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UNITED STATES
DEPARTMENT OF THE INTERIOR
BUREAU OF MINES

Health and Safety District A

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REPORT OF FATAL COAL MINE ROOF-FALL ACCIDENT SAPPER MINE

MCGEE COAL COMPANY

NEWCOMER, FAYETTE COUNTY, PENNSYLVANIA

Code 0/19

December 9, 1966

by

E. M. Rudolph Federal Coal Mine Inspector

and

W. G. Cooper Federal Coal Mine Inspector (Roof Control)

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Originating Office - Bureau of Mines 4800 Forbes Avenue, Pittsburgh, Pa. 15213 W. Dan Walker, Jr., District Manager Health and Safety District A REPORT OF FATAL COAL MINE ROOF-FALL ACCIDENT
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INTRODUCTION

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

On Friday, December 9, 1966, at 11:30 a.m., Karl K. Kerwin, Jr., coal loader, was injured by a fall of roof rock at the intersection of No. 4 room crosscut and an old return airway off No. 1 butt in the Sapper mine. He died about 15 minutes later while being transported to the surface. Kerwin, age 56, had about 20 years mining experience, and was employed at the Sapper mine 8 months. He is survived by his widow.

The Uniontown office of the Bureau of Mines was notified of the accident by George H. McGee, mine operator, at 2 p.m. on the day of occurrence. The writers started an investigation shortly thereafter which was completed the following day.

GENERAL INFORMATION

The mine is opened by 2 slopes and a 22-foot shaft into the Pittsburgh coalbed, which averages 96 inches in thickness in the areas being mined. Employment was provided for 20 persons, of whom 18 worked underground and 2 on the surface. The average daily production of 125 tons of coal was loaded manually.

Present mining consists of the recovery of barrier and chain pillars along the main entries. The working places were driven about 12 feet wide.

The immediate roof is generally 12 inches of roof coal overlain with 10 inches of draw rock, 10 inches of wild coal, and about 10 inches of shale. The main roof is sandstone.

The minimum standards for roof support required crossbars to be set on 4-1/2-foot centers to within 4-1/2 feet of the working faces in pocket-and-wing recovery work. At least one safety post was required between the last permament roof support and each working face. In pillar splits, where normal roof conditions existed, one row of roadway posts was required on the clearance side on 4-1/2-foot centers to within 4-1/2 feet of the faces. Where abnormal roof conditions were present, a second row of posts was required on the tight side, or crossbars were required throughout. Breaker posts were required to be set in all openings to the gobs. In the No. 4 room crosscut (accident area) crossbars were installed 2-1/2 to 3-1/2 feet apart to within 2 feet of the old return airway connection. A safety post was set between the connection and the inby crossbar. The workmen were familiar with the timbering plan and proper methods of roof testing. Additional timbers were installed where roof conditions warranted and were set at the discretion of the workmen and mine foreman. The mine foreman last visited the working place about 10 a.m. and considered conditions normal. As a result of this fatal accident a roof-control resurvey was started during this investigation.

Information for this report was obtained from an investigation at the scene of the accident and from statements made by McGee, Mine operator, and Charles Steigers and Edward Stansick, timbermen. Both Steigert and Stansick were present when the accident occurred, but neither witnessed the occurrence.

The investigating committee consisted of:

McGee Coal Company

George H. McGes

Operator

United Mine Workers of America

Joseph Pisczczz

Representative, District No. 4

Pennsylveria Department of Mines and Mineral Industries

J. M. Muchnok

State Mine Inspector, 13th Bituminous District

United States Bureau of Mines

E. M. Rudolph W. G. Cooper

Federal Coal Mine Inspector Federal Coal Mine Inspector (Roof Control)

The last Federal inspection of this mine was made July 25, 1966.

DEXCRIPTION OF ACCIDENT

About 7 a.m., December 9, 1966, a crew of 18 men entered the mine to begin coal-loading operations. Kerwin, Steigert, and Stansick had been instructed by the mine foreman to timber, scale down loose roof material, and load the remaining gob material where No. 4 room crosscut intersected the old return entry off No. 1 butt (accident area). All had worked in No. 4 room crosscut the previous day and loaded five 2-ton cars of material. Steigert stated that he had personally scaled down all loose roof material prior to loading operations and in his opinion the place was safe.

Prior to loading operations on the December 9th shift, Steigert stated that they had installed the inby crossbar and again scaled down loose roof material in the old return airway. During this time, McGee had visited the area on three different occasions. His last visit was about 10:15 a.m. He stated that the conditions were normal and loose material was not observed and he considered the place safe. However, he suggested that another crossbar be installed and another safety post be set in the center of the old return entry.

After Kerwin had loaded two cars of the fallen material from the old return airway, the three men decided to eat lunch. About 11:25 a.m. Kerwin told Steigert that he would start back to work and prepare a place to set the safety post which the mine foreman had instructed to be set. Steigert stated that Kerwin acquired a coal shovel and proceeded toward the work area. No sooner had Kerwin entered the place when a fall of roof occurred. Both men looked toward the area in which Kerwin had entered and saw him lying on the mine floor with roof rock across both legs. They called to him but received no response. Steigert summoned other workmen to the area and telephoned to the surface to inform McGee of the accident. Kerwin was removed from under the fallen roof material, placed upon a stretcher, and transported to the surface where an ambulance awaited. Thence he was taken to the Uniontown Hospital where he was pronounced dead on arrival about 12:15 p.m.

It was the concensus of the investigating committee that Kerwin had apparently observed some loose roof material on the right side of the crosscut connection and while prying the material with the coal shovel was struck by the falling material. The height of the working place in the accident area was 13 feet (see sketch). A clay vein was observed in the coal rib. Two large pieces of slickensided rock that were reportedly lying on the victim's legs measured 18 inches wide, 18 inches thick, and 16 inches long. Smaller pieces of rocf rock were in close proximity to the accident area and had apparently been removed from the victim.

Injuries to Kerwin consisted of a crushed chest, multiple rib fractures, and compound fractures to both legs.

CAUSE OF ACCIDENT

Working inby the last permanent roof supports and attempting to pry down loose roof material with a coal shovel was the cause of this accident. Failure to evaluate properly dangerous roof conditions was a contributing factor.

RECOMMENDATIONS

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

- 1. No person should travel inby or perform any work under unsupported roof.
- 2. A thorough and complete examination of the mine roof, both visually and by the sound-and-vibration method, should be made at frequent intervals so that a true evaluation of the mine roof can be made.
- 3. When it is necessary to bar down loose material, only a bar of proper length should be used.
- 4. Extreme caution should be exercised where working places intersect abandoned areas and roof conditions have been subjected to weathering and/or deterioration.

ACKNOWLEDGMENT

The cooperation of company officials and employees, United Mine Workers of America, and the State mine inspector is gratefully acknowledged.

Respectfully submitted,

/s/ E. M. Rudolph

E. M. Rudolph

/s/ W. G. Cooper

W. G. Cooper

