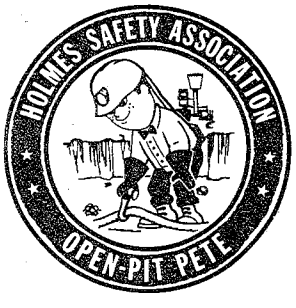
BULLETIN

HOLMES SAFETY ASSOCIATION

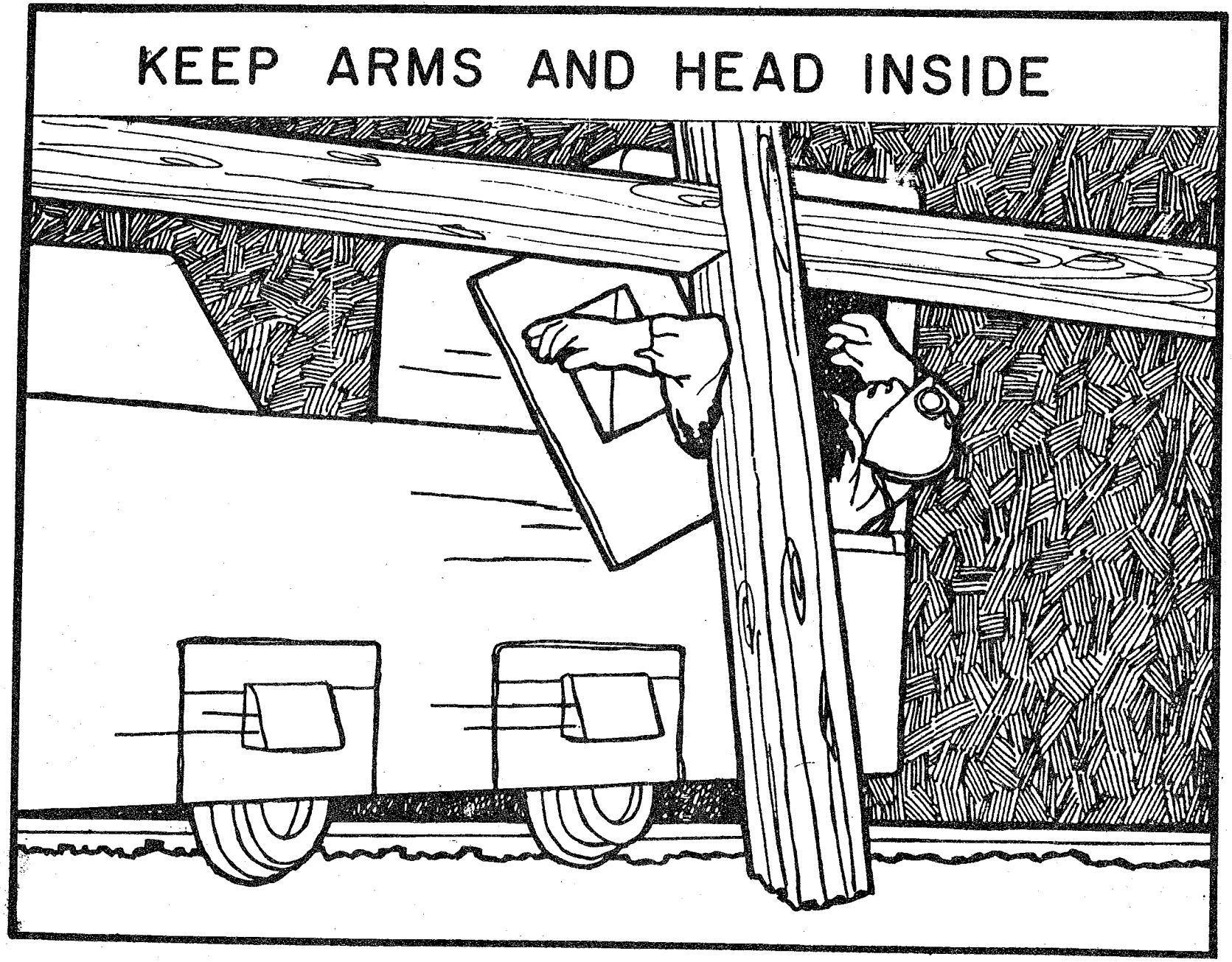
E PLURIBUS UNUM

SAFETY EFFICIENCY

MINERAL INDUSTRIES



May 1988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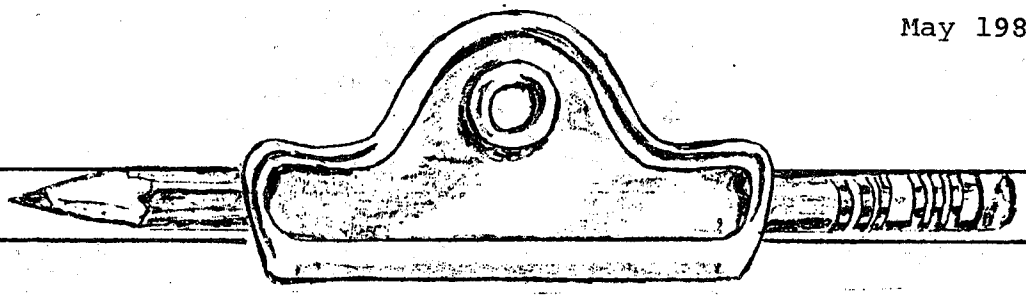

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THIS SAFETY BULLETIN CONTAINING SAFETY ARTICLES ON A VARIETY OF SUBJECTS, FATAL ACCIDENT ABSTRACTS, STUDIES, POSTERS AND OTHER SAFETY INFORMATION FOR PRESENTATION TO GROUPS OF MINE AND PLANT WORKERS IS PROVIDED FREE AS A BASIS FOR DISCUSSION AT ON-THE-JOB SAFETY MEETINGS.

