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# BULLETIN

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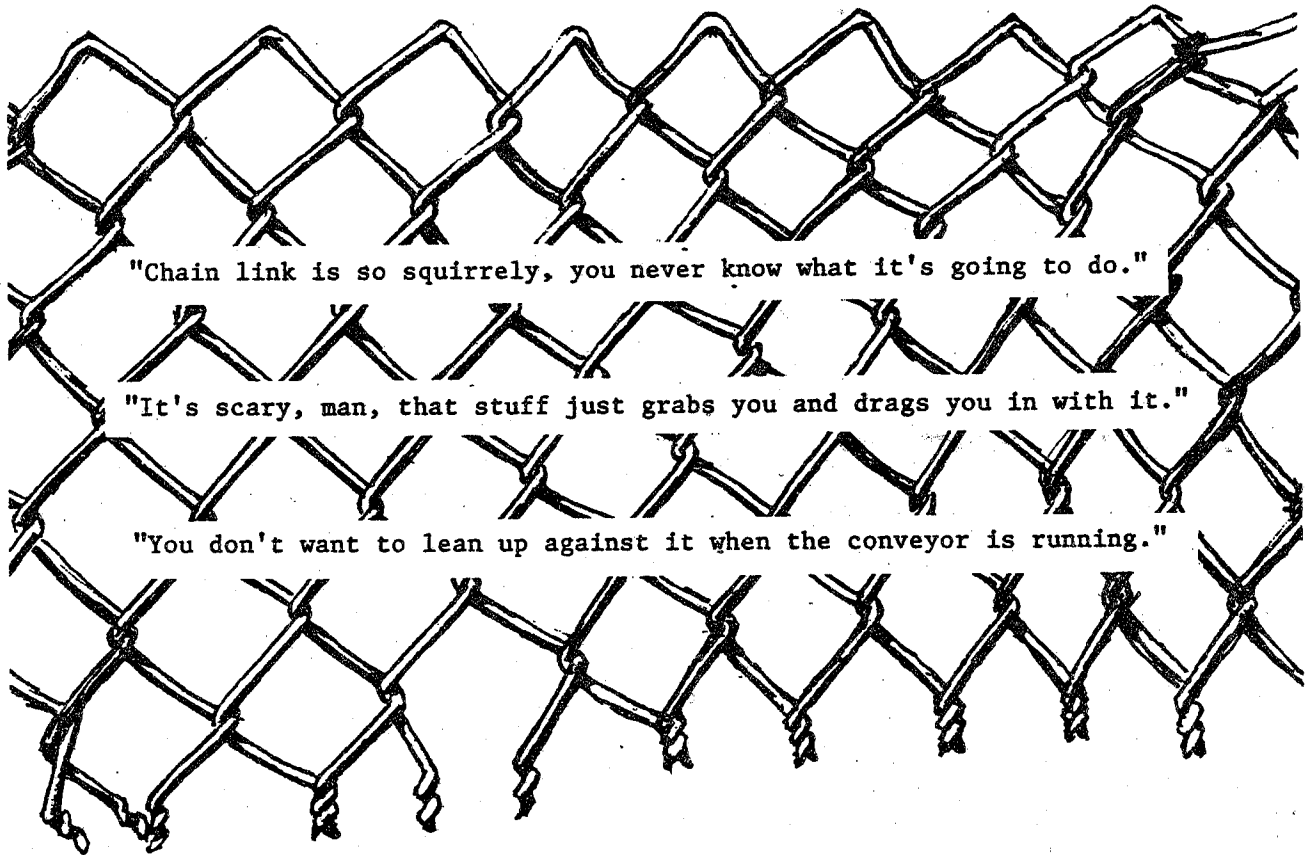


# Hazard Alert

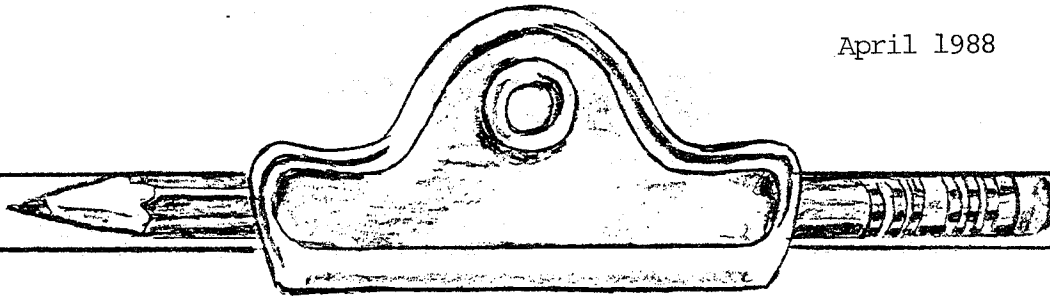


U.S. Department of Labor  
Mine Safety and Health Administration  
Safety and Health Technology Center

## BEWARE LOOSE CHAIN LINK



LOOSE CHAIN LINK GUARDING ON CONVEYORS COULD BECOME  
ENTANGLED IN PULLEYS OR IN OTHER ROTATING COMPONENTS.  
REPAIR OR REPLACE LOOSE OR DAMAGED CHAIN LINK GUARDS



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THIS SAFETY BULLETIN CONTAINING 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 IS PROVIDED FREE AS A BASIS FOR DISCUSSION AT ON-THE-JOB SAFETY MEETINGS.

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



<u>COMPANY</u>	<u>CHAPTER NO.</u>	<u>LOCATION</u>
Jaco Mining Co., Inc.	7501	Harold, KY
Jaco Mining Co., Inc.	7502	Eastern, KY
Jaco Mining Co., Inc.	7503	Harold, KY
Jaco Mining Co., Inc.	7504	Banner, KY
Jaco Mining Co., Inc.	7505	Eastern, KY
Alco Mining Co., Inc.	7506	Summersville, WV
Workman Coal Inc.	7507	Bickmore, WV
East-Hub Coal Co., Inc.	7508	RacCoon, KY
U S E Coal Inc.	7509	Jane Lew, WV
Indian Mountain Coal Co., Inc.	7510	Pound, Va
Thorpe Corporation	7511	Houston, TX
Kauai Aggregates	7512	Wahiawa, HI
Grove Farm Rock Company	7513	Puhi, HI
Kauai Sand & Gravel Inc.	7514	Lihue, HI
Maui Blocks	7515	Wailuku, HI
Allied Aggregates Corporation	7516	Hilo, HI
Allied Aggregates Corporation	7517	Hilo, HI
Allied Aggregates Corporation	7518	Hilo, HI
Hilo Coast Process, HCPC Quarries	7519	Pepeekeo, HI
James W. Glover, LTD.	7520	Hilo, HI
West Haaii Concrete	7521	Kona, HI
West Hawaii Concrete	7522	Kona, HI
West Hawaii Concrete	7523	Waimea, HI
Hawaiian Cement	7524	Aiea, HI
Grace Pacific Quarry & Mill	7525	Waimanalo, HI
C and L Coal Co., No. 1 Mine	7526	Hillier, KY
Faith Coal Sales Inc., No. 7	7527	Shelbiana, KY
Patterson Excavating Co.	7528	Omar, WV
L & M Fuel Corporation	7529	Warfield, KY
Rough Branch Mining Inc.	7530	Langley, KY
KY Resources Coal & Dock Inc.	7531	Maysville, KY
River Front Corporation	7532	Manton, KY
Z & Y Coal Co., Inc.	7533	Lizemore, WV



H.S.A. SAFETY TOPIC

SUFFOCATION, DROWNING, and ASPHYXIA FATALITIES  
IN COAL and METAL/NONMETAL MINING



During a four-year period, 160 fatalities occurred in coal and metal/nonmetal mining due to suffocation, drowning, or asphyxia resulting from a number of accidents.

Table 1 shows the annual distribution of these fatalities in the categories of suffocation, drowning or asphyxiation.

Table 1.--Suffocation, drowning and asphyxiation fatalities

<u>COAL</u>		
<u>Category</u>	<u>Total</u>	<u>Percent</u>
Suffocation	15	42.9
Drowning	15	42.9
Asphyxia	5	14.2
TOTALS	35	100.0

<u>Metal/Nonmetal</u>		
<u>Category</u>	<u>Total</u>	<u>Percent</u>
Suffocation	70	56.0
Drowning	39	31.2
Asphyxia	16	12.8
TOTALS	125	100.0

Table 2 lists the causes of the injury in coal for each of the three categories of fatalities. Being covered by material from falls of roof, pressure bursts and collapse of highwall caused seven (47 percent) of the suffocation fatalities. With the exception of the nine drownings in one accident, vehicles veering into the water caused most (33.3 percent) of the drowning fatalities. Entering unventilated areas caused all of the asphyxiation fatalities.

