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UNITED STATES
DEPARTMENT OF THE INTERIOR
BUREAU OF MINES
POST OFFICE BUILDING
MOUNT HOPE, WEST VIRGINIA

REGION VIII
Accident Prevention and
Health Division

May 1, 1953

Mr. Harry W. Payne, Gen. Mgr.
The American Coal Company of
Allegany County
McComas, West Virginia

Dear Mr. Payne:

This will acknowledge your recent letter in which you requested a copy of the report made by Mr. Vickers on the fatal accident of Harold Wall, age 10, which occurred on August 25, 1952, at your Pinnacle Stripping Operation.

This is to advise you that no formal report was submitted on this accident inasmuch as the Bureau of Mines did not charge this fatality against the coal-mining industry.

The only report submitted by Mr. Vickers was a short letter, on his trip to the scene of the accident, which was for the Bureau's information only.

Sincerely yours,

E. E. Quenon, Chief
Mount Hope Branch

Files ✓

EEQuenon/db

EEQ/

BUREAU OF MINES
MAY 1 1953
Mount Hope, W. Va.

THE AMERICAN COAL COMPANY

—OF—

ALLEGANY COUNTY

MCCOMAS, WEST VIRGINIA

PRODUCING COAL
SINCE 1853

HARRY W. PAYNE
GENERAL MANAGER

MINES

DEERFIELD, W. VA.
McCOMAS, W. VA.
WIDEMOUTH, W. VA.
LONACONING, MD.

August 29, 1953

Federal Mine Inspection Bureau
Mount Hope, West Virginia

Gentlemen:

On August 25, 1952, Harold Wall, age 10, was killed at our Pinnacle stripping operation while stealing coal with his father.

Your Mr. Vickers made an investigation and I would like to have a copy of his report.

Thanking you, I am,

Very truly yours,

Harry W Payne

General Manager.

HWP/e

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UNITED STATES
DEPARTMENT OF THE INTERIOR
BUREAU OF MINES
POST OFFICE BUILDING
MOUNT HOPE, WEST VIRGINIA

REGION VIII
Accident Prevention
and Health Division

September 3, 1952

Mr. Seth T. Reese, Chief
Accident Analysis Branch
U. S. Bureau of Mines
Washington 25, D. C.

Dear Mr. Reese:

Enclosed we are sending you a letter report by our Mr. Ward R. Vickers, Federal coal-mine inspector, relative to the circumstances and cause of the death of Harold Allen Wall and the serious injury to Bettis Wall, in an abandoned strip pit on the property of The American Coal Company of Allegany County, McComas, Mercer County, West Virginia, on August 25, 1952.

In our opinion, this fatality is not chargeable to the coal-mining industry and the report is being sent to you for your information and as a matter of record.

Sincerely yours,

F. J. Furin

F. J. Furin, Acting for
E. E. Quenon, Chief
Mount Hope Branch
Accident Prevention
and Health Division

FD

Enclosures 2

Copy to: Mr. Forbes
Mr. Westfield
Mr. Weaver
Mr. Tomlinson
Files 3

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UNITED STATES
DEPARTMENT OF THE INTERIOR
BUREAU OF MINES
POST OFFICE BUILDING
MOUNT HOPE, WEST VIRGINIA

REGION VIII
Accident Prevention
and Health Division

August 29, 1952

Mr. E. E. Quenon, Chief
Mount Hope Branch
U. S. Bureau of Mines
Mount Hope, West Virginia

Dear Mr. Quenon:

On August 25, 1952, at about 11:30 a.m., a rock slide occurred from the high-wall of an abandoned strip mine near McComas, Mercer County, West Virginia, which resulted in the instant death of Harold Allen Wall, age 10 years, and the serious injury of Bettis Wall, age 35 years, the victim's father.

On the day of the accident Bettis Wall and the victim drove a pick-up truck into the abandoned strip pit which was about 200 yards off the main highway for the purpose of digging house coal. The high-wall at this point was approximately 30 feet high. Witnesses to the accident were not available at the time of the investigation but the evidence indicated they had dug very little coal from underneath the high-wall when the slide consisting of several tons of loose rock and dirt occurred, killing Harold Allen Wall instantly and seriously injuring his father.

