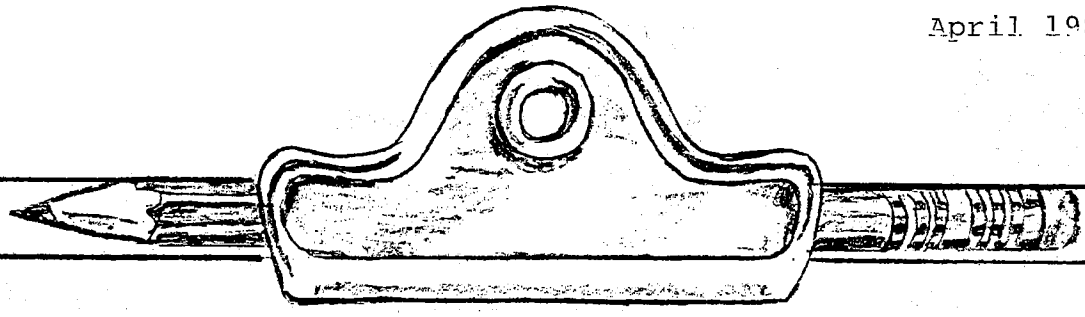
GIVE ACCIDENTS THE KICK IN "86"

THIS SAFETY BULLETIN CONTAINS SAFETY ARTICLES ON A VARIETY OF SUBJECTS, FATAL ACCIDENT ABSTRACTS, STUDIES, POSTERS AND OTHER SAFETY INFORMATION FOR PRESENTATION TO GROUPS OF MINE AND PLANT WORKERS.

AS GROUP SPOKESPERSON, LEADER OR SUPERVISOR, YOU PLAY AN IMPORTANT ROLE IN THE ACCIDENT PREVENTION PROGRAM FOR YOUR COMPANY. THE WAY YOU TALK, THINK AND ACT ABOUT SAFETY DETERMINES, TO A GREAT EXTENT, THE ATTITUDE YOUR COWORKERS WILL HAVE ABOUT SAFETY.

THIS MATERIAL, FUNDED BY THE MINE SAFETY AND HEALTH ADMINISTRATION, U.S. DEPARTMENT OF LABOR, IS PROVIDED FREE AS A BASIS FOR DISCUSSION AT ON-THE-JOB SAFETY MEETINGS. IT MAY BE USED AS IS OR TAILORED TO FIT LOCAL CONDITIONS IN ANY MANNER THAT IS APPROPRIATE.

PLEASE USE THE ENCLOSED GREEN MEETING REPORT FORM TO RECORD YOUR SAFETY MEETINGS AND RETURN TO THE HOLMES SAFETY ASSOCIATION, POSTAGE-PAID.



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HOLMES SAFETY ASSOCIATION

WEARING AND CARING FOR HARD HATS

1. Hard hats should never be worn on top of everyday hats and caps.

2. The sweatband should be adjusted so that the hat will not fall off or be blown off.

3. Hats should be worn squarely on the head, and not at an angle. The head harness is designed to give the optimum contact surface on the head.

4. The wearer should never attempt to repair a cracked shell. Damaged hats should be replaced immediately.

5. All hats and caps are designed to permit complete air circulation inside the crown. Boring holes in the crown for ventilation should be prohibited.

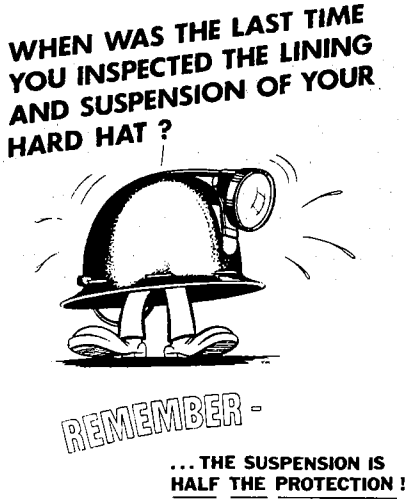
6. Some paints will reduce the dielectric protection, soften the shell material, and thus reduce impact protection.

7. A periodic inspection of hard hats should be made to check for cracks, dents, nicks, and abrasions.

8. Inspection of hats should include a check of the condition of webbing and sweatband.

9. Hats used primarily for electrical protection must be destroyed when damaged.

10. There should be at least 1-1/4 inches of clearance between the top of the head and the inside shell of the hat for impact protection and ventilation.



H.S.A. SAFETY TOPIC

BAD HABITS CREATE UNSAFE CONDITIONS

Accidents are incidents that happen without being planned. They may cause injuries or they may go unnoticed. Accidents are caused either by someone thinking wrong thoughts or not thinking at all.

Our actions are either voluntary or involuntary. Voluntary actions are preceded by our thoughts, and involuntary actions are governed by our habits. Habits are formed by repeating an action until we perform it without thinking. Our thoughts at the beginning of the action determine what kind of habits we acquire.

Safe work habits are essential to prevent accidents. It has long been contended that only one percent of all accidents are unavoidable, and that the remaining 99 percent can be avoided. How many accidents can you remember that could have been avoided if someone would have taken sufficient time to follow known safety procedures?

Some of the unsafe actions that continually result in serious accidents in the mining industry are:

1. Workers entering working places and not testing the roof.

2. Workers walking under known loose roof without sufficient support.

3. Roof supports not installed properly.

These are but a few of the reasons that roof falls continue to be a problem in coal mines.

Mine fires and explosions also continue to cause injuries. These are caused by workers entering abandoned workings without first assuring themselves that suitable examinations and tests had been made; failing to make suitable gas tests before electric equipment was taken into the face regions; disrupting the ventilating air current; not maintaining electric equipment in permissible conditions and poorly made temporary splices in power leads and trailing cables.

ABSTRACT FROM FATAL ACCIDENT

*This fatality could be discussed at your regular on-the-job safety meeting.

FATAL POWERED HAULAGE ACCIDENT

GENERAL INFORMATION: A haulage accident occurred causing fatal injuries to a scoop operator. He had about 5 years mining experience but he had only been employed at this mine for approximately one month as a scoop operator. The accident occurred as he was tramming a scoop loaded with coal from the face of the No. 1 entry to the belt feeder located in the No. 3 entry.