\*William A. Mason, Branch of Hazard Identification and Analysis

Table 2.--Suffocation, drowning and asphyxiation fatalities in coal mining by cause of injury

<u>2A--Suffocation</u>	
<u>Cause</u>	<u>Number</u>
Covered by material from roof fall, pressure bursts	5
Collapse of stockpile, or material in bin	4
Crushed by falling/overturning equipment or machinery	3
Covered by material from highwall	2
Crushed between machinery and object	<u>1</u>
Subtotal	15
 <u>2B--Drowning</u>	
Inrush of water	9
Vehicle veered into water	5
Thrown from vehicle into water	<u>1</u>
Subtotal	15
 <u>2C--Asphyxia</u>	
Entered unventilated area	<u>5</u>
Subtotal	5
TOTAL	35

Table 3 shows the breakdown of the fatalities by cause of injury in metal/nonmetal mining. Working in and around bins, hoppers and stockpiles were the most prevalent areas for the occurrence of suffocations. Forty-nine (70 percent) of the suffocations happened while working in these areas.

Falling from boats, barges and dredges was the largest single accident causing drowning (39 percent). Nine (23 percent) fatalities resulted from falling into the water from the edge of lakes and ponds, or from pipelines. Twenty-one (54 percent) of the fatalities occurred at work locations where the use of life jackets could be expected.

The most common cause of asphyxiation was entering unventilated areas (44 percent), particularly those that had not been used for a long time. Six (38 percent) fatalities resulted from using gas engines or burning fires in enclosed, unventilated areas.

Table 3.--Suffocation, drowning and asphyxia in metal/  
nonmetal mining by cause of injury

<u>3A--Suffocation</u>	
<u>Cause</u>	<u>Number</u>
Covered with material while working in bins, hoppers, R.R. cars	24
Covered with material while working on and around stockpiles	15
Fell into hoppers, covered with material	10
Covered with material from collapsing walls, roofs	9
Caught in rotating rollers, sprockets, shafts	6
Crushed between machinery and object	5
Pinned by prybar while freeing material in chute	<u>1</u>
Subtotal	70
 <u>3B--Drowning</u>	
Fell into water from boat, barge, dredge	15
Truck, front-end loader veered or slid into water	8
Fell into water from edge of pond, lake (occurred in normal working area)	3
Fell into water from edge of pond, lake (victim not in normal working area)	3
Walking on pipeline, fell into water	3
Thrown from machinery into water	3
Bank collapsed, dragline fell into water	2
Mancage lowered into water	1
Inundation of mine	<u>1</u>
Subtotal	39
 <u>3C--Asphyxia</u>	
Entered unventilated area	7
Working in or near toxic or suffocative gases	6
Fire or operating internal combustion engine in unventilated area	<u>3</u>
Subtotal	16
TOTAL	125

### CONCLUSIONS

1. Suffocation, drowning, and asphyxia fatalities have occurred more frequently in metal/nonmetal mining than in coal mining. The analysis indicates no significant reduction in the fatality rate of accidents resulting in suffocations, drownings, and asphyxiations and that many of the fatalities may have been prevented if mine management had rigorously enforced safety regulations.

2. In none of the accidents involving work in bins, hoppers, or tanks was there any indication that safety belts or lines were being worn while work was being performed. The enforcement by management of the requirement for safety belts or lines may have prevented 18 fatalities.

3. The hazards of bridged material, hidden voids, and unannounced draw downs are difficult to detect by persons working on stock/surge piles. Preventing persons traveling or working on these piles would have saved 20 lives.

4. Failure to wear life vests was a contributing cause to drownings that occurred while working on boats, barges and dredges. The presence or absence of railings on barges or dredges was not discussed in any of the reports and may have been a factor in some of the fatalities. Twenty-one (54 percent) of the drowning fatalities in metal/nonmetal mining may have been prevented if the usage of life vests had been enforced by mine management. The application of railings on barges and dredges should be investigated.

5. Lack of proper ventilation contributed to nine (56.2 percent) of the fatalities from asphyxia. Posting warnings and barricading of unventilated areas by supervisors should help to reduce this type of accident.

6. Proper design of highwalls to include spill benches and limiting bench heights so that proper scaling can be done should help prevent suffocations caused by being covered by material sloughing off banks.

7. Particular attention should be directed to the design of haulage roads near rivers, lakes and impoundments. The use of adequate berms or guard rails should prevent vehicles leaving the road and entering the water.

8. Proper exploratory drilling when approaching abandoned working is necessary to prevent inundations from flooded mines.

9. The failure of mine management to prevent the usage of fire or internal combustion engines in unventilated enclosed areas may indicate a lack of knowledge of the hazards associated with these acts.



# HOLMES SAFETY ASSOCIATION

## CHAPTER HISTORY

YEAR	CARRY	ESTABLISH	TOTALS	DELETE	<u>GRAND</u> TOTAL
1964	244	64	308	57	251
1965	251	84	335		335
1966	335	126	461	27	434
1967	434	56	490		490
1968	490	45	535	126	409
1969	409	47	456		456
1970	456	52	508		508
1971	508	96	604		604
1972	604	62	666	182	484
1973	484	62	546		546
1974	546	64	610		610
1975	610	197	807		807
1976	807	299	1,106	88	1,018
1977	1,018	164	1,182		1,182
1978	1,182	281	1,463	116	1,347
1979	1,347	101	1,448		1,448
1980	1,448	145	1,593	74	1,519
1981	1,519	230	1,749		1,749
1982	1,749	520	2,269	123	2,146
1983	2,146	866	3,012	75	2,937
1984	2,937	1,221	4,158	217	3,941
1985	3,941	749	4,690	234	4,456
1986	4,456	515	4,971	193	4,778
1987	4,778	486	5,264	350	4,914
1988	4,914				

April 1988

# HOLMES SAFETY ASSOCIATION

## COUNCIL HISTORY

<u>YEAR</u>	<u>CNCLS</u>	<u>FORMED</u>	<u>DROP</u>	<u>TOTAL</u>	<u>MIG'S</u>	<u>ATTEND</u>
1965	19	1	1	19	185	7,165
1966	19	4	0	23	203	9,031
1967	23	2	0	25	228	9,202
1968	25	2	0	27	215	8,770
1969	27	0	2	25	213	9,212
1970	25	3	0	28	194	8,239
1971	28	1	0	29	164	7,943
1972	29	1	1	29	127	8,220
1973	29	1	1	29	160	10,154
1974	29	3	3	29	136	8,782
1975	29	0	0	29	140	11,619
1976	29	2	0	31	130	11,228
1977	31	7	1	37	229	16,663
1978	37	3	0	40	265	23,201
1979	40	3	0	43	176	9,627
1980	43	1	0	44	186	10,383
1981	44	1	0	45	116	5,882
1982	45	16	19	42	102	5,309
1983	42	4	0	46	146	7,860
1984	46	2	0	48	102	4,696
1985	48	5	0	53	121	5,711
1986	53	1	0	54	111	5,903
1987	54	0	4	50	105	4,936
1988	50					

**ACCIDENTS:**



**Reduce the Rate in '88**

# ABSTRACT FROM FATAL ACCIDENT

April 1988  
\*This fatality could be discussed  
at your regular on-the-job safety  
meeting.



## FATAL OTHER (ASPHYXIATION) ACCIDENT

GENERAL INFORMATION: A material analyst was found unconscious in the laboratory in which he was employed. Failing to respond to first-aid treatment, he was transferred to a local hospital where he was declared dead. Autopsy results attributed the death to suffocation as a result of inhaling the asphyxiant gas, nitrous oxide.

The victim had six years of mining experience, all with this company; the last four years of this experience had been gained in the analytical laboratory.

GENERAL INFORMATION: The cement plant and adjacent quarry consisted of the plant processes which included the milling equipment necessary to supply concentrates to both a wet and dry-type calcining kiln.

DESCRIPTION OF ACCIDENT: The victim reported for work approximately 40 minutes late, and conferred briefly with another lab technician relative to sample processing to be done. A fellow lab technician had reported for work as scheduled and had begun to carry out his routine assignments. He left the laboratory and walked to the control room, arriving shortly after the victim had telephoned sample data to the control room operator. A few minutes later, the bulk load-out operator walked to the laboratory to obtain copies of sample analysis he required in performing his job at the distant bulk-loading facility. He stated that on entering the laboratory he looked for the victim but did not find him. He then walked to the bulk load-out station.

About 40 minutes later, a lab technician noticed that the sample cans the victim was to have filled at plant pick-up points were empty; the latter had apparently failed to make his collection rounds. He alleges that he then found his coworker lying face down in the aisleway.

Reconstruction of this accident indicated that the victim obtained a mask of some nature, possibly the one which was located in the oxygen resuscitator kit and fastened the flexible hose leading from the nitrous oxide piping and controls to the mask he held or fastened it to his face. Turning on the control valve, he sat down in a chair and began breathing near full-strength gas. It is most likely that as a thrill-seeker, he was not aware of the gas' ability to replace the oxygen in his body with nitrogen; death by suffocation was the result.