The strip pit was on the property of The American Coal Company of Allegany County, McComas, West Virginia. The company officials informed me that when the strip pit was abandoned they endeavored to close the road leading to it, but due to the fact that several families lived along the strip road they were unable to do so. The superintendent also stated that they inspected the abandoned strip property at least once each week to see that no one was taking coal illegally.

Bettis Wall, according to a member of the family, had about 18 years experience as a miner. He was not employed by The American Coal Company of Allegany County.

Copy to: Mr. Forbes
Mr. Westfield
Mr. Weaver
Mr. Tomlinson
Mr. Reese 2
Files 2

Since the victims were trespassing on private property, I do not think the above fatality should be charged to the coal mining industry.

Respectfully submitted,

/s/ Ward R. Vickers

Ward R. Vickers
Coal-Mine Inspector

9-2-52 Kanaba Letter to Reese (copies as before)

BUREAU OF MINES
SEP 2 1952
Mount Hope, W. Va.

"Letter report: Release release. OC EEZ

Welch, West Virginia
August 29, 1952

Dear Mr. Quenon:

On August 25, 1952 at about 11:30 A.M. a rock slide occurred from the high-wall of an abandoned strip mine near McComas Mercer County, West Virginia, which resulted in the instant death of Harold Allen Wall aged 10 years, and the serious injury of Bettis Wall age 35, the victim's father.

On the day of the accident Bettis Wall and the victim drove a pickup truck

OK EEZ

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coal illegally.

Beltis Wall according to a member of the family had about 18 years experience as a miner. He was not employed by The American Coal Company of Allegany County.

Since the victims were trespassing on private property, we do not think the above fatality should be charged to the coal mining industry.

Respectfully submitted,

Hard R. Ticker

Coal-Mine Inspector

UNITED STATES
DEPARTMENT OF THE INTERIOR
BUREAU OF MINES
MOUNT HOPE, WEST VIRGINIA

August 25, 1952
3:15 p.m.

Mr. Quenon:

Mr. Vickers called to report that while he was in Mercer county he stumbled up an accident which had just happened. A man and his 10-year old son were at an old strip job getting coal for their personal use when the highwall fell and killed the boy instantly. The father was butchered up pretty badly. Mr. Vickers called the Bluefield Sanitariam but the man was in the X-ray room at that time and could get no information.

Mr. Furin informed him that if he were sure the persons were trespassing that a letter report would be all that was necessary. He said he had the information and would submit a letter report in order that we could transmit to the proper individuals.

Dixon

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Trolley locomotives were used for primary and secondary haulage, and mine cars in the working place were handled by small electric hoists operated by the miners. During the last Federal inspection, the tracks and transportation equipment were in good repair, except that the brakes on some mine cars were defective; however, standing cars and trips were secured properly. Clearance was adequate, and shelter holes were provided at proper intervals. Drags were used on all trips ascending grades, and derail switches were installed at various locations along haulageways.

a 17-ton locomotive was used for gathering trips in the east main section, and a 6-wheel 22-ton locomotive, assisted by another 17-ton locomotive, was used to haul trips from the section to the surface. Two hoists were used to pull loaded cars from the faces of east main entries and 7 left entries, which were turned a short distance outby the faces of east main entries. The hoist used for pulling cars out of the east main entries was at a slight offset on the trolley-wire side of east main entry, and the hoist for the 7 left entries was at a crosscut on the clearance side almost directly opposite. Mine cars were of 2- or 3-ton capacity and were constructed of wood and steel. The trip involved in the accident was made up of 47 cars. The east main entry at the scene of the accident was about 15 feet wide, and clearance over the top of the rail was 54 inches. The track was laid to a 36-inch gage on a uniform grade of 3.7 percent. Clearance of 6 feet was provided on the side opposite the trolley wire, and clearance on the trolley-wire side was 3 feet. A derail switch was in the rail on the trolley-wire side 57 feet outby the hoist, and a second derail switch was in the same rail about 390 feet outby the first derail switch and about 190 feet outby 6 left.