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

May 1988

COMPANY	CHAPTER NO.	LOCATION
Ideal Basic Industries	7534	Seattle, WA
Betty B. Coal Co., Inc.	7535	Norton, VA
Gilbert Development Corp.	7536	Cedar City, UT
W. States Drilling & Blasting	7537	Cedar City, UT
Chieftain #3 Mine	7538	Weston, WV
Boone Hydraulic	7539	Sylvester, WV
Alphaine Corp.	7540	Bickmore, WV
Quality Leasing Inc.	7541	Cannelton, WV
Mercer Transport Inc.	7542	Cannelton, Wv
A G Hill Power Inc.	7543	Corpus Christi, TX
Gilman Insulation Co., Inc.	7544	Corpus Christi, TX
Sunland Construction Co.	7545	Corpus Christi, TX
C. H. Heist	7546	Corpus Christi, TX
Beech Fork Processing Inc.	7547	Van Lear, KY
Tackett Mining Co., Inc.	7548	Honaker, KY
B. Petro, Inc.	7549	Colmar, IL
L. & L. Energy of Hurley, Inc.	7550	Hurley, VA
N. O. W. Coal Co., Inc.	7551	St. Charles, VA
Shaker Run Coal Co., Inc.	7552	Clifftop, WV
Smith Branch Coal Co., Inc.	7553	Grayson, KY
Hillbrook Coal Co., Inc.	7554	Martha, KY
Stalyan Hwit Coal Co.	7555	Harold, KY
R. V. Mining Co., Inc.	7556	Eastern, KY
Big D. Mining Co.	7557	Martin, KY
Bizwil Inc.	7558	Inez, KY
Scandia Mng/Valenting Milling Cos.	7559	Valentine, AZ
Kentucky Mountain Reserve Inc.	7560	Gunlock, KY
K. C. Rogers Coal Co., Inc.	7561	Galveston, KY
B & N Coal, Inc.	7562	Dexter City, OH
B & N Coal, Inc.	7563	Dexter City, OH
Union Quarries, Inc.	7564	Rheems, PA
V Coal Company, Inc.	7565	Point Lick, WV
North Star Coal Company	7566	Bolt, WV

H.S.A. SAFETY TOPIC

Analysis of Continuous Mining Machine Accidents Underground Coal Mines

INTRODUCTION

The operation of continuous-mining machine in underground coal mines can be hazardous to mining personnel, including continuous-miner operators and support labor, working in the area of moving equipment. This report identifies the specific mining activities and types of accidents associated with the use of continuous-mining machines.

ANALYSIS

In a three year period, there were 527 injuries including five fatals under 30 CFR50 that involved the use of continuous-mining machines. Of this number, 272 injuries (52 percent) involved operating the continuous miner, and 193 injuries (37 percent) occurred while working in close proximity to the machine while it was operating (See Table).

Forty-seven cutting or loading machine injuries occurred when the continuous-mining machine bounced, as the ripper heads hit substances other than coal (such as clay veins, rocks or steel), throwing bits and rock back into the operator's compartment. While loading, material flying off the conveyor often struck the operator in the eye, cheek or hand. Back injuries from jarring, or being thrown against the seat during the mining operation, frequently occurred.

Attempting to move trailing cables while tramming the continuous-mining machine from the operator's station caused numerous injuries to the hands, arms and feet which were extended outside the operator's compartment. The most serious hazard to support labor involves handling trailing cables while the machine is moving. This work exposes them to crushing type injuries.

Thirty-four continuous-miner operators were injured when they were thrown into the canopy roof or side of the canopy while operating the miner. Of the 34 injuries, ten occurred while sumping/cutting into the face or mine floor, causing the machine to buck or bounce.

1/Prepared by Mine Safety and Health Technology Center, Denver Colorado.

TABLE

Continuous Miner Accidents By Activity 1982 – 1984

	1982	1983	1984	TOTAL
Operating				
Tramming	87	62	76-(1)*	225-(1)
Cutting/Loading	19	13	15	47
Work in Close Proximity to Machine				
Observing	7	7	5	19
Support Labor	74	56	44-(3)	174-(3)
Machine Maintenance	14-(1)	12	14	40-(1)
Not Specified	12	4	6	22
TOTAL -	213-(1)	154	160-(4)	527-(5)

*Number in parenthesis indicates fatalities.

Six injuries occurred when the machine hung-up on the channel or roof bolt during tramming operations. Five incidents were the result of tramming the continuous miner over irregularities in the mine floor. Thirteen of the injuries to continuous-miner operators involved the machine canopies. Six operators were tramming continuous miners with parts of their bodies outside the operator's compartments. These body parts were crushed between canopy and rib, rock or roof. Three canopy supports failed, allowing the canopy to fall on operator. Two injuries ocurred while adjusting the canopy height. One injury occurred while raising boom of miner; it contacted the canopy, lifting it out of the support bracket which permitted it to fall. While tramming a continuous miner, the cat tread folded under a floating canopy and pushed the canopy into the roof.

Forty-three injuries occurred to support personnel. Twenty-four canopy related injuries occurred when support personnel placed their hands on top of the canopy while the machine was cutting or tramming. Nineteen injuries occurred to support personnel while standing in close proximity to machine, while cutting, loading, or moving operations were being performed.

All of the 40 machine maintenance injuries were a direct result of miners intentionally, or unintentionally, moving a machine component (cats, cutting head, boom, stab jacks, etc.) while the maintenance personnel were working in or under the equipment.

CONCLUSIONS

The 75 injuries caused by bumps, holes, and irregularities in the roadway while tramming could be eliminated by grading or trimming the bottom with the mining machine and filling in soft spots. On-shift examinations for hazardous roadway conditions should be made by supervisory personnel on each coal production shift, and hazardous irregularities eliminated before production work is started.

Continuous-miner operators, injured from material thrown off continuous-miner bits and conveyors during mining operations, might be protected if screen-type shields were placed around the operator's controls.

Miner helper's, support labor and supervisors are in a very hazardous area, due to the position of the continuous miner and shuttle car during cutting or loading operations. The development of an improved cable handling system for the continuous miner would greatly reduce the number of cable-related injuries. Several possibilities for an improved system include an articulated arm mounted on the miner and controlled by the operator, a battery-powered tugger for moving the cable, or a cable reel.

In those cases where the support personnel cannot be removed to a safe distance from the machine while it is operating, improved visual and/or audio warning devices which indicate that the machine is about to be moved would greatly reduce the number of crushing injuries.

H.S.A. SAFETY TOPIC

Coal Mining Deaths Reached Record Low In 1987

As Fatalities Rose In Non-Coal Mining

Accidents in the nation's coal mines claimed 63 lives in 1987, the lowest total in more than 100 years, according to preliminary figures released by the Labor Department's Mine Safety and Health Administration (MSHA).

Also for the first time on record, there were no coal mine accidents in 1987 in which more than one miner died.

The leading causes of coal mining fatalities in 1987 were accidents involving powered haulage equipment and those involving roof and rib falls in underground coal mines. Each accident type accounted for 19 deaths. Together, they represented about 60 percent of all coal mine fatalities that occurred last year.

The 63 coal mining fatalities during 1987 represented a 28 percent decrease from the total of 88 coal mining deaths recorded in 1986. In addition, the rate of fatal injuries per 200,000 employee work-hours declined from .05 in 1986 to .04 in 1987.

There were 67 fatalities in the metal and nonmetal (noncoal) mining industry during 1987; there were 49 deaths in 1986. However, last year's total of 67 was the fourth lowest annual figure ever recorded in non-coal mining. The rate of fatal injuries in metal and nonmetal mining was .03 injuries per 200,000 work-hours, unchanged from 1986 and equal to the historical low rate recorded in six of the past seven years.