April 1988

# ABSTRACT FROM FATAL ACCIDENT

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



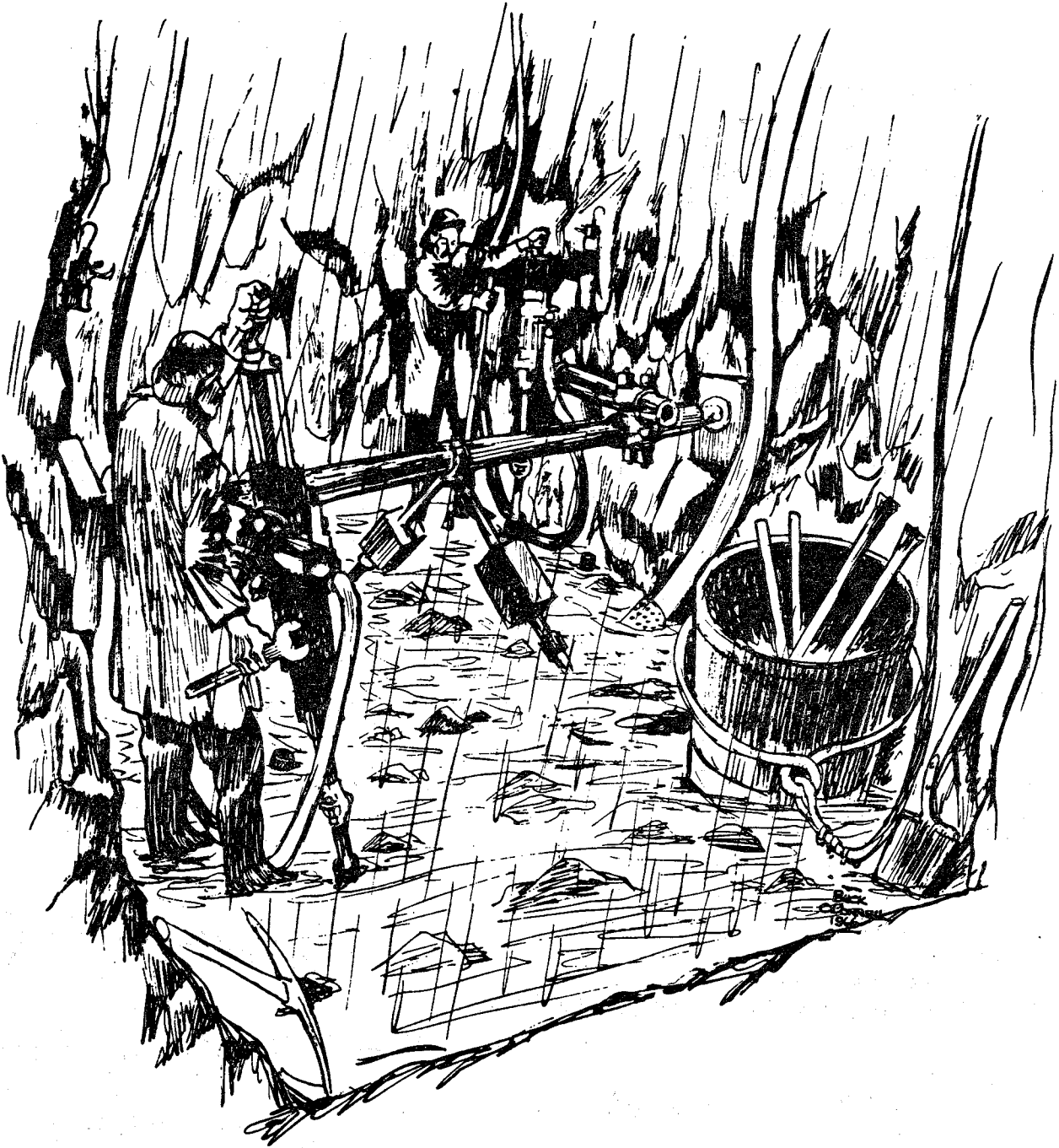
## FATAL SLIDE OF MATERIAL (SUFFOCATION)

GENERAL INFORMATION: A fatal slide of material (suffocation) accident occurred at the mine surface surge pile and truck loading facility. The bulldozer operator and victim had been pushing coal into the surge pile drawoff area with a D8L Caterpillar crawler tractor. The victim had worked at this activity for five years and had a total of five years mining experience.

DESCRIPTION OF ACCIDENT: The victim went to the upper bench of the mine surge pile and truck loading facility to perform his duties as bulldozer operator. A fire had been detected in the coal surge pile. The victim was to operate a D8L caterpillar on the surge pile in an attempt to remove the fire by pushing the burning coal into the drawoff area so it could be loaded out the drawoff tunnel belt into waiting trucks. The surface shift foreman gave instructions to push the coal from the right side of the pile to the drawoff area. He then left to perform his duties. About two hours later, a truck driver hauling coal from the coal-loading facility informed the foreman that the drawoff tunnel door kept plugging. The foreman proceeded to the drawoff tunnel to give assistance in unplugging the door.

About 1/2 hour later, the superintendent went to the truck loading facility to observe how work had progressed in getting the fire loaded out. He arrived at the upper bench, parked his vehicle and walked to the edge of the stockpile. Just as he arrived at the edge, he saw the victim walking very close to where the coal was to be surged into the drawoff tunnel. Before he could say anything, the pile collapsed and the victim disappeared. He immediately ran about 160 feet to the retaining wall above the drawoff tunnel belt where it leaves the tunnel. He informed the other workers and instructed them to leave the belt running. He arranged for the front-end loader to remove the coal from under the belt drive and the victim's body was spotted. Revival attempts were unsuccessful.

CONCLUSION: The accident and resultant fatality occurred because the victim positioned himself on a stockpile of coal being surged, exposing himself to a hazard, a violation of 30 CFR Section 77.209.



**THE SHAFT SINKERS**

*Heavy drifter drills were mounted on arms from a bar mounted the width of the shaft. Only the most rugged men followed shaft sinking, as hand mucking, poor ventilation and acid water made the job rough.*

April 1988

# HOLMES SAFETY ASSOCIATION

Dear Members,

You are cordially invited to join your fellow members, their families and friends of the Holmes Safety Association at the National Council meeting in Evansville, Indiana, May 19, 1988.

A bus tour sponsored by Peabody Coal Co. and the National Council will be available free to guests. If you ever wondered what mining or mining research is all about, this is one tour you shouldn't pass up, so plan now to join your friends. Arrangements are easy to make; just complete the bottom of the registration form so that we can reserve a seat on the bus.

This tour is unique because it includes an interesting combination of stops ranging from the Squaw Creek Open Pit Mining Operation to the Rockport Energy Center.

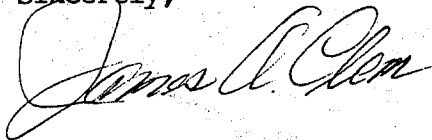
VIRTUALLY EVERYTHING IS TAKEN CARE OF FOR YOU.

You will be accompanied by a friendly and courteous tour Director. It will be a shame to pass up a chance to get a closer look at the mining and mineral industry operations.

THE NUMBER OF TRAVELERS IS LIMITED -- MAKE SURE YOU'RE INCLUDED.

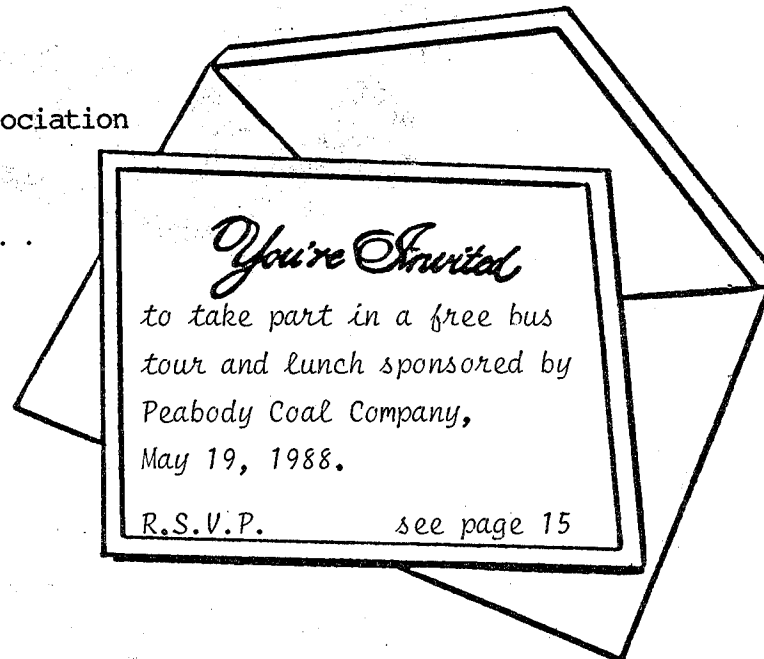
We're looking forward to your visit to the Holmes Safety Association National Council Meeting, May 18-19, 1988.

Sincerely,



James Clem, President  
National Council, Holmes Safety Association

LADIES . . . . . LADIES . . . . .

