JOHN HENRY WRIGHT.

Jno. Henry Wright was born at Byers Green, county of Durham, Eng., March 3, 1885, and came to America in the year 1893. Was employed at the San Toy mine, Perry county, Ohio, October 22, 1906.

Mr. Wright was one of the six persons precipitated to the bottom of the shaft of the San Toy No. 1 mine, November 3, 1906, by the accident to the cage, and the only one who escaped with his life. Both of his limbs were broken, and he suffered other injuries from the accident. His escape from instant death was almost miraculous. A detailed account of this deplorable accident will be found on the opposite page, and also in Mr. Pritchard's report on page 295.

REPORT OF THE CATASTROPHE AT SAN TOY No. 1 MINE, PERRY COUNTY, BY THE CHIEF INSPECTOR OF MINES.

One of the most distressing, and absolutely unnecessary accidents, that has occurred at any mine in the state took place at the San Toy No. 1 Mine, owned and operated by the New England Coal Co., Columbus, Ohio, and located in Perry county, Ohio. The accident occurred on the third of November, in which six men fell off the hoisting cage, a distance of 125 feet, down the shaft. The hoisting shaft is 185 feet deep and is equipped with heavy iron automatic dump cages; they are large skeleton structures with very little protection along the sides, and, in consequence, a wooden crib or cage has always been placed on the iron cage for the safety of men and stock to be taken in and out of the mine. Outside of this wooden cage there is a clearance space of one foot, the iron cage being two feet wider and two feet longer than the wooden one. The wooden structure is a plain crib; four up-rights, boarded and braced along the sides, the ends being braced together with cross pieces at top and bottom; two drop-end gates are used, and dropped down at the surface landing, to bridge the space between the side of the shaft, and the cage so as to enable men and stock to walk on and off the cage with safety. The end-gates are constructed with ordinary boards horizontalwise, and upright cleats running from bottom to top of the gate, the cleats fitting between the up-rights of the crib. The gate is securely hinged on an iron rod or bolt running from outside to outside at the lower end of the up-rights of the crib. Near the top of the gate on each side a slot or opening is cut in the end of the board through which a staple securely fastened in the up-right of the crib projects when the gate is lifted in place; heavy iron pins, 5 inches long, fastened to the uprights of the crib by a permanent chain are dropped through the staple binding together the crib in such a manner that it would seem impossible for it to move. The up-rights of the wooden crib are also counter-sunk into the bottom of the large, heavy cage so as to prevent it from slipping or moving in any way. On the evening of November 3rd nine men started up the shaft in the wooden cage, but before reaching the top an accident occurred by which the end gate and one end of the wooden crib was broken and six of the men precipitated down the shaft, four being instantly killed, one dying soon after, and the sixth one miraculously escaping with broken limbs and other injuries.

The investigation by Jas. Pritchard and myself on the following day, and the evidence adduced at the coroner's investigation, shows that the cager at the bottom of the shaft securely fastened the end gates before giving the signal to the engineer to hoist the men, but by some

means unknown, purposely or accidentally, which, most likely, will never be known, the gate was opened and dropped far enough to come in contact with the shaft timbers, breaking the gate and one end of the wooden crib, and either throwing the men out or causing them to become so excited that they fell out and down the shaft.

The evidence given at the inquest by a number of reliable witnesses was that no previous accident had ever taken place in hoisting or lowering men, or that none of the iron pins had ever been known to become displaced; that the cager at the bottom was responsible to see that it was securely fastened before leaving the bottom, and that the top man was always there to open and drop the gate when the cage landed at the surface, and replace it when the men were out. It also developed that, without doubt, a very loose practice prevailed, and was evidently permitted, which was very liable to cause an accident of this character. It was stated by several witnesses that after the cage gate had been securely fastened, and a cage of men started from the bottom, it was known that some one in the cage would very frequently take the pins out of place, and hold the gate in their hands ready to drop it as quickly as possible, and bolt out as soon as the cage reached the surface landing; being Saturday evening, and men in a hurry to go home, it is more than likely that the lamentable occurrence was the result of this dangerous, unwarranted practice. Three of the men who started up from the shaft bottom on the illfated cage arrived safely at the top, but were unable to give any account as to the cause of the accident, simply stating that in their confusion they saw men falling off the cage and grabbing each other as they fell. A statement was made at the inquest by three boys that two days previous to the accident they were playing with the wooden crib standing on the surface at the shaft, and that in shaking it the iron pins shook out of place, inferring that they might have done so in the shaft and caused the accident.

Mr. Pritchard, the Inspector, returned to San Toy on November 5th, and had the old cage or crib fitted up just as it was when the accident occurred, and by vigorous shaking with several men failed to have any impression on the pins.

There is a second shaft opening and stairway at this mine, but on account of the depth and distance to travel down and up the stairs, the miners are lowered and hoisted in the main shaft.

This is one of the accidents from which convincing proof arises that proper means of ingress and egress ought to be provided in all mines independent of hoisting shafts and electric and high speed haulways. It is also a strong reminder that many deaths in mines result from the want of proper discipline and from the willful refusal and negligence of mine managers and companies to enforce the laws and orders of this Department enacted for the purpose of protecting the lives of those employed in them.