DESCRIPTION OF ACCIDENT: A few minutes after 6 p.m., the victim was tramming a scoop loaded with coal from the face of the No. 1 entry to the belt feeder which was located in the No. 3 entry. Enroute the victim stopped the scoop 140 feet outby the survey station and the cutting machine operator went to see if the victim was having trouble with the scoop. When the cutting machine operator arrived, the victim told him that the brakes on the scoop were sticking so he loosened the plug on the brake master cylinder to reduce the pressure on the brake disc. The victim then got back into the scoop operator's compartment and proceeded on toward the dumping point. After he had traveled approximately two crosscuts (120 feet), the right rear fender of the scoop impacted a coal rib which caused the victim to be thrown into a position in which his head was caught between the top of the scoop and the mine roof. He then slumped over the controls and the scoop began to turn as it continued on down the entry where it struck and came to rest against the corner of a coal pillar.

The feeder operator heard the impact of the scoop against the coal rib and looked up to see the scoop light go out. He hurried to the scene and found the victim slumped over the controls of the scoop. Realizing he was seriously injured the feeder operator went for help. Examination revealed that the victim had received massive head injuries and there were no signs of life.

CONCLUSION: The operator of the S & S scoop was operating this scoop at a faster speed than it could safely be operated in the limited coal height.

The scoop was not being maintained in safe operating conditon.

The defective braking system on the coal scoop may have been a contributing factor to the accident since the brake disc was rusty and had accumulated residue which further indicated that the brakes had not been operative for some time.

ABSTRACT FROM FATAL ACCIDENT

*This fatality could be discussed at your regular on-the-job safety meeting.

FATAL MACHINERY ACCIDENT

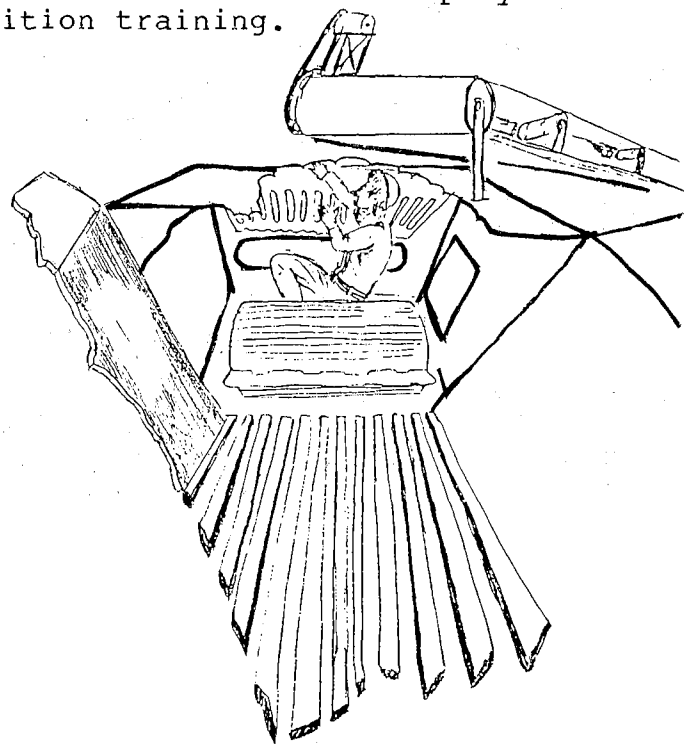
GENERAL INFORMATION: Limestone was drilled and blasted utilizing the single-bench mining method. Quarry products were crushed, screened, sized and conveyed to stockpiles.

DESCRIPTION OF ACCIDENT: The victim, a crusher operator, started the plant diesel engine and then apparently climbed over the engine onto the frame of the oversize product return conveyor, stepped onto the primary screen and entered the feed opening of the crusher. The victim removed all the rock from the crusher and was standing on the impactor drum facing the pan feeder. He used one foot to rotate the drum to ensure freedom of rotation. The drum suddenly began to rotate under diesel power pulling him into the anvil area where massive body injuries were inflicted.

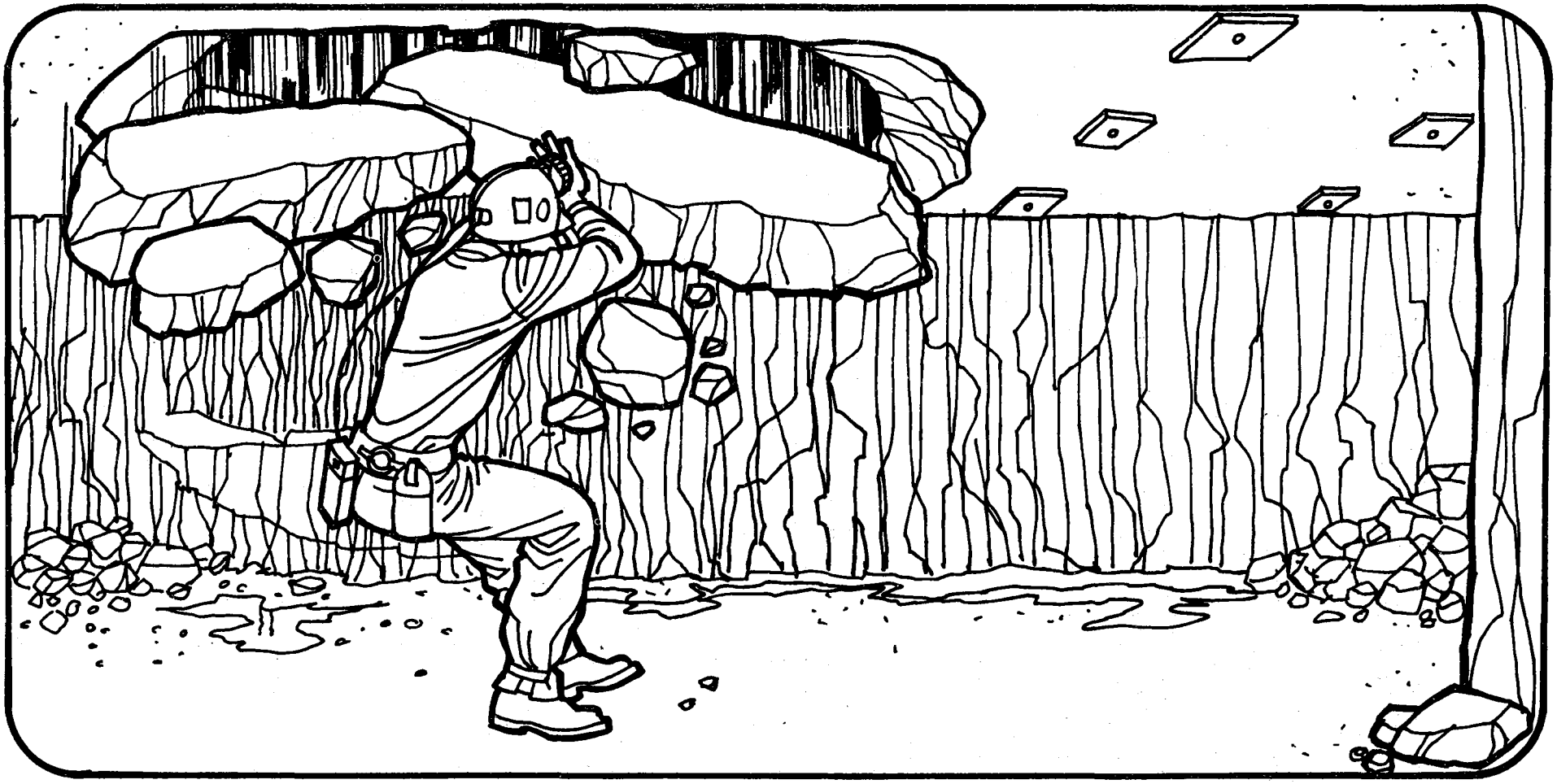
CAUSE OF ACCIDENT: The direct cause of this accident was the entry of the victim into the crusher with the diesel engine running and without the crusher being physically blocked against motion.