The rate of nonfatal, lost-time coal mining injuries during 1987 was 7.58 injuries per 200,000 employee hours, up from 5.17 for 1986. The rate for all types of coal mining injuries was 10.19 per 200,000 employee hours worked, up from 6.79 in 1986.

Coal miners worked a total of more than 309.8 million hours last year, compared to 330.6 million in 1986.

The rate of non-fatal, lost-time injuries in the metal and nonmetal mining industry last year rose to 3.58 injuries per 200,000 work hours from 2.94 during 1986. The rate for all types of metal and nonmetal mining injuries in 1987 was 5.90, up from 4.58 in 1986.

	Total underground coal mine fatalities	Deaths due to underground coal mine falls of roof or rib	Roof/Rib fall deaths as percentage of total underground coal mine fatalities*	Percentage of roof deaths where miners worked beyond permanent support**
1976	103	38	37%	61%
1977	91	37	48%	33%
1978	67	33	49%	42%
1979	107	66	62%	80%
1980	94	32	34%	60%
1981	112	41	37%	59%
1982	82	52	63%	64%
1983	46	23	50%	35%
1984	97	34	35%	34%
1985	47	18	38%	56%
1986	50	28	56%	50%
1987	37	19	51%	53%

* Roof fall deaths have amounted to an average of 46% of the total yearly underground coal mine fatalities during this 12-year period, and well over half the underground fatalities in 1979, 1982, and 1986.

** An average of 52% of the deaths due to roof falls each year involved persons working or traveling beyond supported mine roof during the 12-year period.

H.S.A. SAFETY TOPIC

COUNCIL NEWS

The Pennsylvania Bituminous Council held its Annual Awards Dinner at the Omni Civic Center, Indiana, Pennsylvania, on March 25, 1988.

Featured guests included David C. O'Neal, Acting Assistant Secretary for Mine Safety Health Administration who spoke on the accomplishments of the Holmes Safety Association and William H. Hoover, National Secretary, Holmes Safety Association.

The following councils received awards for the lowest incidence rate:

Group I -- Underground Mines with more than 50,000 employee hours monthly. William "Scotty" Groves District Council

Group II -- Underground Mines with less than 50,000 employee hours monthly. Windber District Council

Group III -- Surface Mines Clearfield District Council

Group IV -- Preparation Plants and Surface Shops Indiana District Council

The meeting was attended by 180 persons.

HOLMES SAFETY AWARD — The 1987 safety plaque for Division II, which includes councils with underground mines averaging less than 50,000 employee hours monthly, was awarded to the Windber District Council. The presentation was made at the annual awards dinner-meeting of the Pennsylvania Bituminous Council, Holmes Safety Association, held recently at the Omni Civic and Convention Center. From left: Walter Koba, supervisor, Mine Safety and Health Administration; David C. O'Neal, Deputy Assistant Secretary, Mine Safety and Health, U.S. Department of Labor; and Ted Glusko, supervisor, Mine Safety and Health Administration.

HOLMES SAFETY AWARD — Recently the Pennsylvania Bituminous Council, Holmes Safety Association, held its annual awards-dinner meeting at the Indiana Omni Civic and Convention Center. Winner of the Group I safety plaque, that includes councils with underground mines averaging 50,000 or more employee hours monthly, was the William "Scotty" Groves District Council. From left are: Robert Newhouse, vice president of the Scotty Groves District Council; David O'Neal, Deputy Assistant Secretary for Mine Safety and Health, U.S. Department of Labor; James Erlinger, council president; and Kristin Valentovish, council secretary/treasurer.

ABSTRACT FROM FATAL ACCIDENT

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

FATAL MACHINERY ACCIDENT

GENERAL INFORMATION: An accident occurred resulting in the death of a first-class mechanic with 11 years total mining experience, the last 4 years as a mechanic.

DESCRIPTION OF ACCIDENT: The crew, entered the mine on a nonproduction shift and traveled to the Main West parallel section. The foreman was informed by the day shift foreman that a shuttle car which was being loaded with coal had lost its power at the end of the shift and there was about one-half shuttle car of coal on the mine floor behind the continuous-mining machine.

While examining the working places, the foreman observed a damaged place in the trailing cable of the shuttle car and instructed the mechanic and roof bolter to assist him in repairing the cable. After it was repaired, he instructed the roof bolter to energize the power on the loading machine, shuttle car, and continuous-mining machine.

In order to install roof bolts in the No. 2 entry, it was first necessary to load the coal and move the equipment out of the entry. The roof bolter operating the loading machine and the mechanic operating the shuttle car, loaded the coal behind the continuous-mining machine and then trammed the shuttle car and loading machine out of the No. 2 entry. They returned to the No. 2 entry to assist the foreman in tramming the continuous-mining machine out of the entry.

After the foreman had trammed the continuous-mining machine away from the face far enough to allow slack in the trailing cable and water hose, he stopped the machine. Looking toward the end of the conveyor boom, started tramming the machine in reverse. He stated that the three workers were located outby the machine boom.

While he was tramming the machine out of the place, he turned to check the position of the cutting head and the rear of the mining machine swung toward the right rib. He heard a noise and stopped the machine. He turned and saw that the mechanic was caught between the conveyor boom and the right coal rib. He immediately moved the machine away from the right coal rib and proceeded to where the victim had slumped to the mine floor.

CONCLUSION: The cause of the accident could not be definitely determined. However, the evidence at the scene and testimony of witnesses indicate that the boom end of the machine swerved to the right crushing the victim because either the right side of the cutter head caught on the right coal rib or the machine operator inadvertently split the tramming controls. The accident resulted in fatal injuries to the victim because he had placed himself in a hazardous position.

May 1988

ABSTRACT FROM FATAL ACCIDENT

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

FALL OF HIGHWALL ACCIDENT

GENERAL INFORMATION: An equipment operator was fatally injured when he was suffocated by sand and gravel material which sloughed off a highwall face and engulfed him in the cab of a front-end loader. He had a total of 14 years experience as an equipment operator.