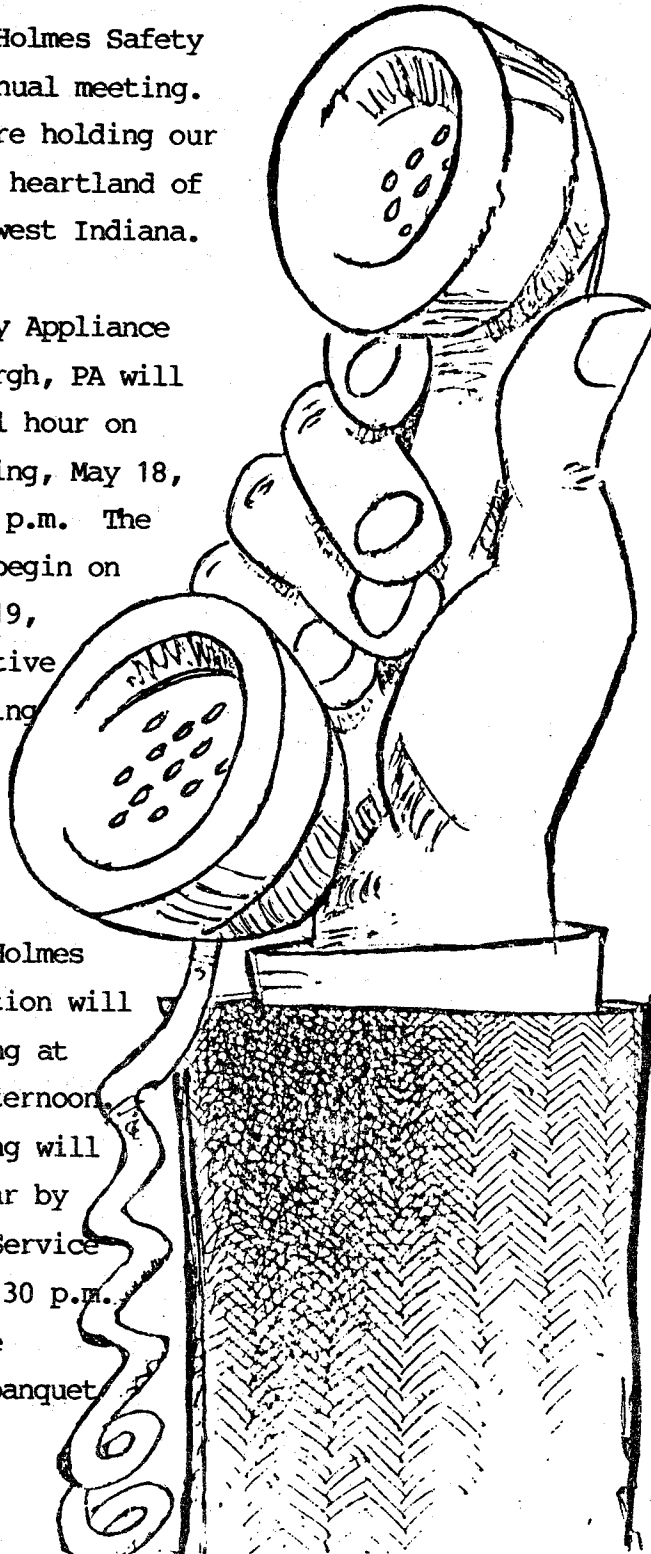


# THIS IS IT THE FINAL CHANCE ..... MAKE THAT CALL

to attend the Holmes Safety Association Annual meeting. This year we are holding our meeting in the heartland of America, southwest Indiana.

The Mine Safety Appliance Co. of Pittsburgh, PA will host the social hour on Wednesday evening, May 18, beginning at 5 p.m. The meetings will begin on Thursday, May 19, with the executive committee meeting at 9 a.m. and the regular meeting of the body at 10 a.m.

The Joseph A. Holmes Safety Association will hold its meeting at 2 p.m. that afternoon. Thursday evening will feature host bar by National Mine Service beginning at 4:30 p.m. followed by the safety awards banquet at 6:30 p.m.



National Council President James Clem, extends a warm welcome to all members to attend this meeting. He is looking forward to a good turnout from the various companies and district councils in Indiana, Illinois and Kentucky.

We have a block of rooms available at the Sheraton Inn-Evansville Airport, 5701 U.S. Highway 41 North, Indiana, (812-464-1010). Please make reservations early.

April 1988

# HOLMES SAFETY ASSOCIATION

## AGENDA FOR HOLMES SAFETY ASSOCIATION AND JOSEPH A. HOLMES ANNUAL MEETINGS

MAY 18 -

WEDNESDAY

REGISTRATION -- SHERATON INN-AIRPORT

5:00 P.M. - 8:00 P.M. COCKTAIL HOUR-HOST BAR/AIRLINE ROOM

MAY 19 -

THURSDAY

9:00 A.M. - BUS TOUR FOR SPOUSES AND GUESTS LEAVES HOTEL  
(VISIT TO WILDERNESS AREA) SQUAW CREEK MINE  
IN BOONVILLE AND ROCKPORT ENERGY INFORMATION  
CENTER) (LUNCH AVAILABLE).

9:00 A.M. - HOLMES SAFETY ASSOCIATION EXECUTIVE MEETING/  
AIRLINE ROOM

9:45 A.M. - COFFEE BREAK

10:00 A.M. - HOLMES SAFETY ASSOCIATION REGULAR MEETING/  
AIRLINE ROOM  
OPENING REMARKS -- PRESIDENT JAMES CLEM  
-- SECRETARY WILLIAM HOOVER

COMMITTEE REPORTS  
AWARD PRESENTATIONS  
ELECTION OF OFFICERS  
STATE AND DISTRICT COUNCIL REPORTS  
OLD BUSINESS  
NEW BUSINESS  
COMMITTEE APPOINTMENTS

12:15 P.M. - ADJOURNMENT

12:15 P.M. - 2:00 P.M. - LUNCH

2:00 P.M. - JOSEPH A. HOLMES BOARD OF DIRECTORS  
MEETING/AIRLINE ROOM

2:45 P.M. - BREAK

3:00 P.M. - JOSEPH A. HOLMES REGULAR MEETING/AIRLINE ROOM

4:00 P.M. - ADJOURNMENT

4:00 P.M. - TOUR BUS RETURNS TO HOTEL

4:30 P.M. - 6:30 P.M. - COCKTAIL HOUR+HOST BAR/AIRLINE ROOM

6:30 P.M. - SAFETY AWARDS BANQUET/AIRLINE ROOM  
BUFFET DINNER  
DISTRICT COUNCIL COMPETITION AWARDS  
CHAPTER FORMATION AWARDS  
DOOR PRIZES



April 1988

**HOLMES SAFETY ASSOCIATION and  
JOSEPH A. HOLMES SAFETY ASSOCIATION  
ANNUAL MEETINGS  
EVANSVILLE, INDIANA  
MAY 18-19, 1988**

**ROOM RESERVATION:\***

Sheraton Inn located at Evansville Airport--Special Convention Rate of:  
\$34 - Single ( ) No. of Rooms Required ( )  
\$39 - Double ( ) No. of Rooms Required ( )

Arrival Date \_\_\_\_\_ Departure Date \_\_\_\_\_

**\*ROOM PAYMENTS DUE ON DEPARTURE AT HOTEL DESK.**

Buffet Dinner Featuring: Garden Salad, Baked ham, Roast Beef au Jus,  
Turkey w/dressing, Broccoli Spears w/sauce,  
Carrots Vichy, Whipped Potatoes, Dessert,  
Coffee and Tea.

No. of Banquet Tickets @ \$16.00 (including tax and gratuity) \_\_\_\_\_ \*

**\*PAYMENT OF BANQUET TICKETS MUST ACCOMPANY REQUEST.** Make checks  
payable to William H. Hoover, National Treasurer, HSA.

Name (please print) \_\_\_\_\_ Phone \_\_\_\_\_

Title \_\_\_\_\_

Representing \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Please return reservation no later than May 6 to:

MSHA, Holmes Safety Association  
4800 Forbes Avenue  
Pittsburgh, Pennsylvania 15213

\*\*\*\*\*

The President of the National Council, James Clem, has finalized  
arrangements for a tour on May 19 sponsored by Peabody Coal Co. and the  
HSA National Council. Departing the hotel by bus at 9 a.m., the tour  
includes a visit to a wilderness area (a reclaimed strip mine), the  
Squaw Creek Mine (an operating strip mine) in Boone Co. and the  
Rockport Energy Information Center (lunch will be provided). The tour  
will conclude back at the hotel at 4 p.m. This is one trip you do not  
want to miss. The tour will be free of charge, but seats are limited;  
please make plans and return this form as soon as possible.

Please reserve \_\_\_\_\_ (#) seats on bus tour.



# A MATTER OF HABIT

You can get into the habit of being safe on any kind of job, whether at work or at home. The safe way can become something you do Matter-of-Factly -- and do it without stopping to think about it.

Take for example, if you get into the habit of shutting machines off before you make adjustments on them, that habit will keep you from doing an unsafe thing - attempting to work on or adjusting moving machinery.

If you get into the safe lifting habit -- of lifting with your strong, heavy leg muscles -- the habit won't let you lift with your weak back muscles. If you get into the habit of turning your whole body when handling materials by pointing your toe the way you go -- you won't twist and strain your lower back muscles.

Establish good habits like looking at things and asking yourself "What if I do this, will I get hurt?" or "What if I do that, will someone else be hurt?" or by looking around before you start jobs and asking yourself "Why is that guard missing or why isn't that guard that ought to be there in place?" It's all a matter of habit. Habits will never allow you to overlook first aid for an injury--no matter how small it may seem.