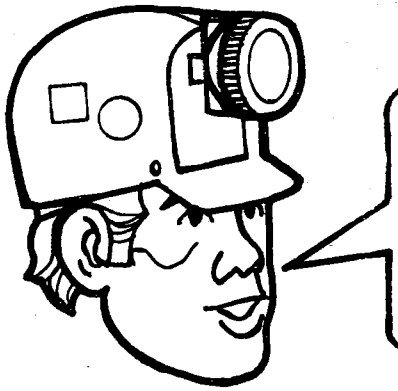
The failure of management to recognize the unsafe operating procedures used by the employees and to enforce the usage of lockout procedures contributed to the direct cause of this accident. The inability of supervision to communicate directly in a common language with all employees may also have contributed to this accident.

RECOMMENDATIONS: Management should develop safe operating procedures and reduce them to written, bilingual form. Such procedures should be used in both employee task and hazard-recognition training.



REAP





1984 - 21 Miners
1985 - 10 Miners
1986 - 1 Miner

ALL DIED UNDER ROOF FALLS INBY PERMANENT ROOF SUPPORTS

W H Y ?

REAP
ROOF EVALUATION - ACCIDENT PREVENTION

April 1986

H.S.A. SAFETY TOPIC

INADEQUATE LOCKOUT

Human beings are so inclined toward momentary forgetfulness or inattention to safety that the safety engineer often must apply every bit of foresight and ingenuity to protect machine operators against failure to take sufficient safety precautions.

Among the most valuable devices available in such endeavors are those that automatically guard against human error either mechanically or by means of electrical controls.

Such safety devices must always be positive and should be fail safe. A safety device that does not function without special precaution on the part of the employee is often worse than no safety device at all.

How important automatic safety devices can be was demonstrated by the serious injury of a man who attempted to adjust a large semi-automatic flash-welding machine. The machine in question was approximately 20 feet high and was operated electrically. The metal parts to be welded together were place in the feed side of the machine by hand and properly positioned. The operator then cycled the machine by means of button controls close to the point of operation. When the cycle was completed the welded assemblies were moved mechanically and discharged from the rear of the machine.

In order to make an adjustment it became necessary to move the mechanism by hand rather than putting it through a power cycle. The only way this could be done was by sending someone up on a platform 10 feet above floor level on the left side of the machine that placed that person in a position where he or she could not be seen from the normal point of operation. The person ascended to the platform and applied a hand crank to the end of a square shaft that was recessed in the side of the machine frame. By turning the crank manually the mechanism could be moved slowly and brought into position for adjustments to be made.