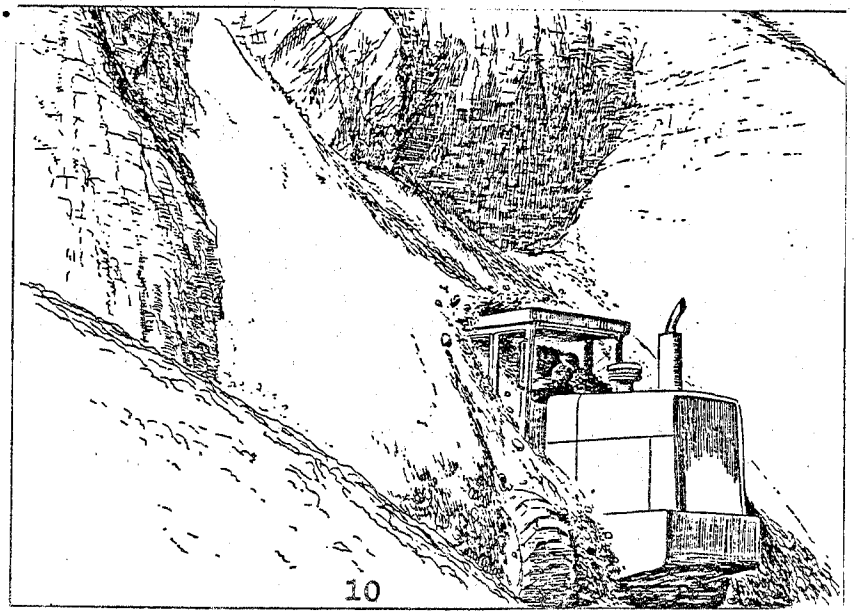
DESCRIPTION OF ACCIDENT: The victim reported to work at the gravel pit. He was left to work alone, and unchecked, without any communications. Work progressed without incident, as he operated the small screening plant and the front-end loader. Sometime after lunch, possibly mid-afternoon, the victim was operating the front-end loader at the toe of the north highwall face, where he was surrounded by three sides of a 40-50 foot dangerous, overhanging, and vertical highwall that collapsed. The sand and gravel material inundated the loader, breaking the windshield and engulfed the operator in the cab.

CAUSE OF THE ACCIDENT: The direct cause of the accident was the collapse of an active and unstable dangerous highwall.

Contributing factors to the severity of the accident were:

1. The operator did not ensure that the mining methods established for safe control of the pit highwall were being followed. The victim operated a front-end loader at the face of a dangerous highwall at a height more than three times the reach of the loader bucket.

2. The victim's failure to recognize the dangers of the pit highwall. Operating a front-end loader in an unsafe area at the pit highwall that collapsed on the loader and himself.



TYPICAL MINING OF THE ERA GONE BY

STEEL SHARPENING

Early day steel was cruciform in shape. Sharpening the steel required beating the bit end and hammering with the dolly or die. Final shaping was done on the anvil with a small hammer. Air for the forge was supplied by a large hand bellows. Drill steel was solid, as steel mills had not yet learned to roll hollow steel.

H.S.A. SAFETY TOPIC

SAFETY IS RETURNED IN FULL VALUE

Safety, like virtue, is its own reward.

Safety is returned in full value, in coin of the same type as that used to secure it. Safety, therefore, occupies almost the unusual position of both a giver and a receiver, or a producer and a consumer.

The safety rewards that are returned are almost in direct proportion to the safety practices that are exerted. Each person can, therefore, write his own ticket. The reward may be as big, or as little, as desired.

But safety, again like virtue, is also often exposed to many temptations, although not of a similar type. Safety temptations are usually those that occur impulsively, without giving proper thought to the hazards involved.

Some of the most common temptations develop, for example, from haste toward the end of the shift, resulting in failure to install the needed roof bolts or timbers; failure to take the necessary steps to assure proper face ventilation; failure to clean up excessive fine coal dust and apply sufficient rock dust; taking many shortcuts, hoping to gain some favorable advantages, chance-taking that usually results in grief; carelessness or indifference in handling equipment; and many other similar typical occupational temptations and hazards.

It is unfortunate, but a fact, that it is easier to gradually drift away from safe working habits and occasionally indulge in some acts that are not conducive to safety, than it is to stand firm and resist such temptations when the occasion arises. Even living is too dangerous a business for there to be much sense in taking chances that are unnecessary, or flirting with danger for any but the most urgent or humane reasons. But the practice of safety will return comfort, about the same proportion that safe working practices are used.

Safety thus, in this manner, pays its own rewards.

"I wouldn't be caught dead under unsupported roof"
submitted by: Tom McLaughlin, Safety instructor, Rochester and Pittsburgh Coal Company

May 1988

H.S.A. SAFETY TOPIC

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**

An equipment operator was killed when the front-end loader he was operating went over the edge of an elevated roadway, overturned and crushed him when the roll-over protection failed. He had been backing along the elevated portion of the roadway, returning from dumping stripped material, when the loader went over the edge and flipped onto its top. There were no berms along the elevated roadway and the roll protection was not certified as appropriate for the equipment upon which it was installed. Fatal Case #24

2. **POWERED HAULAGE**

A general mechanic was killed when the forklift truck he was operating struck a metal support column and overturned crushing him. The victim had been transporting a pump motor to a pump station. When he turned the forklift to the right prematurely, onto a secondary road, the forklift's right front wheel struck and rode up onto a pipe support stanchion pier causing the forklift to overturn. Restricted forward visibility was determined to be a factor contributing to the accident. Fatal Case #25

3. **ELECTRICAL**

A company vice president was killed by stray electrical current while trying to move a radial stacker conveyor. Electric current passed through the victim's body when he contacted the conveyor frame. A 440-volt wire which supplied power to the conveyor motor had shorted out. Fatal Case #26

4. **MACHINERY**

A mine foreman was killed when a derrick boom fell, and struck the ladder upon which he was standing, causing him to fall into the quarry. The victim was standing on the ladder so that he could get a good view of the stone block being lifted and so that he could signal the derrick operator. The boom was nearly horizontal and at this angle the maximum load capacity was 9 tons. The block being lifted weighed approximately 12 tons. The friction clutch began to slip and the brake was applied. A brake adjustment bolt broke and the boom fell. Fatal Case #27

5. **MACHINERY**

A contractor laborer was killed when struck by a 48-foot length of 6-inch pipe. As the pipe was raised from a flatbed truck the lead man noticed that the caliper clamp was not centered on the pipe. The signal was given to lower the pipe back onto the truck. While being lowered, the heavy end pivoted horizontal to the load and hit the side of the trench in which the victim was working. The pipe slipped out of the clamp and fell into the trench striking the victim. Fatal Case #28

6. **SLIP OR FALL OF PERSON**

While assisting maintenance workers replace a worn out section of belt, a watchman was killed when he fell from the framework of an elevated conveyor. Although the victim was a watchman, he routinely assisted the other crew members in the performance of maintenance duties. He had been standing on the conveyor framework straddling the new section of conveyor belt. While helping to pull the belt along the top rollers, he slipped and fell 13-1/2 feet to the ground. The victim was not wearing a safety belt and line. Fatal Case #29

7. **ELECTRICAL**

A laborer was killed by stray electrical current while trying to start a flotation pump. The victim primed the pump with water and attempted to start the pump. He was electrocuted when he pushed the electric start switch. The victim was standing in 18 inches of water when the fault occurred. Fatal Case #30

8. **POWERED HAULAGE (CONVEYOR)**

A mill utility man was killed when he was drawn into a conveyor takeup pulley. For reasons unknown, the victim climbed down between an elevated conveyor catwalk and the conveyor framework onto the conveyor counterweight assembly. He apparently lost his balance and fell directly into a rotating self-cleaning takeup pulley. The takeup pulley was located 5 feet below the catwalk and 17 feet above the ground. Fatal Case #31

9. **FALLING MATERIAL**

An owner/contractor was killed when the ditch in which he was working caved in on him. The victim and an employee were preparing the ditch for installation of a pipeline leading to a new settling pond. The ditch was 30 inches to 35 inches wide and about 10 feet deep. The walls of the ditch were near vertical and not supported.