Two types of drags were used on the rear of trips ascending grades; the type used by gathering crews was an iron bar provided with a regular mine-car link on one end so that it could be held by the coupling pin on the car; and the type used on main-line trips, known locally as a push drag, was an iron bar connected to a steel plate bent at a 90-degree angle and arranged so that the drag could be attached to the rear of a car and a locomotive used to push the trip without detaching the drag. The usual procedure for the brakeman on the gathering locomotive in east main was to remove the drag used on the trip when the trip was placed where the main-haulage locomotive was coupled to it and for the motorman on the locomotive used to push the trip to place the push drag on the trip before it was started.

According to one of the officials, a company rule requires that, when a hoist is installed along an entry where a shelter hole or crosscut is not near the hoist, and there is danger of a wreck occurring near the hoist, a shelter hole be provided at the hoist.

Information on events related to the accident was given by Alex Crerar and Joseph Summits, operators of the gathering and main haulage locomotives, respectively, William Skreshesky, brakeman on the gathering locomotive, and John Mastillo, coal loader and eyewitness, who was operating the hoist opposite the hoist the victim was operating at the time of the accident.

The investigating committee included the following persons:

Pennsylvania Department of Mines

Michael W. Thomas	Inspector, 24th Bituminous District

Berwind-White Coal Mining Company

Harry C. Crist	General Superintendent
Irvin Buchwalter	Division Engineer
Samuel Lehman	Mine Foreman
Mathew Sherwin	Company Inspector
Emanuel Crew	Night Foreman
Stephen Sherlock	Assistant Foreman
William Smith	Superintendent of Transportation

United Mine Workers of America

Ernest Greathouse	Safety Committeeman
John Knecht	Safety Committeeman

United States Bureau of Mines

S. A. Andrejko, Jr.	Federal Coal Mine Inspector

DESCRIPTION OF ACCIDENT

The gathering crew, consisting of Alex Crerar and William Kreshesky, had made their first trip into the east main section and had assembled the 47-car trip of loaded cars as follows: Seven cars were pulled from the east main and 7 left entries, the drag was placed on the rear car, the derail switch immediately outby the hoists in east main was opened, and the trip was pulled to 6 left; 7 cars were pulled from 6 left, coupled to the cars pulled previously, and the 14 cars were pulled to 5 left and left standing; and 33 cars were pulled from 1 left, 2 left, 3 left, and 4 left entries and pushed back against the standing cars at 5 left. All brakes on the cars were set, and 2 skids were placed under the wheels of a car near the middle of the trip to prevent it from running toward the face of east main. The brakeman then uncoupled the gathering locomotive from the trip, and the locomotive was moved into the entrance of the 4 left to await the

arrival of the main-line haulage locomotive. The 22-ton main-haulage locomotive, operated by Joseph Summits, arrived and was coupled to the trip, and, while awaiting the arrival of the 17-ton pusher locomotive, the brakeman walked to the inby end of the trip, took the drag off the last car, released all the brakes set on the trip, and walked back to the locomotive. The men waited for the pusher locomotive for about 20 minutes and, thinking that it might be some time before it arrived, decided to couple the gathering locomotive, which was still in the entrance to 4 left, to the 22-ton locomotive and move the trip toward the surface. The 22-ton locomotive was on the 4 left switch, and it was necessary to drop the trip back about half a car length to clear the switch. Before dropping the trip back, it was necessary to close the derail switch outby 6 left. Kreshesky stated his intention to do so but was told by Summits, the operator of the 22-ton locomotive, "You already made one trip down there, I will go back and close the derail switch." Alex Crerar then got in the cab of the 22-ton locomotive and, when Summits signaled that the derail switch was closed, released the brake on the locomotive. The trip had moved about 10 feet when it began gaining speed and Crerar attempted to stop it but was unable to do so. Summits and Kreshesky saw the trip getting away and hurriedly started setting brakes on the cars, but the trip had gained so much speed that they were able to set only a few of the brakes.