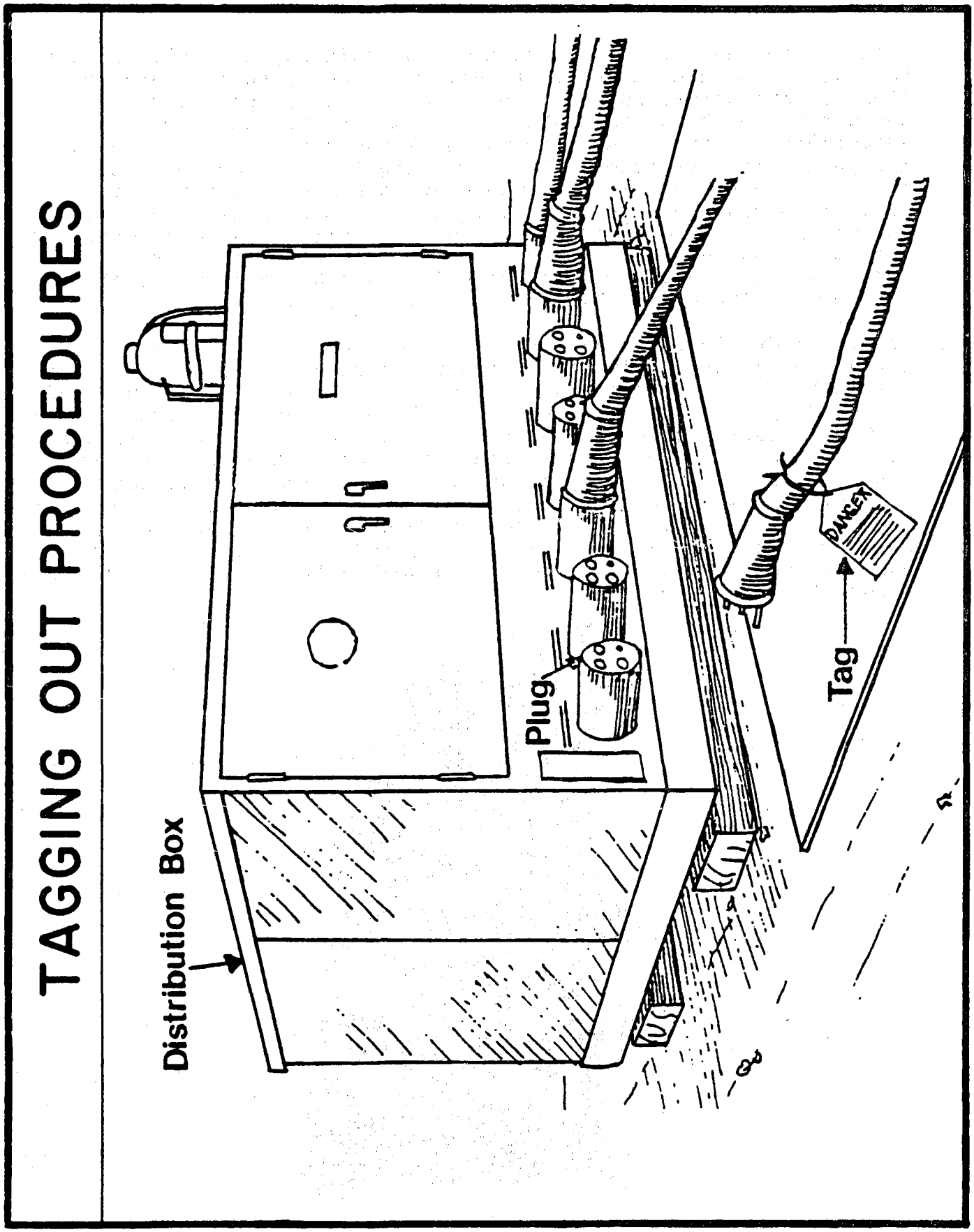
For the protection of the person making the adjustment a switch was provided close to the point where the crank was inserted with the intention that the power could thus be cut off while the manual adjustment was made. The man who was to perform the operation on this day had done the job before and knew about the safety switch but on this particular occasion he failed to make use of it.

-MORE-

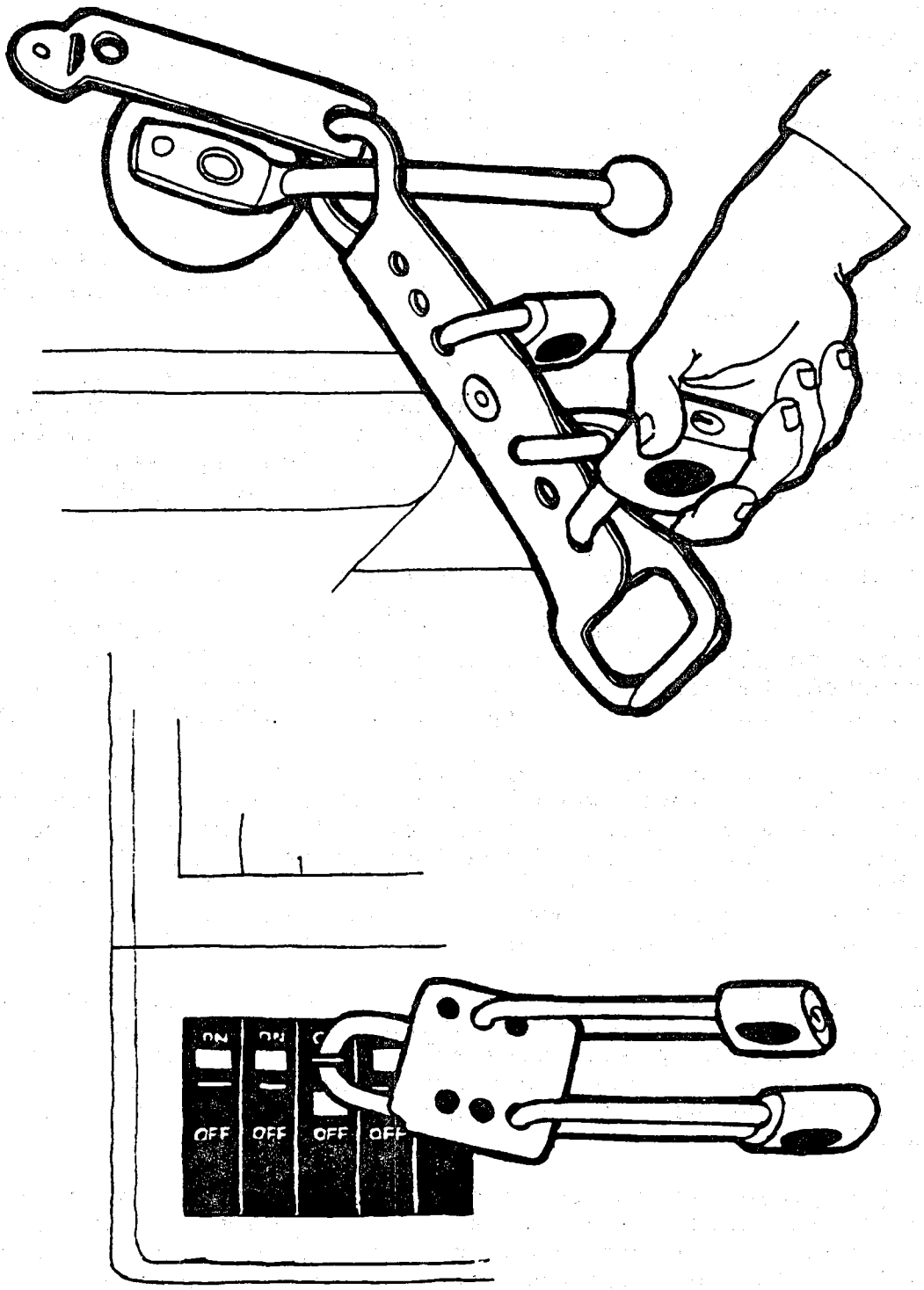
When he had the crank in place and was beginning to apply pressure to move the mechanism, another employee came up to the machine close to the normal point of operation and at a spot where he could not see the workman who was attempting to make the adjustment. Without thinking to check the situation the second man pushed the operating buttons causing the machine to rotate rapidly with the result that the heavy crank spun out of the victim's hands and struck him a tremendous blow under the jaw. The crank handle not only fractured the victim's jaw but inflicted extensive and nearly fatal injuries to the entire right side of his head. The damage was so extensive that his survival could only be attributed to skillful surgery and medical care.