Fatal Case #32

10. **NONPOWERED HAULAGE**

A laborer drowned when the boat in which he was standing sunk. The victim and the mine owner's son were paddling the boat away from the dredge and in the process of securing the dredge anchor rope. The boat was unstable and the victim lost his balance. He fell toward the right rear portion of the boat which caused it to rapidly take on water and sink. The owner's son unsuccessfully tried to help the victim. Neither were wearing a lifejacket and the victim could not swim.

Fatal Case #33

11. **FALLING MATERIAL**

A truck driver was killed when the material on which he was standing sloughed into a load-out bunker. After loading his truck, the victim apparently noticed that a large amount of material was clinging to the sides of the load-out bunker. Using a pick he went up to the top of the bunker to break the material loose. When the material broke loose the victim fell into the bunker and was buried.

Fatal Case #34

12. **MACHINERY**

A shovel operator was killed after the trackmounted clamshell he was operating slid down a bank into a creek. The victim was cleaning debris from the creek. He apparently got too close to the edge while tramming forward and the machine started down the bank. The victim jumped from the back of the machine and landed in soft material on the bank. A large rock positioned above the victim rolled down the bank striking him in the head. A spotter had been present all day except for the last few minutes prior to the accident.

Fatal Case #35

13. **MACHINERY**

A surveyor was killed when he was run over by a motor grader. The victim was surveying a new haulage road. A road grader was working nearby. Apparently the victim walked in back of the grader and crouched down to shoot a survey point. The motor grader backed up running over the victim. The motor grader had backup alarm but it was not working.

Fatal Case #36

14. **MACHINERY**

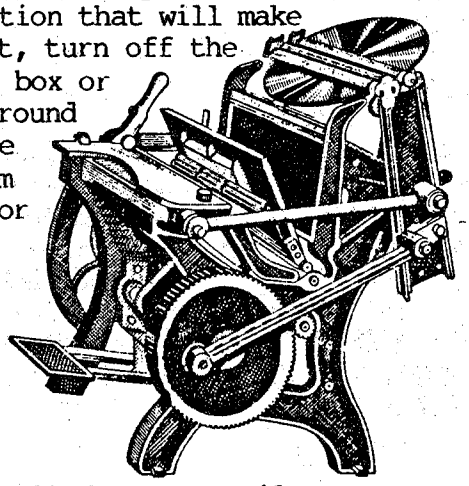
An equipment operator was killed when he fell from a suspended load on which he was standing. A flotation pump mounted on a steel platform was being raised by a crane. The load was attached through metal eyes located on each corner of the metal platform. Three of the four metal eyes failed and the victim fell into the river bank below. Fatal Case #37

15. **POWERED HAULAGE**

A plant operator was killed while working inside a crusher feed hopper. The victim apparently entered the feed hopper to bar loose hung-up material. While the victim was inside, a front-end loader filled the hopper with rock burying the victim. The victim did not inform anyone prior to his entering the feed hopper.
Fatal Case #38

CLEANING FOR SAFETY'S SAKE

One of the cleanup jobs to be done at the end of a day's work in a shop is to secure the stationary power tools. It's part of leaving a shop in the clean and orderly condition that will make it much safer for all subsequent users. First, turn off the switch at the machine and at the distribution box or panel. Any materials that have accumulated around the machine during use should be removed. The next step is brushing wood or metal chips from the working surfaces. The grooves in tables or the framework should be cleaned with a wooden stick or a narrow brush. Be careful to avoid having your hands come in contact with sharp cutting edges or steel shavings. Also avoid accidentally dropping portable power tools or removable machine parts.



Using shop towels, clean cutting oils machine tools. Remember to protect wood tools with chalk dust, not oil. If the machine is equipped with a cover, install it carefully. Last (and surely not least), replace guards that were removed for cleaning.

Think about PREVENTION not PENALTIES

When a mistake occurs in your department, what's your first reaction? "WHO DID IT?" WHO'S TO BLAME?" It's a natural reaction, but the wrong one. Blaming people doesn't repair the damage or eliminate future errors. All it does is make people afraid to take responsibility and anxious to hide their mistakes.

An excellent way to get people to face up to their responsibilities, to recognize what they've done wrong, is to take part of the responsibility yourself. Couldn't you possibly be a little bit to blame, somehow, someway? Admit it immediately -- it's the best starting point to get cooperation.

When something has gone wrong, only one thing is important. Find out how it happened, what caused it, and how it can be prevented in the future. Make clear that you're not on a witchhunt--you just want to make sure it can't happen again.

If you lead the way by admitting your responsibility, others will be encouraged to recognize theirs. And that's the important thing. When people are willing to admit their errors, you have better chance of figuring out how a mistake really happened and how it can be prevented in the future. Otherwise you may never find out.

It doesn't matter who made the blunder. That's done and over with. Blaming someone may give you some personal satisfaction, but it won't improve matters one bit. Concentrate on HOW, not WHO. Think about PREVENTION, not penalties.

Don't investigate mistakes while you are angry or irritated. Cool off first. Then go about it calmly, matter-of-factly, trying to get the facts that will help everyone do a better job next time. It's the best way--by far.

May 1988

May 1988

HOLMES SAFETY ASSOCIATION

Improve Safety and Efficiency

at your mine
through the Holmes Safety Assn.

ENROLL NOW!

The Holmes Safety Association engages in a humanitarian effort and is noncommercial in character. Its sole objectives are to prevent fatalities and injuries and to improve health and safety among officials and employees in all phases of the mineral industries.