But don't forget that while there's safety in good habits like those we've been talking about, there's pain and danger in bad habits. Take for example the person with the bad habit of getting out on the left side of the car right into traffic without even looking. That habit of theirs could land them where it has landed others. You can probably think of other similar bad habits, ones that you do, right here at work. So then, how do you go about establishing a good habit? There are three simple steps:

STEP ONE: First you start the job right. You learn the safe job habits.

STEP TWO: Secondly, you practice the right habits, and you keep on doing them and doing your job right, properly, safely, every time you do it.

STEP THREE: Finally, you never let a habit slip away. You take no short cuts or chances. You just keep doing what you're supposed to do in the right way, the safe way.

You're going to have habits, good or bad, whether you want them or not. That's the way human beings work, and it's just as easy to learn the right way, the safe way, as it is to learn the wrong way. Be smart and learn the right way -- you'll certainly benefit. You cannot afford to let bad habits cause you pain, and hurt you financially. **IT'S UP TO YOU.**

submitted by:  
Ken Curtis  
Echo Bay Minerals

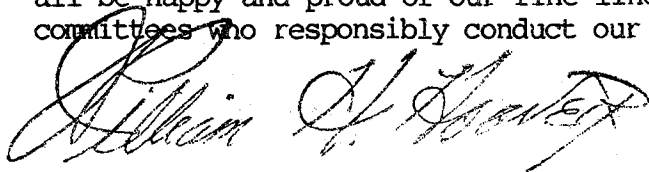
## From the Secretary's desk

To quote one of our nation's outstanding statesman, Abraham Lincoln:

**"You can't please all the people all the time."**

But we try. Pleasing all readers with articles and safety topics that are interesting and informative is a difficult task, but we do our best. We want to keep this monthly safety Bulletin on the high standard that it has been. Members like to know about other chapter and council members and about happenings nationwide. If you have an article you would like printed, mail it to the National Council headquarters in Pittsburgh. These articles will be printed as space is available, but are subject to editing.

This past year of 1987 has been a pretty good one for most of us. Some of us have had some minor setbacks, but we survived. We can all be happy and proud of our fine line of officers and dedicated committees who responsibly conduct our activities.



William H. Hoover  
National Secretary





# WE CAN'T BRING THEM BACK

The following are brief descriptions of a few 1987 Underground and Surface Coal mine fatal accidents. There is a lesson to be learned in each accident. Take time out to review at your safety meetings:

## 1. POWERED HAULAGE:

A locomotive engineer was fatally injured when a bottom-dump railcar turned over on its side crushing him. The accident occurred at a secondary crusher dump area while the victim was dumping ore cars. The victim was operating the train remotely and was standing next to the car when it turned over. Apparently one of the bottom-dump doors did not open which caused the car to become unbalanced. It is believed that the back and forth movement of the car over a full pocket caused the already unbalanced car to turn over. Fatal Case #1

## 2. POWERED HAULAGE:

An independent truck driver was fatally injured when he was struck by an unidentified vehicle. The victim got out of his truck to check the trailer bed for sand leaks. Reportedly, he had on previous occasions left the cab of his vehicle after it was loaded to get water from a puddle with a styrofoam cup. The water was used to wet the sand so that it would not leak from the tailgate. It was dark when the accident occurred, and the victim could not be readily seen by the operators of other vehicles working in the area. Fatal Case #2

## 3. MACHINERY:

A maintenance man was fatally injured when he was struck by a boom attached to a front-end loader bucket. The boom attachment was being used to lift a diesel motor off a sand dredge. The boom was stabilized by two sections of wire rope attached to the end of the boom and connected to each side of the bucket with 3/4-inch clevises. The original clevis pins had been lost and were replaced with 5/8-inch diameter bolts. The bolt used in the left side clevis broke which allowed the boom to swing to the right and strike the victim. Fatal Case #3

**4. SLIP OR FALL OF PERSON:**

A dredge operator drowned when he fell into 12 feet of water while attempting to disconnect a discharge pipeline. The victim had straddled the discharge pipe, and was sliding out toward the connecting joint when he slipped into the water. The lifejacket and boat that were provided for safe access were not used by the victim.

Fatal Case #4

**5. POWERED HAULAGE:**

A truck driver was fatally injured when the 170-ton haul truck he was operating went over a 50-foot bank at a dumping area into the pit. An electric shovel located at the base of the dump was loading ore into railcars. As the victim backed up to dump, the bank gave way and the truck went over the bank landing on its top. The dump site had not been advanced far enough ahead of the shovel to prevent the truck from dumping over an undercut bank.

Fatal Case #5

**6. POWERED HAULAGE:**

An electrical supervisor was fatally injured when he was crushed between a moving railcar and a fixed electrical contact bar at an automatic coal dumping facility. (The plant consisted of a coal-fired utility plant that been had modified by adding a fluidized calciner to the pulverized coal combustion unit to produce lime for cement production.) The victim had climbed onto a moving railcar to manually activate an electrical solenoid valve to open the hopper dump doors. Problems had been previously encountered numerous times with the automatic opening and closing of the railcar dump doors. The victim's foot slipped and while holding onto the side ladder with one hand he was caught between the moving railcar and the electrical contact bar.

Fatal Case #9

**7. MACHINERY:**

A company president was fatally injured while measuring a breaker plate inside an impact crusher. Shortly after lunch, the crusher operator unaware that anyone was inside the crusher, energized the equipment. The victim had not taken any precautionary measures to prevent the equipment from being energized nor did he tell anyone what he was going to do.

Fatal Case #10

8. **ELECTRICAL:**

A laborer was fatally injured when he came in contact with an energized power cable while helping install a water pump. The victim was working from the bucket of a backhoe which was being used to position a dewatering pump in the sump area of the pit. Once in position, the pump was started. The victim attempted to remove the steel sling, which was used to suspend the pump from the bucket. When he contacted the sling, he was electrocuted.

Fatal Case #11

9. **POWERED HAULAGE:**

A service mechanic was killed when his service truck rolled backward crushing him against the steel frame of a shaker screen. Evidence indicated that after parking the truck, he walked back about 30 feet and sat down on a pile of spilled material next to the shaker screen. The victim left the truck out-of-gear and did not set the park brake.

Fatal Case #14

10. **ELECTRICAL:**

A conveyor-belt tender was electrocuted while breaking tree limbs adjacent to an energized powerline. The victim had been observed previously breaking limbs from trees near an energized non-insulated powerline using a length of non-insulated power cable. Apparently, he would throw one end of the cable over a branch and then, holding both ends, would pull down and break off the branch. It is believed that when he tossed up one end of the cable, it contacted an energized powerline causing electricity to pass through his body.

Fatal Case #16

11. **MACHINERY:**

A mechanic was killed when struck by a 2-1/4-inch diameter wire rope that came out of the groove of a shovel dipper boom sheave. The victim had been helping to change out the 2-1/4-inch diameter crowd cable. The cable fell about 25 feet from the sheave wheel of the dipper boom striking the victim across the head and upper body.

Fatal Case #18

12. **SLIP OR FALL OF PERSON:**

A plant operator was killed after falling backward and striking his head against the steel framework of a conveyor. The victim had been cleaning up material which had built up under the conveyors in a screening room. Although there were no witnesses to the accident, it is believed that the victim tried to take a shortcut across a small, slow moving conveyor to a conveyor stop switch. He apparently lost his balance while on the conveyor or while stepping onto loose material.

Fatal Case #19

13. **POWERED HAULAGE:**

A truck driver was killed after losing control of his truck. The victim was returning to the quarry for another load when his 85-ton haul truck left the road and struck three 7-foot high piles of material used to block entry to an unused roadway. When the truck struck the third pile, the rear of the truck was thrown sideways. The impact and sudden turn apparently threw the victim from the truck and he was run over by the left rear dual tires. The truck was not provided with seat belts. Fatal Case #20

14. **MACHINERY:**

A foreman was killed when he was thrown from a portable stacking conveyor frame upon which he was standing. The victim and a laborer were removing the tail pulley assembly from the partially constructed stacking conveyor. When the last bolt was removed from the tail pulley, the tail end of the conveyor frame started moving upward. The laborer stepped off but the victim remained on the structure. The victim was catapulted into the air and struck his head on the conveyor frame as he fell to the ground. Fatal Case #21

15. **ELECTRICAL:**

An electrician was electrocuted while repairing an air disconnect switch. The victim was working from an insulated fiberglass bucket supported by a crane adjacent to a power pole. The nearby powerline was energized to 4,160 volts. He contacted the energized conductor with one hand and a grounded metal switch with the other hand. Fatal Case #22

16. **ELECTRICAL:**

An electrician was electrocuted when he came in contact with an energized wire. The victim was attempting to install a jumper cable on a magnetic line starter circuit. Apparently, when he started to unscrew a lug bolt on the starter, he contacted the energized wiring. He did not de-energize and lock out the power circuits. Fatal Case #23



# EVERYONE PAYS FOR SUBSTANCE ABUSE AT WORK!

The costs are more than economic for:

## THE ABUSERS

Often, they have legal and health problems, conflicts at home, accidents on and off the job.

## THEIR FAMILIES

Substance abuse is a major factor in half of all divorces, and it contributes to domestic violence, child abuse and sexual abuse.

## OTHER WORKERS

Working with substance abusers can be unpleasant and dangerous. Their work habits can affect fellow employees' safety, efficiency, satisfaction and enjoyment.

