

## Grindstone Miner Killed At Banning

A mine accident at West Newton yesterday took the life of a Grindstone man.

Robert W. Murray, 36, of House 132, died instantly in a roof fall about 10:30 a.m.

The accident occurred at the Banning # Mine of the Republic Steel Corp.

According to mine officials, other workers in the section where the fall occurred escaped injury.

Born in Cardale, Mr. Murray was the son of Robert and Elizabeth Murray, Tower Hill 2.

He was a member of the Grindstone Christian Church, Banning Local, UMW, and the Grindstone Vol. Fire Dept.

In addition to his parents, he is survived by his widow, Christine; three daughters, Cynthia, Kathy and Susan, all at home; a brother, Duane Murray and a sister, Mrs. Darlene Endsley, both of Brownsville.

Friends will be received in the Skirpan Funeral Home, Brownsville, after 7 this evening. Funeral arrangements are incomplete.

1965 Robert Murray killed in Banning roof fall



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# COAL FATAL

UNITED STATES  
DEPARTMENT OF THE INTERIOR  
BUREAU OF MINES

Health and Safety District A

REPORT OF FATAL COAL MINE ROOF-FALL ACCIDENT  
BANNING NO. 4 MINE  
REPUBLIC STEEL CORPORATION  
NORTHERN COAL MINES DISTRICT  
WEST NEWTON, WESTMORELAND COUNTY, PENNSYLVANIA

March 29, 1965

by

J. W. Holcomb and Everett Turner  
Federal Coal Mine Inspectors

Originating Office - Bureau of Mines  
4800 Forbes Avenue, Pittsburgh, Pa. 15213  
W. Dan Walker, Jr., Acting District Manager  
Health and Safety District A

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INTRODUCTION

This report is based on an investigation made in accordance with provisions of the Federal Coal Mine Safety Act (66 Stat. 692; 30 U.S.C. Secs. 451-483).

On Monday, March 29, 1965, about 11 a.m., Robert W. Murray, cutting-machine operator, was killed instantly in a roof-fall accident. The accident occurred in an entry where bulkheads were to be erected between the old Banning No. 3 mine and the Banning No. 4 mine. The entry had been driven under the Youghiogheny River. Murray was 36 years old, married, and had three dependent children. He had 16-1/2 years mining experience, 11 years of which were operating cutting machines.

The Bureau of Mines office at Pittsburgh, Pennsylvania, was notified of the accident by the chief office clerk about 12 noon, Monday, March 29, 1965, and the investigation was started the same day.

GENERAL INFORMATION

The mine is opened by an 850-foot slope and 6 shafts, which vary in depth from 125 to 163 feet. Operations are in the Pittsburgh coalbed, which averages 96 inches in thickness in this area. A total of 336 persons was employed, of whom 268 worked underground and produced 5,390 tons of coal a day. The mine was operated 3 shifts a day.

During the last Federal inspection, completed February 5, 1965, Bureau-approved roof-control plans were complied with and the plans were considered adequate. Where conventional timbers were used, the plan required crossbars on 4-foot centers and safety posts or jacks in by the last crossbar when men were required to work in that area.

Where roof bolts were used the plan required the bolts to be installed on 4-foot centers lengthwise and on 4- and 8-foot centers crosswise. Bolts were installed through wooden crossbars or steel channels when installed 8 feet apart. Bolts were 5/8-inch-diameter high-strength steel, 6-1/2 feet long or long enough to anchor in hard shale, and were anchored with expansion shells. Embossed-steel bearing plates 1/4 by 6 by 6 inches were used.

In the area where the accident occurred, the roof had been supported with roof bolts installed through steel channels on 4-foot centers, and wooden crossbars, each supported by two roof bolts, had been installed between the steel channels. At the time of the accident, one steel channel and two crossbars had been removed and two bolts removed from a second steel channel. Four posts had been installed along the wide side of the track in the area where the channels and crossbars were being taken down.

Shear cuts had been made in the roof and ribs on both sides to depths of about 3 feet in preparation for the installation of bulkheads. The loose coal from the shear cuts in the ribs had been loaded out. The shear cuts in the roof on each side of the piece of roof coal involved in the accident had intersected at the back of the cuts and the rib coal had been removed underneath these cuts.