FOR FURTHER INFORMATION, CALL OR WRITE:

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Linda M. Lofstead
HSA Coordinator
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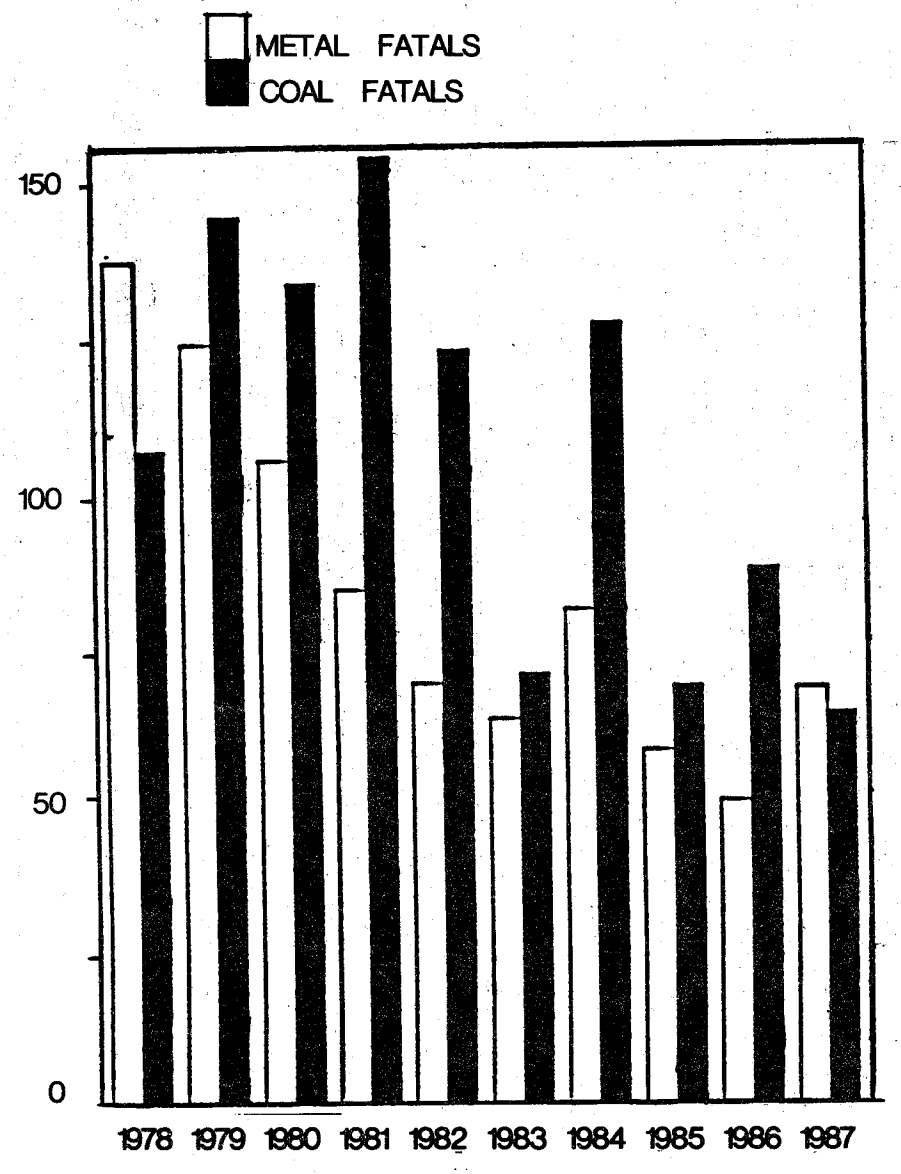
May 1988

H.S.A. SAFETY TOPIC

Mining Fatalities, 1980-1987

Year	1980	1981	1982	1983	1984	1985	1986	1987
Coal Mining	133	153	122	70	125	67	87	63
Metal and Nonmetal Mining	103	84	68	62	80	57	46	67
All Mining	236	237	190	132	205	124	133	130

10 Year survey shows record lows in fatalities



1987 DISTRICT COUNCIL COMPETITION FINAL STANDINGS

COAL—UNDERGROUND

COUNCIL NAME	CNCL NUM	QUARTER 4 WORK HOURS	QUARTER 4 LOST TIME ACC	QUARTER 4 FTLS	QUARTER 4 INCIDENCE RATES	QUARTER 4 NO MTGS	QUARTER 4 NO CHAP	QUARTER 4 STD	YEAR-TO-DATE: JANUARY THRU DECEMBER 1987 WORK HOURS	YEAR-TO-DATE LOST TIME ACC	YEAR-TO-DATE FTLS	YEAR-TO-DATE INCIDENCE RATES	YEAR-TO-DATE TOT NO MTGS	YEAR-TO-DATE AVG NO CHAP	YEAR-TO-DATE STD	
GROUP I																
SOUTHEAST OHIO COUNCIL	OH02	847,905	31	0	7.31	2	6	2	3,673,436	110	0	5.99	11	6.8	1	
NORTH CENTRAL COUNCIL	WV11	1,021,078	50	0	9.79	1	4	3	3,998,112	185	0	9.25	3	4.3	2	***
WILLIAM "SCOTTY" GROVES COUNCIL	PA06	1,458,903	76	0	10.42	3	15	4	5,935,135	291	0	9.81	11	17.3	3	
JOHN E. JONES	IL02	0	0	0	.00	0	0	1	8,303,196	424	0	10.21	3	10.5	4	***
WALTER W "KINGFISH" KESSLER	IL07	856,308	46	0	10.74	1	4	5	3,567,943	190	0	10.65	4	4.8	5	**
COAL RIVER COUNCIL	WV02	1,023,187	69	0	13.49	2	45	6	4,644,928	272	1	11.75	7	54.0	6	
RAYMOND A GOTHARD	IL03	988,564	89	0	18.01	1	6	7	3,884,029	251	0	12.92	4	6.0	7	
INDIANA COUNCIL	PA07	1,481,647	190	1	25.78	1	17	8	6,602,450	786	1	23.84	7	17.0	8	
TOTAL		7,677,592	551	1	14.38	11	97		40,609,229	2509	2	12.37	50	120.5		
GROUP II																
POTOMAC VALLEY	MD01	570,709	23	0	8.06	1	7	2	1,943,488	104	1	10.81	5	7.3	1	
NEW RIVER VALLEY COUNCIL	WV10	0	0	0	.00	0	0	1	2,913,625	201	0	13.80	3	20.0	2	***
TOTAL		570,709	23	0	8.06	1	7		4,857,113	305	1	12.60	8	27.3		
GROUP III																
WINDBER COUNCIL	PA11	39,293	0	0	.00	1	8	1	232,578	5	0	4.30	4	7.3	1	
N COLO/S WYOMING HSA DISTRICT COUNCIL	WY02	210,855	15	0	14.23	1	5	6	870,223	38	0	8.73	4	5.0	2	
KANAWHA VALLEY	WV07	0	0	0	.00	0	0	2	708,368	33	0	9.32	2	50.0	3	***
CLYMER COUNCIL	PA04	74,309	2	0	5.38	3	6	4	294,151	14	0	9.52	11	6.3	4	
KISKI - TRI-COUNTY COUNCIL	PA08	98,879	8	0	16.18	1	5	7	414,961	28	1	13.98	7	5.0	5	
MON VALLEY COUNCIL	WV08	0	0	0	.00	0	0	2	113,246	8	0	14.13	1	2.5	6	***
JOHN O MILLER COUNCIL	PA09	254,339	12	0	9.44	2	2	5	1,222,348	108	1	17.83	8	2.0	7	**
TOTAL		677,675	37	0	10.92	8	26		3,855,875	234	2	12.24	37	78.0		

