

# COAL FATAL

Report of a Haulage Accident May 7, 1935; South Wilkes-Barre Colliery; Wilkes-Barre, Pennsylvania; 7 Killed  
(From Bureau of Mines report by R. D. Currie)

South Wilkes-Barre Colliery is an anthracite mine with two main shaft openings. No. 3 shaft, which is the main hoisting shaft, is 1005 feet deep to the Baltimore level. This shaft has 3 compartments, two of which are used for hoisting with balanced cages.

The 7 men who were killed are commonly called "Cagers" or foot men, whose duty it is to travel from one level to the other and place loaded cars on the cages and remove empty cars from the cages in the usual operation of hoisting coal from the mines. At the time of the accident, these 7 men were traveling on the cage from the Baltimore to the Hillman Vein, and had reached a point approximately 100 feet below the Hillman Vein when a piece of rock falling from somewhere above, struck the cage. The piece of rock destroyed the cage bonnet and apparently knocked 3 of the men off the cage to the sump below. Of the 4 men remaining on the cage, one of them apparently was not killed outright but died several hours later.

The piece of rock which fell and struck the cage dropped approximately 630 feet before striking the cage. This piece of rock is about 9x15x30 inches, and was apparently sand rock, this weighing about 175 pounds.

The outstanding feature of this shaft is the fact that 7/8 inch boards were used to line the east and west ends of the shaft, and these boards, provided no support and in no way added to the safety of the shaft. On the other hand, they made it impossible for shaft men to properly inspect the condition of the side walls of the shaft. A crew of shaft men inspect this shaft every night and take care of any repairs necessary to timber, guides, or side walls. This crew, consisting of a foreman and three regular men, who make a detailed report of the condition of the shaft in a special book provided for this purpose before going off shift, reported on the night prior to the accident that the shaft was in safe working condition.

The board lining is being removed from this shaft, and 2-inch lagging is being placed in the shaft at any points where spalling off is noted. This will make it much safer and more easily inspected. The lagging will undoubtedly add to the support of the loose shale and rock, whereas the board lining was only a blind to prevent the inspection of these hazardous conditions.

There is a change of formation at approximately the point where the piece of rock fell from the shaft, and a weathered shale underlies the sand rock bed from which the piece fell out. Undoubtedly if the board lining had not obscured the view of these conditions, it would have been observed by the shaft crew and could have been remedied.

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