

# GOAL FATAL

1942 0005

Report of a Haulage Accident December 15, 1942; Laing No. 1 Mine;  
Laing, West Virginia; 5 Killed  
(From Bureau of Mines Report by William T. Rachunis and Warren  
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A disaster occurred, about 11:30 p.m., December 15, 1942, on a man car operating on a surface incline of the Laing No. 1 Dorothy mine, resulting in the death of 5 men and slightly injuring 6 others. The accident was caused by the sudden acceleration in the speed of the man car while 14 men were being lowered to the bottom of the incline; eleven of the 14 men jumped from the speeding car.

The surface incline, provided for transporting men and supplies to and from the mine level, extends from approximately the level of Cabin Creek to near the level of the mine openings into the mountainside. This incline is approximately 1,600 feet long, and the grade varies from 15 to 60 per cent.

The man-and-supply car is provided with a removable rack, equipped with seats, which is used when men are being either hoisted or lowered. The man car can accommodate a maximum of 15 men at a time. The 3/4 inch diameter hoist rope is attached to the man car by means of a clevis-type socketed coupling. There are two bridle or safety chains attached to the man car and to a clamp on the rope about 14 inches above the socketed coupling. An automatic stop or derailing device is not provided to stop the man car in the event the rope breaks above the safety- or bridle-chain clamp.

The hoist, installed on the top of the incline is operated by a gear-connected, 50-horsepower, 220-volt alternating-current open-type induction motor. A locomotive-type controller, which is fully enclosed and capable of being reversed, is provided. The hoist is equipped with a friction-type drive, and a hand-operated brake. There is no indicating dial on the hoist to show the position of the man car on the incline, and the hoist operator is not in position to see the man car except when it is near the top of the incline. The hoist is not equipped with automatic overwind, speed-control, or stop devices.

Telephones are installed at the bottom of the incline and in the hoist house, and are used to communicate with the hoist operator when men are being hoisted. There are no means of signaling the hoist operator from the man car or from intermediate points along the incline. When men are being lowered, an attendant is stationed at the top of the incline to see that the workmen get aboard the man car in an orderly manner. Each workman is given a brass check, which he presents to the attendant who is responsible for seeing that the men get aboard the man car according to their proper turn, and that too many do not ride at any one time. When the man car is loaded, the attendant signals the hoist operator by either waving his arm or calling "All right".

The accident followed the sudden acceleration in the speed of an incline man car on which the 14 men were being lowered.

The 14 men had completed their work in the mine and had been checked on the man car at the top of the incline, after which the attendant at the top had given the signal for the hoist operator to

lower them to the bottom. As the man car continued to gain speed for a distance of approximately 300 feet after leaving the top landing, the men evidently assumed that the man car was out of control and they began jumping off. An instant after the eleventh man had jumped off, the man car stopped momentarily, and 2 more stepped off. The man car then continued to move down the incline for a distance of about 100 feet to where it was derailed by running over one of the injured men who was on the track. At this point, which is approximately 400 feet from the top of the incline, the fourteenth or last man stepped off the man car after it had stopped.

The night shift hoist operator, who has had nine years experience operating hoists, had been hoisted up the incline, and had relieved the operator on duty a short time before the accident occurred.

Upon questioning, the hoist operator seemed to be somewhat confused as to just what had happened. However, it is evident that the friction or clutch drive of the hoist was disengaged. After receiving the signal to lower, the hoist operator released the brake and opened the controller without knowing the friction or clutch drive was disengaged. The hoist operator realized something was wrong when the speed of the hoist drum increased. He then applied the brake and stopped the drum momentarily after which the brake was released. The hoist operator stated that he did not think anything serious had occurred until he noticed there was slack in the hoist rope.