METAL/NONMETAL—UNDERGROUND

COUNCIL NAME	CNCL NUM	QUARTER 4 WORK HOURS	QUARTER 4 LOST TIME ACC	QUARTER 4 FTLS	QUARTER 4 INCIDENCE RATES	QUARTER 4 NO MTGS	QUARTER 4 NO CHAP	QUARTER 4 STD	YEAR-TO-DATE: JANUARY THRU DECEMBER 1987 WORK HOURS	YEAR-TO-DATE LOST TIME ACC	YEAR-TO-DATE FTLS	YEAR-TO-DATE INCIDENCE RATES	YEAR-TO-DATE TOT NO MTGS	YEAR-TO-DATE AVG NO CHAP	YEAR-TO-DATE STD	
GROUP I																
N COLO/S WYOMING HSA DISTRICT COUNCIL	WY02	1,457,927	15	0	2.06	1	5	1	5,426,353	67	0	2.47	4	5.0	1	
TOTAL		1,457,927	15	0	2.06	1	5		5,426,353	67	0	2.47	4	5.0		

COAL–SURFACE

COUNCIL NAME	CNCL NUM	QUARTER 4 WORK HOURS	QUARTER 4 LOST TIME ACC	QUARTER 4 FTLS	QUARTER 4 INCIDENCE RATES	QUARTER 4 NO MTGS	QUARTER 4 NO CHAP	QUARTER 4 STD	YEAR-TO-DATE: JANUARY THRU DECEMBER 1987 WORK HOURS	YEAR-TO-DATE LOST TIME ACC	YEAR-TO-DATE FTLS	YEAR-TO-DATE INCIDENCE RATES	YEAR-TO-DATE TOT NO MTGS	YEAR-TO-DATE AVG NO CHAP	YEAR-TO-DATE STD	
GROUP I																
SOUTHERN INDIANA JT SAFETY COM & HSA	IN02	821,034	8	0	1.95	2	6	2	3,476,656	34	0	1.96	5	6.0	1	
N COLO/S WYOMING HSA DISTRICT COUNCIL	WY02	1,170,465	16	0	2.73	1	19	4	4,977,601	60	0	2.41	4	19.0	2	
SOUTHERN ILLINOIS OPEN-PIT	IL06	728,653	6	0	1.65	1	11	1	3,458,398	47	0	2.72	4	11.5	3	
SOUTHEAST OHIO COUNCIL	OH02	664,627	8	1	2.71	2	11	3	2,254,811	34	1	3.10	11	11.3	4	
COAL RIVER COUNCIL	WV02	565,320	13	0	4.60	2	15	5	2,265,628	74	1	6.62	7	30.0	5	
TOTAL		3,950,099	51	1	2.63	8	62		16,433,094	249	2	3.05	31	77.8		
GROUP II																
GROVE CITY/CLARION COUNTY COUNCIL	PA05	429,796	2	0	.93	0	12	1	1,612,475	15	0	1.86	1	13.5	1	***
N. INDIANA JT. COMM. FOR COAL MINE SAF	IN01	512,149	8	0	3.12	1	6	2	1,899,715	31	0	3.26	5	6.0	2	
SHAWNEE OPEN-PIT	IL05	386,057	7	0	3.63	1	4	3	1,153,562	22	0	3.81	3	3.5	3	***
TOTAL		1,328,002	17	0	2.56	2	22		4,665,752	68	0	2.91	9	23.0		
GROUP III																
KISKI - TRI-COUNTY COUNCIL	PA08	31,926	0	0	.00	1	2	3	132,460	0	0	.00	7	2.0	1	**
MON VALLEY COUNCIL	WV08	0	0	0	.00	0	0	4	275,634	2	0	1.45	1	11.3	2	***
WESTERN MARYLAND	MD02	188,788	3	0	3.18	1	19	7	770,164	10	0	2.60	4	16.8	3	
NEW RIVER VALLEY COUNCIL	WV10	0	0	0	.00	0	0	4	645,115	12	0	3.72	3	22.5	4	***
WINDBER COUNCIL	PA11	94,454	0	0	.00	1	2	1	134,608	3	0	4.46	4	1.3	5	**
CLYMER COUNCIL	PA04	17,887	2	0	22.36	3	2	9	69,545	2	0	5.75	11	2.0	6	**
KANAWHA VALLEY	WV07	0	0	0	.00	0	0	4	510,091	16	0	6.27	2	50.0	7	***
JOHN O MILLER COUNCIL	PA09	35,546	0	0	.00	2	1	2	159,116	6	0	7.54	8	1.0	8	**
INDIANA COUNCIL	PA07	140,229	7	0	9.98	1	5	8	612,660	25	0	8.16	7	5.0	9	
TOTAL		508,830	12	0	4.72	9	31		3,309,393	76	0	4.59	47	111.8		

* NO DATA EXISTS FOR A QUARTER
** CHAPTER AVERAGE IS LESS THAN 5
*** NUMBER OF MEETINGS IS LESS THAN 4

May 1988

HOLMES SAFETY ASSOCIATION

ANNOUNCES 1987 DISTRICT COUNCIL WINNERS

Eighteen coal and metal and nonmetal underground and 17 surface district councils were at the starting gate and off, competing for the H.S.A. fourth Annual National District Council competition awards; however, four underground and three surface councils scratched during the run.

The majority of councils completed the turn with the third quarterly report, then failed to submit the final fourth quarter. Why? The final tally left 14 underground and 13 surface councils crossing the finish line.

Congratulations are in order to 13 of 18 underground and 15 of 17 surface district council chapter mines for being fatality free in 1987.

Underground Council Mines, Coal and Metal and Nonmetal, reported 54.74 million work hours, five fatals and 3,116 non-fatal days lost NFDL for an incidence rate of 11.40 per 200,000 work hours of exposure WHE. Work hours decreased 13.44 million, injuries increased 495 and fatals decreased 11 in number over 1986.

Surface Council Mines, reported 24.40 million work hours, two fatals and 393 NFDL for an incidence rate of 3.24 per 200,000 WHE. Work hours decreased 0.8 million, injuries increased by eight and fatals fell by two in number over 1986.

Combined, underground and surface council mines reported seven fatalities and 3,509 NFDL for 1987, at an incidence rate of 8.88 with 79.16 million hours of work time. The 1986 corresponding frequency of occurrence was 6.63 for 106.9 million hours of work time.

The combined underground and surface fatality rate was 0.017 compared with 0.004 in 1986. The rate of nonfatal days lost NFDL was 8.86; an increase of 1.86 over the same period last year.