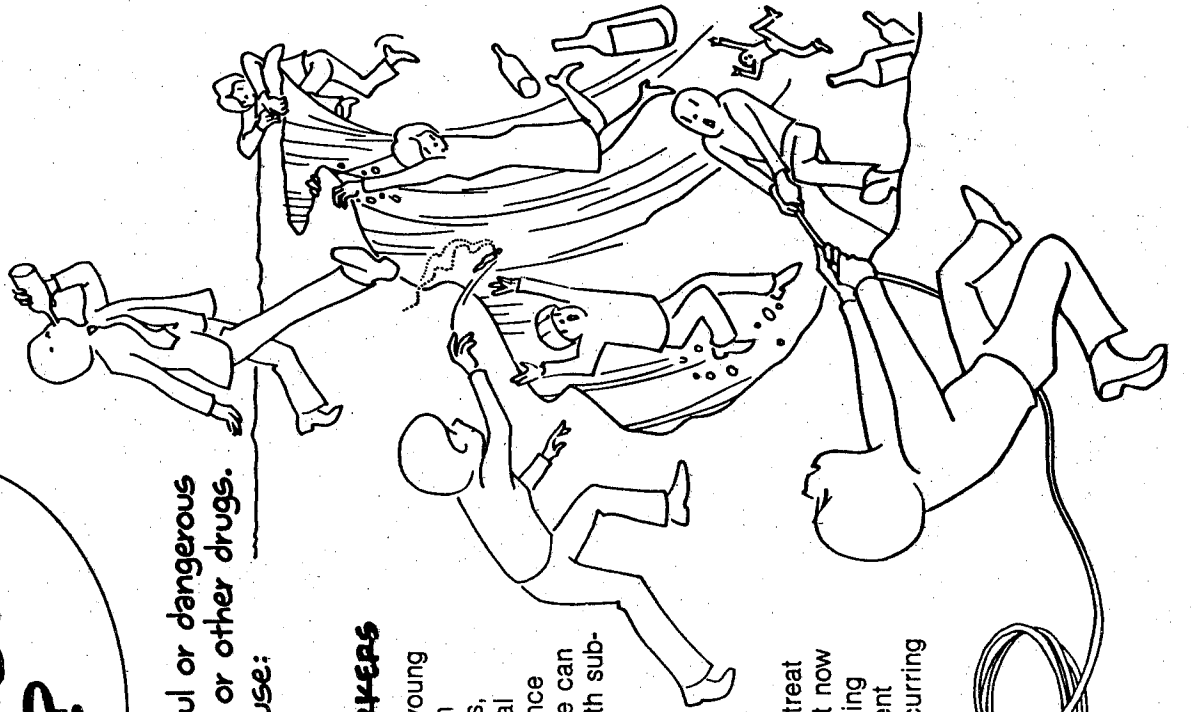
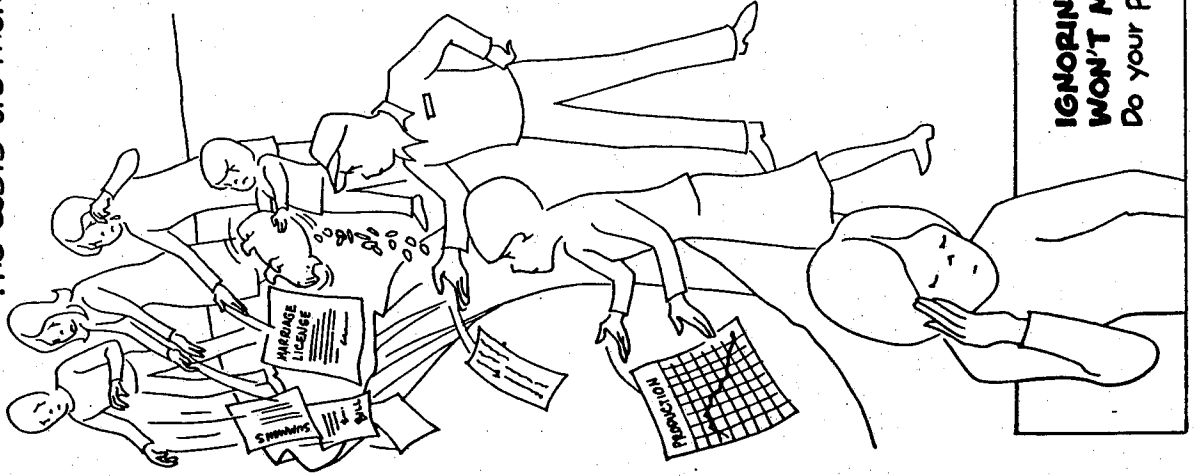
## EMPLOYERS

Substance abuse affects safety, production, attitude and much more.

It's a fact -- substance abuse ruins lives.

**IGNORING THE PROBLEM  
WON'T MAKE IT GO AWAY!**

Do your part to fight it. Learn more . . .



What is  
**SUBSTANCE  
ABUSE**  
?

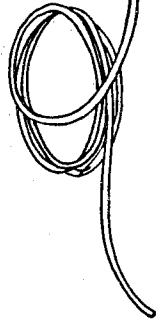
It's the harmful or dangerous use of alcohol or other drugs.  
Substance abuse:

### AFFECTS ALL TYPES OF WORKERS

Male and female, young and old, production workers, executives, supervisors, clerical workers, maintenance personnel -- anyone can have a problem with substance abuse.

### CAN BE PREVENTED OR TREATED

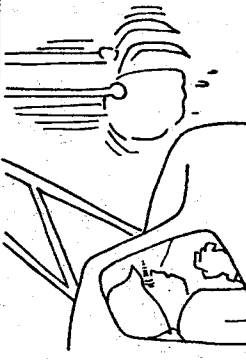
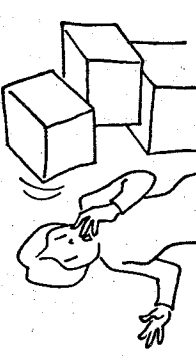
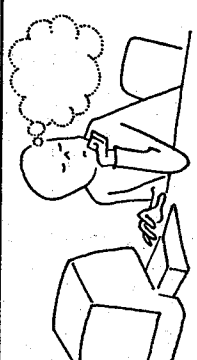
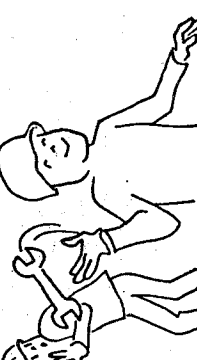
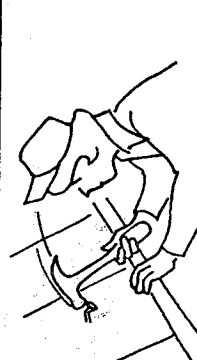
Professionals can treat problems that exist now -- and people working together can prevent problems from occurring in the future.




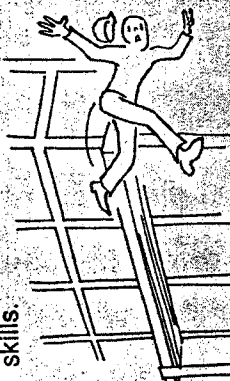

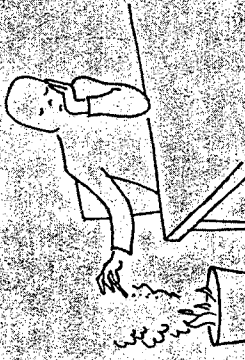

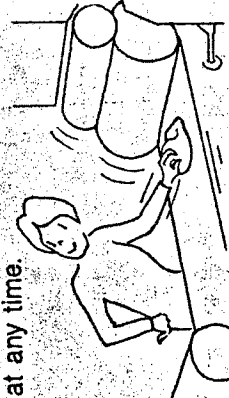


# SUBSTANCE ABUSE CAUSES WORK INJURIES, TOO

People need good judgment and physical skills to stay safe -- but alcohol and other drugs can make any job dangerous.