The investigating committee consisted of the following:

Company Officials

C. C. Virgin	Superintendent of Industrial Relations
L. S. Horne	Superintendent
A. B. Martinelli	Mine Foreman
W. K. Catney	Safety Supervisor
Frank Masney	Assistant Mine Foreman
J. Sabolek	Assistant Mine Foreman

United Mine Workers of America

G. Simboli	Safety Committeeman
I. Cavrak	do.
A. Gohasky	do.
Milton Stark	Cutting-Machine Operator's Helper

United States Bureau of Mines

J. W. Holcomb  
Everett Turner

Federal Coal Mine Inspector  
Federal Coal Mine Inspector

DESCRIPTION OF ACCIDENT

The workmen, who were preparing places for the erection of bulkheads between the old Banning No. 3 mine and Banning No. 4 mine, entered the mine at 8 a.m. After arriving underground where they were to work, Masney, the assistant foreman, held a safety meeting. Masney then examined the working places. Murray and Stark, after replacing some worn or broken bits in the cutter chain, proceeded to make some sheer cuts at No. 1 bulkhead location (main entry). Two other workmen went to the parallel entry (where the accident occurred) to install the post along the track and remove the roof bolts, steel channels, and crossbars. After they had installed the four posts and while attempting to remove bolts through the steel channels, Murray and Stark brought the cutting machine to the parallel entry. Murray parked the cutting machine just outby the location where the bulkheads were to be built. Masney, along with the other two workmen, went to the main entry (No. 1 bulkhead site). After examining the place and instructing the workmen to load out the loose material, he returned to the parallel entry. When Masney returned to the parallel entry, Murray was supporting the right end of a steel channel while Stark was removing a roof bolt from the left end of the channel. After the bolt was removed, Murray placed the channel across the track and Stark took the impact wrench to the next inby channel where a bolt in the end (right side) of the channel had to be removed before the channel could be taken down. Masney had moved along-side of Stark while Murray was standing near the front end of the cutting machine under a bolted channel. Reportedly, the only examination of the roof in this area, after the cutting machine was brought to the location, was a visual observation.

Stark could not reach the roof bolt with the wrench so he attempted to move a concrete block, with his foot, under the bolt so he could stand on it and loosen the bolt. Stark said he heard Murray say, "Wait a minute," and he and Masney heard a noise (the fall) but did not see it. They turned and saw the fallen material and Murray lying on his back. They removed the victim (employee) to a safe location and examined him but could not ascertain any sign of life. The victim was placed on a stretcher and taken to the surface where he was pronounced dead by Dr. A. H. King, Sr., at 11:55 a.m. Both Masney and Stark expressed their belief that Murray had moved under the unsupported roof to move the crossbar so that Stark could stand on it and reach the bolt, and that the roof fell without warning.

## CAUSE OF ACCIDENT

The removal of roof bolts, steel channels, and crossbars in an area that had been considerably weakened by the shearing of the roof, as much as 3 feet and the shearing of large offsets in the ribs (for the bulkheads), without providing adequate temporary supports, was the cause of the accident. The four posts set in the clearance space were not located so as to give maximum protection. The failure of the foreman and workmen to properly examine and evaluate the weakened roof condition was a contributing factor.

## RECOMMENDATIONS

Compliance with the following recommendations may prevent accidents of a similar nature:

1. The adopted roof-support plans that prohibit any person from advancing beyond the last permanent support, except those who are assigned to install temporary supports, should be strictly followed.
2. Permanent roof supports, such as roof bolts, crossbars, or channels, should not be removed unless equivalent protection is provided. Good evaluation of conditions should be made by all underground personnel before setting substitute or temporary roof supports.
3. Persons exposed to danger from falls of roof, face, or ribs should examine and test the roof, face, and ribs before starting work and at frequent intervals thereafter. A visual examination should not be substituted for a sound-and-vibration test but should be in addition to the accepted sound-and-vibration method of testing roof.

## ACKNOWLEDGMENT

The cooperation of the company officials and employees during this investigation is gratefully acknowledged.