To be in competition for 1988, all district councils are reminded that the first quarterly district council report should be mailed no later than 60 days following the end of the first quarter and for every quarter thereafter.

I believe one of the problems of not getting the last quarterly report in to the National Council involves the change of council officers at the end of the year (election time). Outgoing secretaries should take time to instruct the newly elected secretary of the reporting procedure.

We hope to see you at the forthcoming National Council and Joseph A. Holmes Safety Association Business Awards and Banquet Meetings at the Sheraton-Inn Evansville, Evansville, Indiana, on May 19, 1988. There will be a social hour on Wednesday and Thursday before the banquet. Bring spouses and guests--there will be a family bus tour during the business meeting on May 19, 1988.

William H. Hoover
National Secretary

HOLMES SAFETY ASSOCIATION

JANUARY - DECEMBER 1987

GROUP I - UNDERGROUND COAL - LEVEL OF 3,000,000 OR MORE (WHE)

Southeast Ohio District Council, Wilkesville, Ohio, reported 3,673,436 (WHE), fatality free with 110 lost-time injuries for an incidence rate of 5.99 per 200,000 hours of exposure.

GROUP II - UNDERGROUND COAL - LEVEL OF 1,500,000 -- 2,999,999 (WHE)

Potomac Valley District Council, Oakland, Maryland, recorded 1,943,488 work hours, one fatal and 104 lost-time accidents for an incidence rate of 10.81 per 200,000 hours of exposure.

GROUP III - UNDERGROUND COAL - LEVEL OF 1,499,999 OR LESS (WHE)

Windber District Council, Windber, Pennsylvania, totaled 232,578 hours of work time, fatality free, with five occupational injuries for an incidence rate of 4.30 per 200,000 hours of exposure.

GROUP I - SURFACE COAL - LEVEL OF 2,000,000 OR MORE (WHE)

Southern Indiana Joint Safety Committee and Holmes Safety Association Council, Lynnville, Indiana, had an aggregate work time of 3,476,656 hours fatality free, with 34 occupational injuries and an incidence rate of 1.96 per 200,000 hours of exposure.

GROUP II - SURFACE COAL - LEVEL OF 1,000,000 -- 1,999,999 (WHE)

Northern Indiana Joint Committee for Coal Mine Safety District Council, Linton, Indiana, reported 1,899,715 hours, fatality free, with 31 lost-time accidents for an incidence rate of 3.26.

GROUP III - SURFACE COAL - LEVEL OF 999,999 OR LESS (WHE)

Western Maryland District Council, Grantsville, Maryland, reported 770,164 hours, zero fatalities, and 10 lost-time accidents for an incidence rate of 2.60.

GROUP I - UNDERGROUND METAL/NONMETAL - LEVEL OF 3,000,000 OR MORE (WHE)

Northern Colorado/Southern Wyoming Holmes Safety Association District Council, Rawlins, Wyoming, had an aggregate work time of 5,426,353 hours, fatality free, with 67 lost-time accidents, and an incidence rate of 2.47 per 200,000 hours of exposure.

HOLMES SAFETY ASSOCIATION

NATIONAL DISTRICT COUNCIL
1984 - 1987 SAFETY AWARD WINNERS

1987

I	COAL UNDERGROUND	Southeast Ohio, Wilkesville, Ohio
II	COAL UNDERGROUND	Potomac Valley, Oakland, Maryland
III	COAL UNDERGROUND	Windber, Windber, Pennsylvania
I	COAL SURFACE	S. Indiana Joint, Lynnville, Indiana
II	COAL SURFACE	N. Indiana Joint, Linton, Indiana
III	COAL SURFACE	Western Maryland, Grantsville, Maryland
I	M/NM UNDERGROUND	N. Colorado/S. Wyoming, Rawlins, Wyoming

1986

I	COAL UNDERGROUND	Guyandotte, Pineville, W. Virginia
II	COAL UNDERGROUND	Potomac Valley, Oakland, Maryland
III	COAL UNDERGROUND	Windber, Windber, Pennylvania
I	COAL SURFACE	S. Indiana Joint, Lynville, Indiana
II	COAL SURFACE	Western Maryland, Grantsville, Maryland
III	COAL SURFACE	Southeast Ohio, Wilkesville, Ohio

1985

I	COAL UNDERGROUND	N. Central, Fairmont, West Virginia
II	COAL UNDERGROUND	Potomac Valley, Oakland, Maryland
III	COAL UNDERGROUND	Windber, Windber, Pennsylvania
I	COAL SURFACE	S. Indiana Joint, Lynnville, Indiana
II	COAL SURFACE	Guyandotte, Pineville, West Virginia
III	COAL SURFACE	Mon Valley, Morgantown, West Virginia

1984

I	COAL UNDERGROUND	Guyandotte, Pineville, West Virginia
II	COAL UNDERGROUND	Southeastern Ohio, Wilkesville, Ohio
III	COAL UNDERGROUND	Mon Valley, Morgantown, West Virginia
I	COAL SURFACE	Grove City/Clarion, Clarion, Pennsylvania
II	COAL SURFACE	Clearfield, Clearfield, Pennsylvania
III	COAL SURFACE	N. Central, Fairmont, West Virginia

THE LAST WORD

Some things never change...

"SIX MISTAKES OF MAN!"

While preparing a paper over 2,000 years ago, Cicero, the distinguished writer and statesman, said that he considered the six great mistakes of man to be:

(1) The delusion that individual advancement is made by crushing others.
(2) The refusal to set aside trivial preferences.
(3) The neglecting of the development of the mind, and the failure to acquire the habit of reading and study.
(4) The tendency to worry about things that cannot be changed.
(5) The attempt to compel other persons to believe and live as we do.
(6) The insistence that a thing is impossible, solely because we ourselves cannot do it.

In spite of the thousands of articles presently being written on the subject of human relations, it would be difficult to find a more accurate thesis than this.

SHOW 'EM HOW

This is the time of year when the kids start checking off the days on the calendar. The end of school and the start of vacation aren't far off. You can bet they've been storing up plenty of energy for romping and playing through the summer months.

Let's hope their days of leisure are safe ones. Let's hope they remember to follow the good examples of safe thinking and safe doing that you've been setting when you're around them. Of course, you are safetyminded at home, **aren't you?**

REMEMBER:
Those who have passed before us for our safety and freedom.

COULD THIS BE  ....YOU?

THE ACCIDENT: After loading a truck with lumber, a forklift truck operator backed his vehicle behind the truck, then dismounted to adjust the forks. Meanwhile, the truck driver backed up the truck, pinning the operator between the truck frame and the forks inflicting extensive bodily damage.

WHY IT HAPPENED: The driver didn't walk around his vehicle, before backing up, to ensure that it was unobstructed.

CIRCLE YOUR VEHICLE BEFORE BACKING UP.

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)

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:

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

COME *grow* WITH US