It wasn't difficult to design effective means of properly safeguarding the equipment. The hand-operated cut-off switch was eliminated. The opening into which the crank handle was inserted for hand operation was covered by a plate and an interlocking switch installed so that the crank could not be inserted without opening the cover and thus automatically actuating an electrical cut-off. It would be easy to attribute this accident to the failure of the man to lock out the control circuit at the point of operation or to attribute it to "failure to warn or secure." However, the application of an interlocked lockout device left no possibility of human error and was undoubtedly the most effective means of accident prevention.

-MORE-


TAGGING OUT PROCEDURES
Distribution Box
Plug
Tag
DANGER

LOCKING OUT PROCEDURES



SAFETY INSPECTIONS CAN PREVENT ACCIDENTS

The planned safety inspection is a regular, systematic, close look at machinery, tools, equipment, and other environmental factors to spot unsafe conditions so that they can be corrected before they cause or contribute to an accident. To illustrate the need for greater use of planned safety inspections, think about these recent disabling injuries which could have been prevented by planned safety inspections.

A burner in a shipyard was severely burned when molten metal splashed and ignited part of his clothing, which had been soaked by oxygen from a defective lever on a heating torch. Inspection would have spotted the defective lever.

A steel plant employee lost a finger when it was caught between the tool rest of a grinder and the material he was grinding. The opening between the wheel and the guard was too great because the grinding wheel diameter had been worn down by use, but the tool rest had not been adjusted. Inspection would have spotted the improper opening.

A mine employee suffered two broken toes when the wheel of a mine car ran over his foot. The employee put his foot on the rail as he held a defective automatic coupler so that it could connect with another coupler. This obviously unsafe condition could have been corrected, before it contributed to an accident, if a supervisor had been assigned a safety inspection responsibility for that car.

A steel plant employee, replacing motor-base bolts on an electric motor, lost a finger when he stuck it in a motor frame bolt hole to check alignment. Belt tension rotated the motor on the one remaining bolt. Three of the four bolts holding the motor had either sheared off or had loosened and fallen out because of vibration. Inspection would have spotted the missing bolts before three of the four bolts were lost or had failed.

A fabricated steel construction employee was seriously injured by a 1/2 inch-thick steel plate which fell on his foot. The plate slipped from the plate hooks as it was being moved by an overhead crane. The plate hooks were greasy and one leg of the hook was bent. Planned safety inspection would have spotted the damaged plate hook.

Every employee should inspect the tools and equipment before using and should report defective and unsafe tools and equipment. Unfortunately, employees don't always inspect, or may knowingly use, unsafe tools and equipment. When they do, accidents can be expected.

Supervisors' planned safety inspections can spot unsafe conditions that are overlooked or ignored by employees. To prevent accidents caused by unsafe conditions, train your employees to report promptly any unsafe tools or equipment and follow up with your own regular, systematic planned safety inspection. Most important of all, when an unsafe condition is reported or spotted, take prompt corrective action.

Correcting the unsafe condition is the only sure way to prevent the condition from contributing to an accident.

* * * * * *

TO ALL MEMBERS

The 1986 slogan decal is now available in limited supply. Send requests to:

Jeanne Ryan
MSHA
Holmes Safety Association
4800 Forbes Ave., Rm. A268
Pittsburgh, PA 15213
(412) 621-4500 Ext. 650/649
FTS-721-8650 or 8649

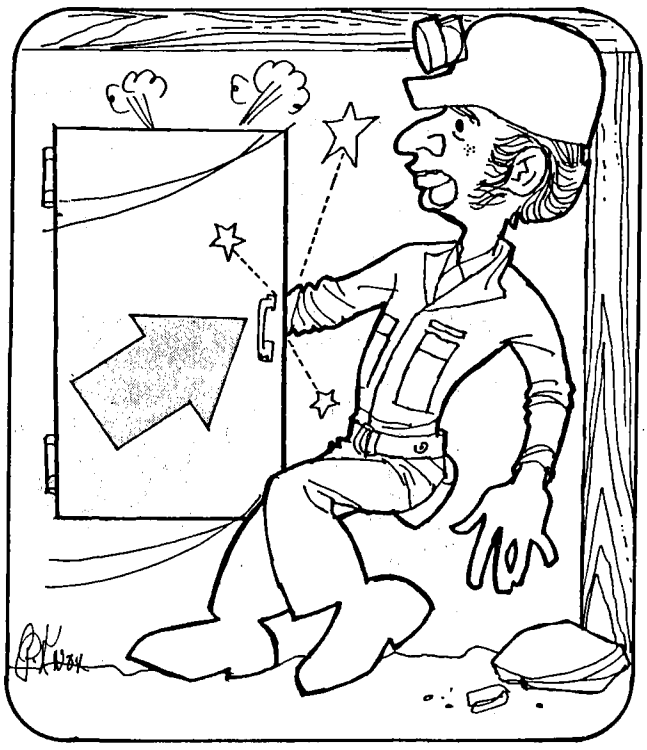
GIVE ACCIDENTS THE KICK IN "86"

H.S.A. SAFETY TOPIC

SAFETY TIP

Opening and traveling through mandoors have contributed to a number of injuries reported by inspection personnel in the past. The injuries have been to all parts of the body and are usually serious in nature. A number of factors have contributed to the accident situation including difference in air pressure, height of the mine, equipment carried by the inspector, loose material, illumination and dust. Injuries associated with mandoors can be prevented by the following.