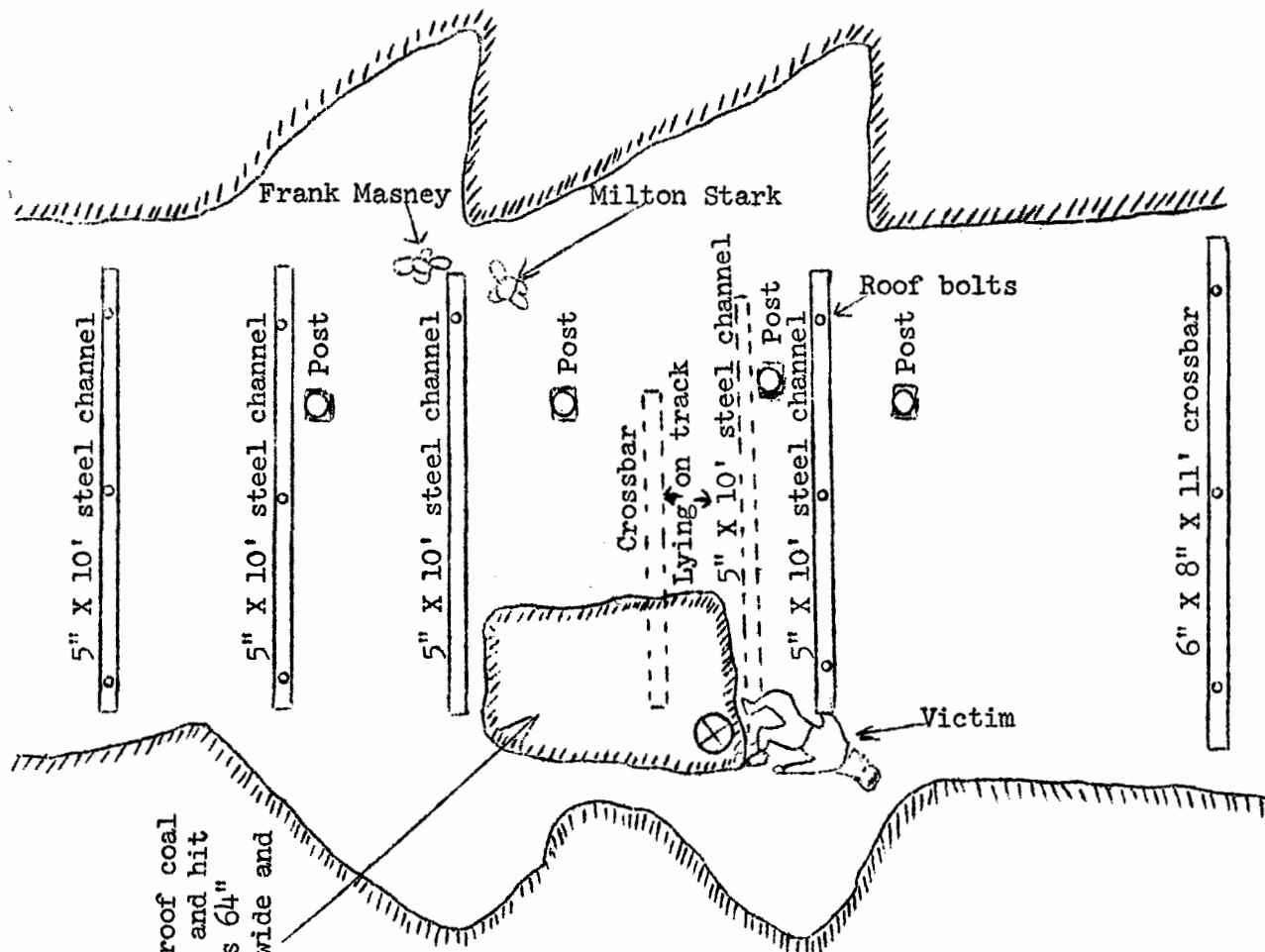
Respectfully submitted,

/s/ J. W. Holcomb

J. W. Holcomb

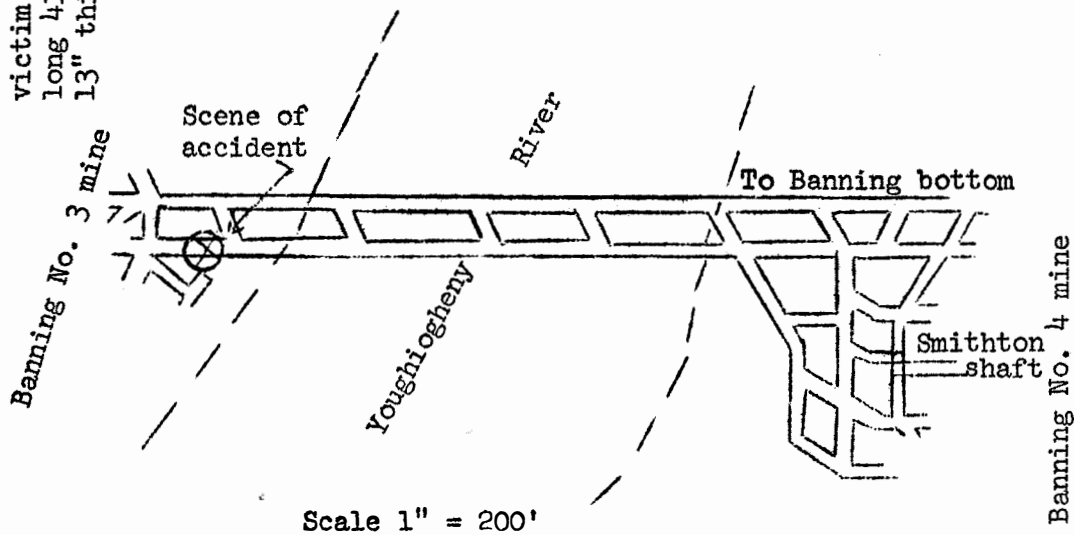
/s/ Everett Turner

Everett Turner



Piece of roof coal that fell and hit victim was 64" long 41" wide and 13" thick

Scale 1" = 4'



Scale 1" = 200'

Sketch of Scene of Fatal Coal Mine Roof-Fall Accident  
 Banning No. 4 Mine  
 Republic Steel Corporation  
 Northern Coal Mines District  
 West Newton, Westmoreland County, Pennsylvania

March 29, 1965