<p><b>Substance abuse can cause:</b></p> <p><b>IMPAIRED EYESIGHT</b></p> <ul style="list-style-type: none"> <li>- blurred, double or multiple vision;</li> <li>- difficulty tracking objects; poor side vision; hallucinations.</li> </ul> 	<p><b>SLOWER REACTION TIME</b></p> <ul style="list-style-type: none"> <li>- significantly slower reflex actions.</li> </ul> 	<p><b>LESSENERED CONCENTRATION</b></p> <ul style="list-style-type: none"> <li>- inability to focus on a task long enough or carefully enough to complete it.</li> </ul> 	<p><b>POOR JUDGMENT</b></p> <ul style="list-style-type: none"> <li>- overconfidence, inability to weigh consequences.</li> </ul> 	<p><b>POOR COORDINATION</b></p> <ul style="list-style-type: none"> <li>- decreased ability to perform simple tasks; poor balance and motor skills.</li> </ul> 
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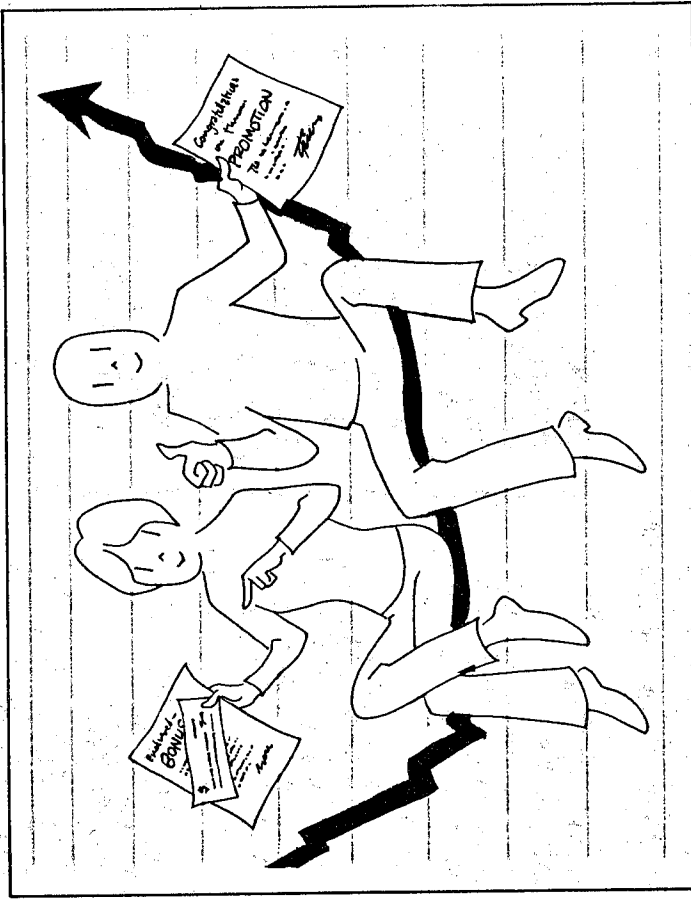
Impaired skills can cause:

<p><b>MOTOR VEHICLE ACCIDENTS</b></p> <p>Any worker who drives under the influence of alcohol or other drugs risks a serious crash.</p> 	<p><b>FALLS</b></p> <p>More than 200,000 workers are injured in falls each year, many because of impaired skills.</p> 
<p><b>INJURIES FROM HAZARDOUS MATERIALS</b></p> <p>Overconfidence or lack of concentration can cause failure to follow proper procedures.</p> 	<p><b>FIRES</b></p> <p>An impaired or careless worker is always a fire hazard.</p> 
<p><b>INJURIES FROM IMPROPER USE OF TOOLS OR MACHINERY</b></p> <p>Poor judgment or concentration makes accidents likely.</p> 	<p><b>OTHER INJURIES</b></p> <p>A careless attitude or impaired skills can cause an accident in any environment, at any time.</p> 

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# KEEP YOUR WORKPLACE SAFE, HEALTHY AND EFFICIENT

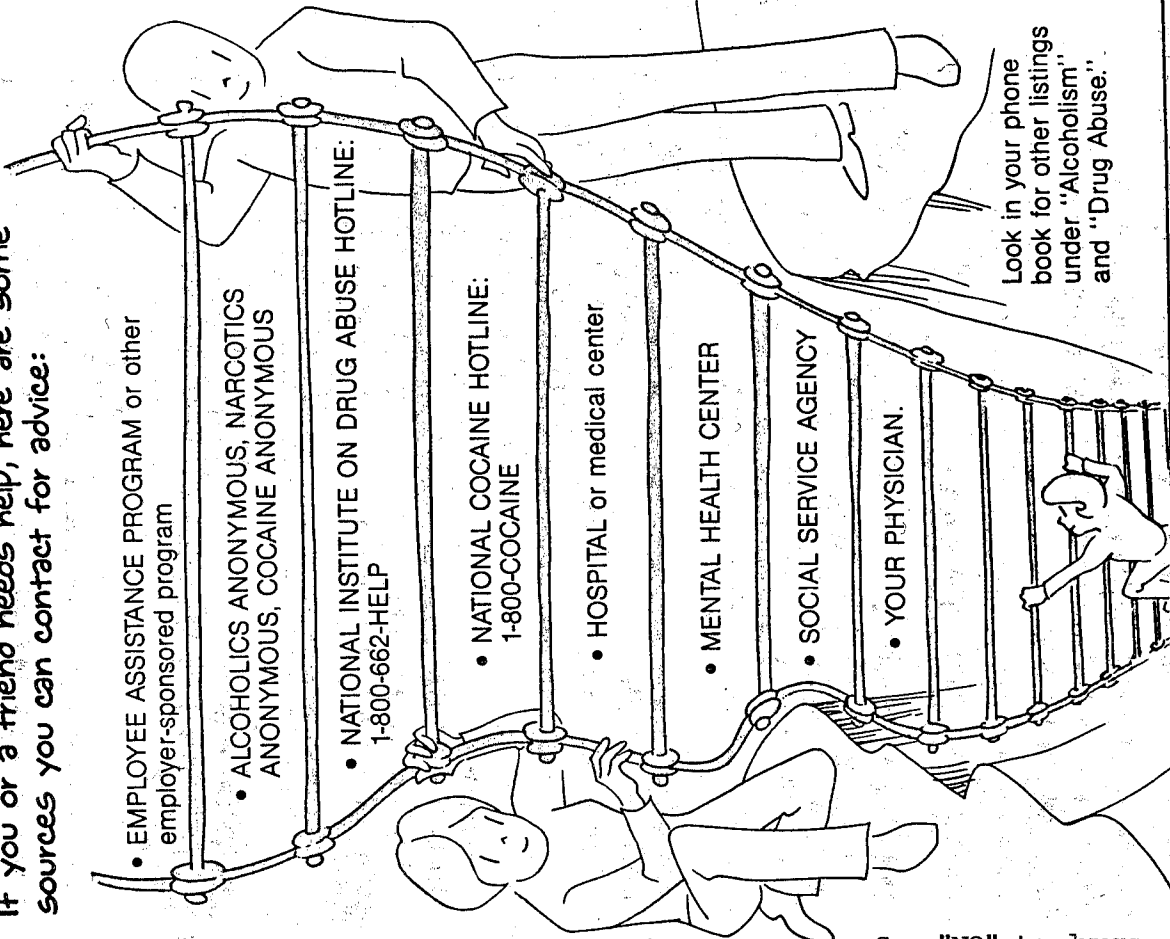
- ✓ **LEARN** about substance abuse - its dangers and warning signs.
- ✓ **ENCOURAGE** others to avoid substance abuse.
- ✓ **GET HELP** if you need it.



Help prevent substance abuse at work.

## WHERE TO GET HELP

If you or a friend needs help, here are some sources you can contact for advice:



• EMPLOYEE ASSISTANCE PROGRAM or other employer-sponsored program

• ALCOHOLICS ANONYMOUS, NARCOTICS ANONYMOUS, COCAINE ANONYMOUS

• NATIONAL INSTITUTE ON DRUG ABUSE HOTLINE: 1-800-662-HELP

• NATIONAL COCAINE HOTLINE: 1-800-COCAINE

• HOSPITAL or medical center

• MENTAL HEALTH CENTER

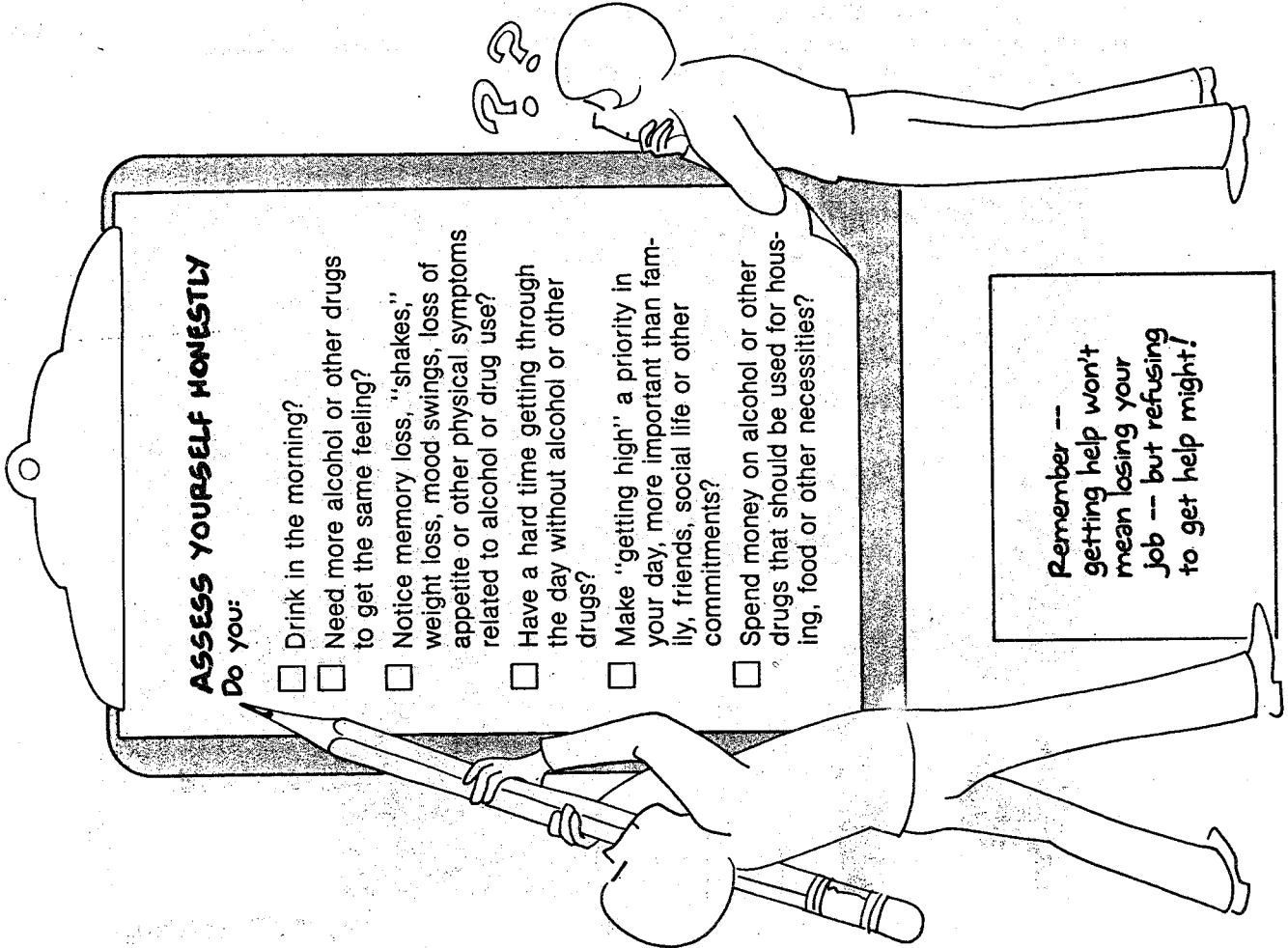
• SOCIAL SERVICE AGENCY

• YOUR PHYSICIAN.

Look in your phone book for other listings under "Alcoholism" and "Drug Abuse."

Remember -- contact with your EAP or other source of help will always be kept **CONFIDENTIAL**.

# DON'T WAIT UNTIL IT'S TOO LATE!

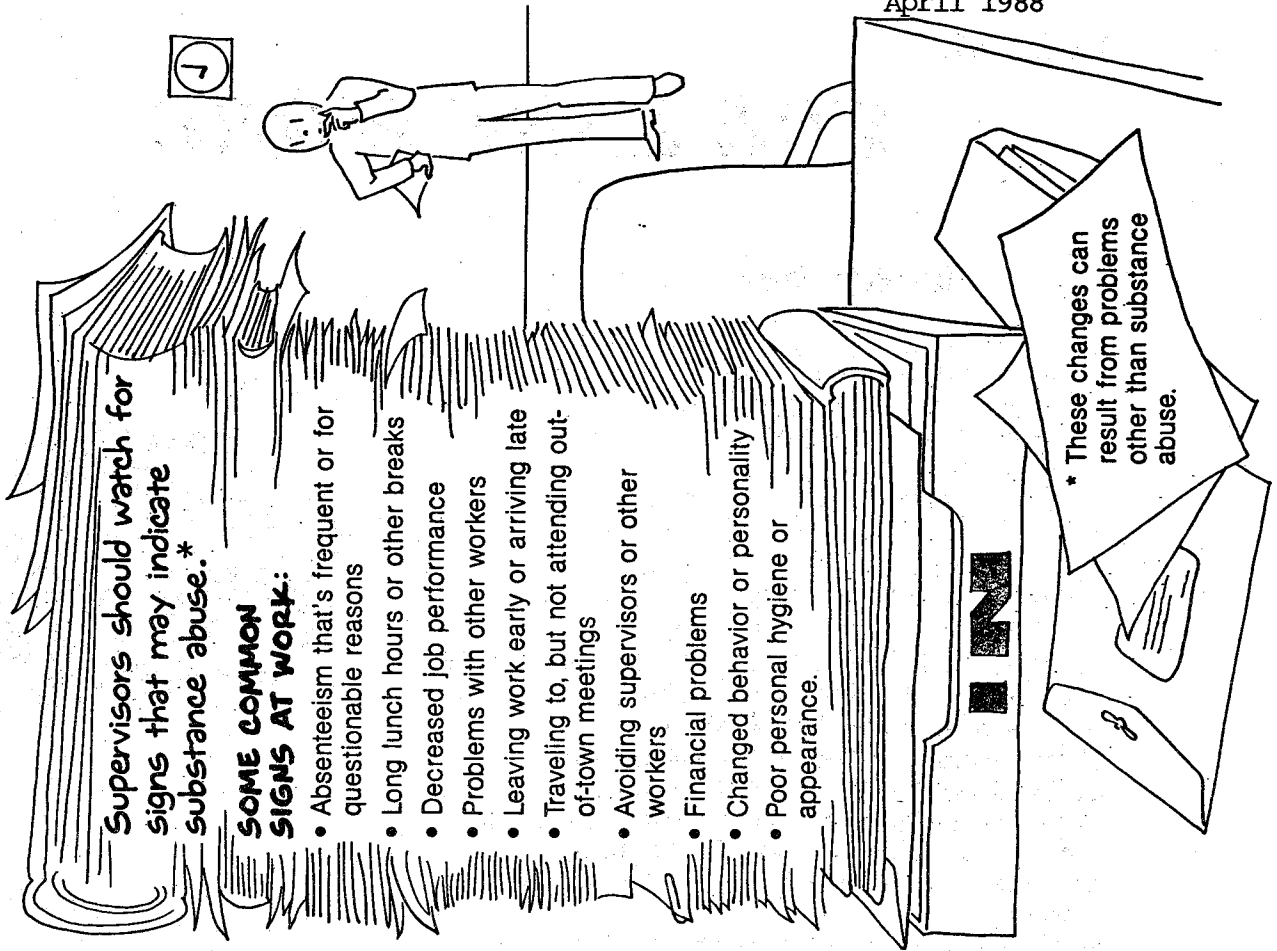


## ASSESS YOURSELF HONESTLY

Do you:

- Drink in the morning?
- Need more alcohol or other drugs to get the same feeling?
- Notice memory loss, "shakes," weight loss, mood swings, loss of appetite or other physical symptoms related to alcohol or drug use?
- Have a hard time getting through the day without alcohol or other drugs?
- Make "getting high" a priority in your day, more important than family, friends, social life or other commitments?
- Spend money on alcohol or other drugs that should be used for housing, food or other necessities?

Remember --  
getting help won't  
mean losing your  
job -- but refusing  
to get help might!



Supervisors should watch for signs that may indicate substance abuse.\*

### SOME COMMON SIGNS AT WORK:

- Absenteeism that's frequent or for questionable reasons
- Long lunch hours or other breaks
- Decreased job performance
- Problems with other workers
- Leaving work early or arriving late
- Traveling to, but not attending out-of-town meetings
- Avoiding supervisors or other workers
- Financial problems
- Changed behavior or personality
- Poor personal hygiene or appearance.

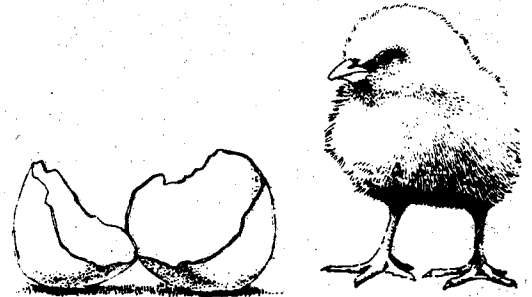
\* These changes can result from problems other than substance abuse.

# THE LAST WORD

## MANAGER'S CREED

If he is pleasant, he is too familiar;  
If he is sober-faced, he is a sour-puss;  
If he is young, he doesn't know anything;  
If he is old, he is an old stiff;  
If he goes to Church, he's a hypocrite;  
If he doesn't, he's a heathen;  
If he drinks, he's an old souse;  
If he doesn't, he's a tightwad;  
If he talks to everybody, he's a gossip;  
If he doesn't, he's stuck up;  
If he insists that the rules of the Agency  
be kept, he's too particular;  
If he doesn't, he's careless;  
If he looks around, he's snooping;  
If he doesn't, he's unobservant;  
If he tries to settle all complaints, he  
must have the wisdom of Solomon;  
If he worries about them, he'll soon go  
crazy;  
He should have the patience of Job, the  
skin of a rhinoceros, the wits of a fox,  
the courage of a lion, be blind as a bat,  
and silent as a sphinx. He must know all,  
see all, say nothing, but solve everything.

# HAPPY EASTER



**POSTAGE AND FEES PAID**  
**U.S. Department of Labor**  
LAB 441

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

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**

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

Please include any change of address below:

# Joseph A. Holmes Safety Association

## Awards Criteria--Outline

### Type "A" Awards - For Acts of Heroism

The awards are medals with Medal of Honor Certificate.

### Type "A" - For Acts of Heroic Assistance

The awards are Certificates of Honor.

### Type B-1 Awards - For Individual Workers

(40 years continuous 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

Department of Labor  
MSHA, Holmes Safety Association  
4800 Forbes Avenue  
Pittsburgh, PA 15213

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DOL  
PERMIT NO. G-59

**COME**  
*grow*  
**WITH**  
**US**