- Maintain proper body position and check resistance of the door;
- Where handles are not provided, use tool and block and keep hands away from edges of door;
- Wear approved eye protection;
- Locate and face power circuits;
- Arrange equipment on body to keep from becoming fouled in door opening;
- Pass extra equipment through door before entering;
- Place hands and feet only in places that can be observed;
- Wear snug fitting clothing.



H.S.A. SAFETY TOPIC

HOME FIRE ESCAPE

If a fire should break out in your home, have you planned a safe escape for your family? Does each one in your family know exactly what to do in case of fire? If you have a plan, have you practiced the plan? An average of 1500 home fires occur each day. Also, this is the time of year that our heating systems are called upon the most and in some cases these systems are defective. The result can be a serious fire. Of course, there are many other ways that fires are started in the home, such as careless handling of matches and cigarettes or defective electrical circuits.

The plan of escape from a burning home depends upon the type of construction. For instance, is the home a single story, a two story, or an apartment in a multistoried building? According to statistics approximately three-fourths of all fire victims die upstairs from downstairs fires. Most people sleep upstairs and the smoke and gases carry upward from fires at lower levels and often many people die before anyone is aware that the house is on fire.

Since stairs are often blocked, other ways of escape should be provided and the family should practice all routes of escape. Remember that gas is more dangerous than flame, so getting to fresh air is urgent. Garage decks or porch roofs are excellent places to wait outside until rescue arrives. Rope ladders can be purchased and permanent anchorages should be ready. A ladder that swings downward under the weight of a person is a good device of escape without accommodating burglars.

An upstairs phone extension is an important safety measure. Keep emergency phone numbers handy. Since children can't remember long numbers, teach them to dial zero and tell the operator of an emergency including the address.

If you smell smoke at night, place the palm of your hand against the bedroom door and if it is hot do not open it. The area outside the door is a deadly trap of superheated air and gas. Call to other occupants to keep their doors shut; get out through a window if you can; telephone from an extension phone; or, yell for help.

- MORE -

If the door doesn't feet hot, brace your body against the door and just barely open it. When you are assured that it is safe, proceed to the stairs, keeping as close to the floor as possible. Never waste time getting dressed or picking up valuables. Most of all, don't panic, don't jump from heights, and don't go back into the fire area to recover valuables.

* * * * *

FIRES - Self Starting

Any substance or combination of material which can react chemically with liberation of heat is a possible source of spontaneous ignition. The possibility of ignition depends upon the rate at which heat is produced and the rate at which it can escape.

The most common of the numerous conditions favorable to spontaneous ignition is the oil-soaked rag or piece of waste. Prevention involves merely a more rigid standard of housekeeping, discarding, or cleaning of oily materials promptly. If they cannot be disposed of immediately, a covered metal container should be provided.

Strict regulations should be enforced regarding the storing of greasy or oily clothing. Piles of trash or rubbish should not be permitted to accumulate in the basement, attic, or anywhere. Old newspapers stacked in a pile have been known to catch fire spontaneously. A tightly covered metal container should be provided for the mop heads which should be removed from the handle and stored as soon after using as possible.

Every rubbish pile is not necessarily a dangerous one. But why take a chance. Make good housekeeping an ongoing practice.

FIRE PREVENTION CHECK LIST

ELECTRICAL EQUIPMENT

- ☐ No makeshift wiring
- ☐ Extension cords serviceable
- ☐ Motors and tools free of dirt and grease
- ☐ Lights clear of combustible materials
- ☐ Safest cleaning solvents used
- ☐ Fuse and control boxes clean and closed
- ☐ Circuits properly fused
- ☐ Equipment approved for use in hazardous areas (if required)
- ☐ Ground connections clean and tight

FRICTION

- ☐ Machinery properly lubricated
- ☐ Machinery properly adjusted and/or aligned

SPECIAL FIRE-HAZARD MATERIALS

- ☐ Storage of special flammables isolated
- ☐ Nonmetal stock free of tramp metal

WELDING AND CUTTING

- ☐ Area surveyed for fire safety
- ☐ Combustibles removed or covered
- ☐ Permit issued

OPEN FLAMES

- ☐ Kept away from spray rooms and booths
- ☐ Portable torches clear of flammable surfaces
- ☐ No gas leaks

PORTABLE HEATERS

- ☐ Set up with ample horizontal and overhead clearances
- ☐ Secured against tipping or upset
- ☐ Combustibles removed or covered
- ☐ Safely mounted on noncombustible surface
- ☐ Not used as rubbish burners

HOT SURFACES

- ☐ Hot pipes clear of combustible materials
- ☐ Ample clearance around boilers and furnaces
- ☐ Soldering irons kept off combustible surfaces
- ☐ Ashes in metal containers

SMOKING AND MATCHES

- ☐ "No smoking" and "smoking" areas clearly indicated
- ☐ Butt containers available and serviceable
- ☐ No discarded smoking materials in prohibited areas

SPONTANEOUS IGNITION

- ☐ Flammable waste materials in closed, metal containers
- ☐ Flammable waste material containers emptied frequently
- ☐ Piled material cool, dry, and well ventilated
- ☐ Trash receptacles emptied daily

STATIC ELECTRICITY

- ☐ Flammable liquid dispensing vessels grounded or bonded
- ☐ Moving machinery grounded
- ☐ Proper humidity maintained

HOUSEKEEPING

- ☐ No accumulation of rubbish
- ☐ Safe storage of flammables
- ☐ Pasageways clear of obstacles
- ☐ Premises free of unnecessary combustible materials
- ☐ No leaks or drippings of flammables and floor free of spills
- ☐ Fire doors unblocked and operating freely with fusible links intact

EXTINGUISHING EQUIPMENT

- ☐ Proper type
- ☐ In proper location
- ☐ Unobstructed
- ☐ Clearly marked.
- ☐ In working order
- ☐ Service date current
- ☐ Personnel trained in use of equipment

PORTABLE FIRE EXTINGUISHER CHARACTERISTICS

Fire Class	Extinguishing Agent	Available Sizes	Horizontal Range, Ft.	Discharge Time, Sec.
A	Water	1½-5 gal	30-40	45-180
A,B	Foam	1½-2½ gal	35	35-60
A, B, C	Ammonium phosphate	2-3 lb.	5-20	8-25
B, C	Carbon dioxide	2½-20 lb	2-4	15-30
B, C	Potassium bicarbonate	2-30 lb	5-20	8-25
B, C	Potassium chloride	2-30 lb	5-20	8-25
B, C	Potassium bicarbonate/urea	17-19 lb	15-30	26-30
B, C	Halon 1211	2½ lb	4-6	8-10
B, C	Halon 1301	2-4 lb	8-12	8-12

HOLMES SAFETY ASSOCIATION

STAY SAFE

Despite numerous warnings, some people continue to insist on smoking in bed. But every cigarette, cigar or pipe you smoke in bed carries the possibility of a fatal fire. Bed and bedding are highly combustible materials.