The run-away trip traveled about 430 feet before it stopped, and 9 cars went through the open derail switch and struck the hoist being operated by Mr. Gubete. The hoist was moved about 13 feet from its original position by the derailed cars, and the body of the victim was found 25 feet inby the hoist.

According to John Mastillo, Gubete was pulling a car out of his working place, when he (Mastillo) came out on the entry to pull out the car he had loaded. Mastillo noticed that the rope of the hoist operated by Gubete would not interfere with the rope of the hoist he was to use and started to pull a loaded car from his own place. He heard a rumbling noise, turned around and saw the first car of the run-away trip go through the open derail, called to the deceased, "Look out, Charlie," and ran into the crosscut. He waited a few minutes in the crosscut and, when everything seemed to be quiet, went out on the entry looking for Gubete. He found the victim's body along the "tight" side of the entry with his head under a derailed car and the rest of his body against the rib. It is believed that Gubete, who was standing at the outby side of the hoist, had attempted to run toward a crosscut inby the hoist.

The locomotive involved in the accident was examined and found in good condition. The brakes and sand rigging were in good working order.

CAUSE OF ACCIDENT

The fatality was the result of an error in judgment in attempting to drop a 47-car trip on a steep grade with one locomotive, when two locomotives ordinarily were used to pull the trip, with only two skids under the trip, and all brakes on the cars released. The derail switch being only 57 feet from the hoist did not provide sufficient protection for persons operating the hoist. It is believed also that this fatality would have been avoided if a shelter hole had been provided at the hoist.

RECOMMENDATIONS

Compliance with the following recommendations should prevent accidents of a similar nature.

1. Where derail switches are installed, they should be installed at a sufficient distance outby any point where men work to provide maximum protection.

2. Where the locomotives are inadequate to control the trip, sufficient skids or other adequate means should be used.

3. The company's rule requiring shelter holes at hoists should be complied with.

ACKNOWLEDGMENT

The cooperation of the company officials and employees, and of Michael W. Thomas, State Mine Inspector, during this investigation is gratefully acknowledged.

Respectfully submitted,

S. A. Andrejko, Jr.

/s/ S. A. Andrejko, Jr.

S. A. Andrejko, Jr.
Federal Coal Mine Inspector

FATAL ACCIDENT DATA

1. Daily employment 774 Time of accident: _____ a.m. 11:30 p.m.

2. General location of accident East main entry near 7 left.

3. Job when injured coal loader Regular job coal loader

4. Age 63 Years experience regular job 30 years In mines 33-1/2 years

5. Dependents: Widow X Number of children under age 18 1 Others _____

6. Method of loading in place where accident occurred: Mechanical _____
Hand into cars or conveyors into cars Other _____

Note: Items 7 to 14 should be included if the fatality results from a fall of roof, face, or rib.

7. Location: Face ____ Room ____ Haulageway ____ Idle Workings ____ Other _____

8. Type of permanent support in use at location where accident occurred:
Posts _____ Cross bars _____ Bolts _____ None _____

9. Type of temporary support in use in place where accident occurred:
Posts _____ Cross bars _____ Jacks _____ None _____

10. Did injury occur inby last permanent roof support? Yes _____ No _____

11. Distance from last supports to face: Permanent _____ Temporary _____

12. Was standard support plan adopted? _____ Was it followed in this place? _____

13. Last prior visit by mine official: Date _____ Time _____ a.m. _____ p.m.

14. Approximate dimensions of fall in inches: Length _____ Width _____
Max. thickness _____

Note: Items 15 to 19 should be included if the fatality results from a haulage accident.

15. Location: Main haulage road _____ Secondary haulage road X
Face area _____ Slope _____ Shaft _____ Surface _____

16. Direct cause run-away trip

17. Indirect causes Inadequate control of loaded trip

18. Contributing physical and/or mechanical hazards _____

19. Contributing unsafe practices Removing the drag off the rear car of the trip and releasing brakes on all loaded cars.