At least once a week we hear or read of a fire that results in property damage, personal injury and sometimes death. Fires injure and kill thousands of people each year.

If you insist on smoking at all, refrain from smoking in bed.

* * * * * *

BUMPING INTO PEOPLE AND THINGS

Have you ever been walking close behind someone when they stop suddenly and you bump into them. On the street or in a store, this sort of thing is usually squared by mutual apologies. In other places, it may be more serious--one of you may stumble into a machine or may be carrying something heavy enough to smash the foot it drops on, or one or both of you could take a good tumble.

The same thing applies when your car follows the car ahead too closely. The car ahead makes a sudden stop and BANG! The driver should have signaled, should have kept far enough behind to stop in time. Or perhaps you weren't paying close enough attention. Either way, in such a case you're in the wrong, whether afoot or driving.

The most inexcusable bumping occurs when people are running--maybe to be first in line. There have been sprained ankles and wrists, toes have been trampled on, eye-glasses have been smashed, and so on.

Prevention of bumping accidents boils down to this: It's simply a matter of looking where you're going, walking with some care, and having a proper respect for the rights of others. So watch where you're going. If something distracts your attention, stop. And look again before you start moving. Simple, isn't it?

HOLMES SAFETY ASSOCIATION

PERSONAL DANGER--FALLS

Slips and falls are serious perils.

Many falls where injuries are sustained aren't plunges from high places, but rather are commonplace tumbles at the same level or a few feet above.

Why do so many falls happen? Some can be traced to unsafe conditions--hazards that have been created or allowed to develop in the physical surroundings, for example, breaks in flooring... slippery spots...makeshift platforms...damaged ladders...lights burned out in walkways and stairs...tools and equipment scattered in aisles...cords and piping stretched across floors.

Other fall accidents result from unsafe acts, such as running in aisles...hurrying on stairs...failing to use handrails...climbing on improvised supports...using wrong ladders from given jobs... overreaching in high spaces...tilting back in chairs...leaving slip hazards or tripping obstacles in the way of walkers.

Because falls pose dangers, redouble your defense against them.

1. Keep alert for fall "traps" (unsafe conditions). Exercise extra caution when you encounter one. Eliminate the hazard if time permits and you can do so without risk. Otherwise, let your supervisor know that correction is needed.

2. Avoid unsafe acts that can lead to falls. Don't create slipping and tripping hazards in your own environment or elsewhere.

HOLMES SAFETY AND JOSEPH A. HOLMES SAFETY ASSOCIATION
ANNUAL MEETINGS
MAY 19-21, 1986
REGISTRATION INFORMATION

ADVANCE REGISTRATION

Advance registrations will be accepted until May 9. Cancellations for dinner will be refunded, if written request for cancellation is postmarked no later than May 16.

ACKNOWLEDGEMENTS

We have a block of 50 rooms and advance registrations will be acknowledged upon receipt. Room payments due on departure at lodge cashiers desk.

RESERVATION REQUEST MAY 19-20-21, 1986
CANAAN VALLEY RESORT STATE PARK
$38 - Single ( ) No. of Rooms Required ( )
$44 - Double ( ) No. of Rooms Required ( )
Arrival Date _____ Departure Date _____

BANQUET BUFFET TICKETS $15 includes tax and gratuity*
Includes: Roast turkey breast, sugar cured ham, beef stroganoff, 2 vegetables, rice, potatoes, salad bar, dessert, coffee/tea.
No. of banquet tickets at $15 _____.

*Payment for buffet must accompany reservation request. Checks payable to William H. Hoover, National Treasurer, Holmes Safety Association.

NAME _____ PHONE _____
REPRESENTING _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____

Please return no later than May 9, 1986 to:
MSHA, Holmes Safety Association
4800 Forbes Avenue, Room A268
Pittsburgh, PA 15213

GOLFERS: Advance request for tee-off time and golf carts are required payment at pro-shop.
Check:
_____ Single _____ Twosome _____ Threesome _____ Foursome

Golf rates $12 green fee (18 holes) carts. $13.50 cart rental for two. Tee-off time _____.

If you care to play tennis, check _____. We'll make arrangements for you.

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U.S. Department of Labor
LAB 441

MSHA, Office of Holmes
Safety Association
Educational Policy & Development
4800 Forbes Avenue, Room A268
Pittsburgh, PA 15213

HOLMES SAFETY ASSOCIATION

HOLMES SAFETY ASSOCIATION

ANNUAL MEETING

To accomodate the 4,000 safety chapters and 53 district councils spread throughout the 50 states, the Executive Body of the National Council has voted to change the location of its annual spring meetings to various state and district sites each year.

This year, the state of West Virginia, representing over 1,000 chapters, 16 district councils and one state council, will host the meeting at Canaan Valley Resort State Park in Davis, West Virginia, "a wholesome family type resort in a superb natural setting," says the New York Times. The resort has a restaurant, snack bar and lounge in addition to a swimming pool, tennis courts, 18-hole golf course, mini golf, gift shop and walking and hiking trails.

Itinerary:

Monday-May 19

Travel Day
Social Hour-Cash Bar

Tuesday-May 20

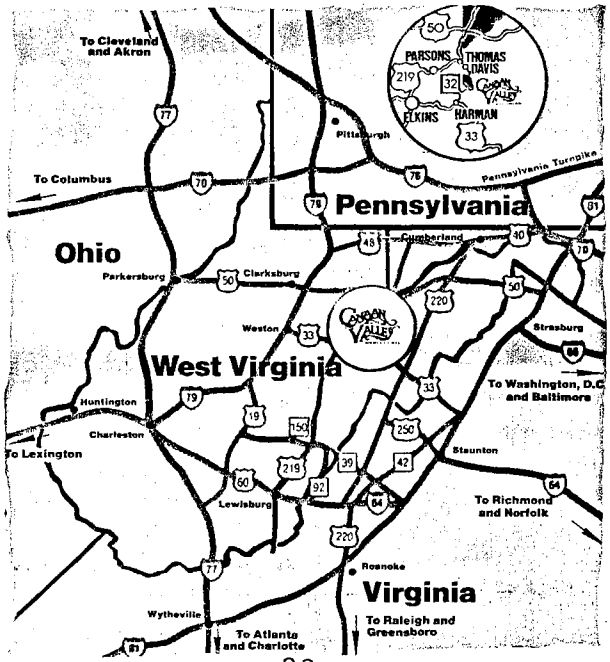
Golf
Ladies' Tour and Luncheon
Free Beer & Snacks--6-8 p.m.

Wednesday-May 21

HSA Exec. Mtg.--9 a.m.
HSA Reg. Mtg.--10 a.m.
Jos. A. Holmes Mtgs.--2-4 p.m.
Host Bar--5-7 p.m.
Dinner and Awards Banquet--7 p.m

Thursday-May 22

Travel or
Stay and Play Golf etc.



HOLMES SAFETY ASSOCIATION

Notebook

HATS OFF TO A GOOD START

1. The following Kentucky coal mine districts: Hazard, London, Harlan, Pikeville, West Kentucky, and Martin had zero fatalities for the month of January 1986.

2. The eighth National Conference of Women Miners will be held June 27-29, 1986 at the Heart O' Highlands Motel in Paintsville, Kentucky.

3. Do you know somebody deserving recognition for dedicating their time and efforts for the improvement of health and safety of employees in the mining, mineral extraction and allied industries? If so, let us know.

Get that "GOOD FEELING". Join the HSA Safety Program. For more information we're only a telephone call away.

Linda Lofstead
MSHA-HSA
4800 Forbes Avenue
Pittsburgh, PA 15213
412-621-4500 Ext. 650 or 649
FTS 721-8650 or 8649

William H. Hoover
300 W. Congress Room 7K
Tucson, AZ 85701
602-620-6631
762-6631

*Members: Short news of your Council activities can be included in the Notebook. Information needed two months in advance. Forward to:

Louise
MSHA-Holmes Safety Association
4800 Forbes Avenue, Rm. 268A
Pittsburgh, PA 15213

THE LAST WORD

APRIL SHOWERS

Believe it or not, it was too much water that caused the village of Gangi Sulle Madonie, Italy, to go dry for almost a week. Days of heavy rainfall caused a landslide that broke an aqueduct and cut off the village's water supply.

* * * *

LOOKING BUT NOT SEEING!

The old prospector came down out of the hills for the first time in years and died when he saw his first automobile. He didn't see it soon enough.

* * * *

WORST RECORD

Percentagewise, Kansas City, Missouri, had an unsurpassable automobile accident record in 1899. There were only two cars in the city at the time, and they collided in the main street.

* * * *

STRANGE SIGN

Most drivers are used to seeing deer and cattle crossing signs. But down in Florida in Everglades National Park is a warning sign that has startled many motorists-"Alligator Crossing."

PET PEEVES

What irks you most about passenger-car driver's behavior? One trucking company polled its drivers on the subject and found they considered failure to signal to be the worst fault of all. Other pet peeves were: failure to dim lights, tailgating, failure to pass a slow-moving vehicle ahead, excessive speed and ignoring stop signs and traffic lights.

* * * *

ROUTINE CHECK-UP

A Des Moines, Iowa, man arriving at a hospital for a routine physical check-up, stumbled over a barricade in the parking lot and broke his arm.

* * * *

HE SHOULD KNOW BETTER

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.

* * * *

ATTENTION!

HAVE YOU REPORTED YOUR LAST MONTHLY SAFETY MEETING? IF NOT, WE WOULD APPRECIATE IT IF YOU WOULD KINDLY COMPLETE THE POSTAGE-PAID GREEN FORM (5000-22) AND MAIL IT BACK TO US.

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Pittsburgh, PA 15213

5000-22
(Rev. 12-78)

United States Department of Labor
MSHA
Mine Safety and Health Administration

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.)

_____
(Signature)

_____
(Telephone No.)

_____
(Title)

FILL OUT - FOLD AND STAPLE - FREE MAIL-IN

NOTE: BE SURE OUR ADDRESS SHOWS

- -

If you do not care to receive this Bulletin, please check here and return this form. ☐

Please include any change of address below:

The Joseph A. Holmes Safety Association was founded in 1916 by 24 leading National organizations of the mining industries.

The Joseph A. Holmes Safety Association is named to commemorate the first director of the Bureau of Mines for his efforts in reducing accidents and illness throughout the mineral industries.

The following is the different award criteria:

Type "A" Awards - For Acts of Heroism

The awards are medals with Medal of Honor Certifrcate.

Type "A" - For Acts of Heroic Assistance

The awards are Certificates of Honor.

Type B-1 Awards - For Individual Workers

(40 years continous work experience without injury that resulted in lost workdays)
The awards are Certificate of Honor, Gold Pins and Gold Decal.

Type B-2 Awards - For Individual Officials

(For record of group working under their supervision)
The awards are Certificate of Honor.

Type C Awards - For Safety Records

(For all segments of the mineral extractive industries, meeting adopted criteria)
The awards are Certificate of Honor.

Other Awards - For Individual Workers

(For 10, 20, or 30 years without injury resulting in lost workdays)
The awards are 30 years-Silver Pin and Decal, 20 years-Bronze Pin and Decal, 10 years-Decal bearing insignia.

Special Awards - For Small Operators

(Mine operators with 25 employees or less with outstanding safety records)
The awards are Certificate of Honor.

Contact: HSA Office