

Coal Fatalities Re: Harness/Lines other Falls from Elevated Positions (1996-February 20, 2004)

COAL MINE FATALITY - On February 3, 2004 a 46-year old supervisor was fatally injured when he was thrown from the elevated bucket of a Simon-Telect 42-foot aerial bucket truck. The victim and two others were dismantling a building at the time of the accident. (STILL UNDER INVESTIGATION)

COAL MINE FATALITY - On June 9, 2003, a 49-year old supervisor with 29 years mining experience was fatally injured when he was thrown from the elevated bucket of a Simon-Telect 42-foot aerial bucket truck. The victim and two other miners were dismantling a de-energized electrical substation on the surface area of an underground mine. To secure a steel "I-Beam" structure, a nylon rope was attached between the bucket of the aerial lift and the steel structure. After the steel structure was disconnected from the substation, the rope broke, causing the aerial bucket to shift suddenly, throwing the victim out of the bucket. The victim fell 28 feet 11 inches to the ground. The steel "I-Beam" structure then rolled onto the raised frame of the aerial bucket truck. Best Practices. Use appropriate fall protection, including safety harnesses and safety lines, where there is a danger of falling; use equipment for its intended purpose and within the design specifications of the manufacturer; conduct pre-operational checks on equipment prior to operation and ensure that outriggers and equipment are ready for intended use; size ropes/slings for maximum load applications and protect them from being cut when a load is applied; ensure that all workers are properly trained in the task to be performed, such as hoisting, rigging, equipment design capabilities, etc.

COAL MINE FATALITY - On Thursday, February 20, 2003 a 44-year old preparation plant operator with 25 years of total experience fell approximately 19 feet through a four-foot square opening in the upper level flooring at a conveyor drive station. He fell onto a conveyor tail pulley at a lower level of a surface facility. The flooring had been removed to allow materials to be lowered for construction work. The opening had been protected with nylon rope and flagging. The victim, a plant foreman, was aware of the work being performed. He was taken to the hospital for emergency medical treatment and died of his injuries at 3:00 a.m., Wednesday, February 26, 2003. Best Practices. Protect accessible floor openings with substantial railings or barriers to prevent falls of persons. Cover openings in floors with substantial material when the opening is not in use. Always use fall protection equipment, safety belts and lines, when working near openings where there is a danger of falling. Establish procedures and train personnel in procedures for removing, protecting, and replacing flooring during construction or maintenance.

PA 8/13/02 At approximately 3:00 a.m., a 66-year-old highwall drill operator was fatally injured when he fell twenty-three feet off the edge of a highwall. The victim was walking from his truck along the drill bench to his highwall drill in dark and foggy conditions when the accident occurred. The victim was able to call for help using a cell phone. The victim was rescued, however, he later expired as a result of injuries. Best Practices. Provide and use appropriate lighting in work areas after dark. Establish and use designated travel-ways to travel to and from work areas. Always be aware of your surroundings and any hazards that may be present.

WY 3/14/01 A 58-year old preparation-plant utility man, with 27 years experience, was fatally injured while he was performing clean up duties at a raw coal reclaim dump area. The victim was last seen at about 7:00 p.m., washing down a concrete pad at the mouth of a reclaim tunnel. There were no eyewitnesses to the accident. However, the victim either fell through an opening, measuring approximately 56 inches by 80 inches, in a platform located at the mouth of a reclaim tunnel, or entered the area through a coal feeder opening located in the raw coal stock pile. The victim was later discovered after being discharged from a raw coal silo. Best Practices. Enclose all openings over conveyor belts that have the potential for a person to inadvertently fall through onto a moving conveyor belt. Establish safe work positions free of fall hazards for persons performing wash down of surface facilities.

AL 8/29/01 At approximately 3:40 PM, an accident occurred which resulted in fatal injuries to a contract employee at the Coal Preparation Plant. An ironworker/welder was performing work on the 5th floor of the plant when a sixteen (16) by four (4) foot section of the concrete floor from which he was working collapsed, causing the miner to fall thirty four (34) feet to the 2nd floor. Demolition of existing structure to install upgraded equipment was being performed in preparation to connect the structural beams for a new addition to the plant when the accident occurred. Best Practices. The integrity of elevated surface structures should be examined both visually and physically before any work is performed on the structure. Safety belts and lines should be worn to secure persons at any location where a hazard of fall may exist. Work place examinations should be made by a competent person to

identify hazards associated with demolition and construction. Demolition of structures should be performed in a manner using sound engineering and construction techniques and processes.

KY 11/27/01 At approximately 8:15 PM, an accident occurred which resulted in fatal injuries to the Plant Operator at the coal preparation plant. The plant operator was working on the sixth floor of the preparation plant with a co-worker, attempting to hang a chain hoist to a hoist track. They were attempting to attach the hoist to the hoist track in an open doorway. One safety bar was installed across the doorway and while lifting the hoist, it was dislodged. While attempting to attach the hoist, it was dropped and subsequently the victim slipped and fell approximately 101 feet to the ground. Best Practices. Safety belts and lines should be worn to secure persons at any location where a hazard of fall may exist. Protect and guard all openings through which persons may fall. Keep work areas clear of all extraneous materials and other stumbling or slipping hazards.

WV 3/2/00 At 10:30 a.m. a fatal fall of person accident claimed the life of a 47-year-old electrical contractor. The accident occurred in the Preparation Plant on top of the raw coal classifying cyclone sump where the victim was attempting to remove electrical conduit that had been previously installed over the operating sump. The cyclone was covered with a 10 gauge perforated metal covering. Although there were no eyewitnesses to the accident, the victim apparently stood on the metal covering while he was performing this work. The metal covering gave way and the victim fell through the covering into the operating raw coal classifying cyclone sump, which resulted in fatal injuries. Best Practices. The integrity of surface structures should be examined both visually and physically before any work is performed on the structure. Safety belts and lines should be worn to secure persons at all work locations where a hazard of falling may exist.

KY 3/2/01 A 56 year old bulldozer operator, with 37 years mining experience, slipped and fell while exiting the operator's compartment of a Model 355 Komatsu bulldozer. The victim apparently lost his footing and fell approximately 6 feet to the ground. The victim received injuries to his neck and was immediately transported to a nearby hospital and later to the University of Kentucky Medical Center where he was treated for the neck injuries and was subsequently released. The victim's condition deteriorated and on September 23, 2000, seventeen days after the initial accident, he was re-admitted to the hospital where he died that same day as a result of complications deriving from what is believed to be a blood clot. Best Practices. Always use handrails when mounting or dismounting equipment with elevated work stations. Always make sure of foot placement on elevated surfaces before dismounting equipment or exiting operator's compartments. Always maintain 3 points of contact (two hands and one foot or two feet and one hand) when climbing onto or dismounting equipment.

VA 12/5/00 At 10:02 a.m., a 45-year-old environmental monitoring technician, with 20 years mining experience, sustained fatal injuries from a fall while he was in the process of readying equipment to collect samples from the exhaust emission stack of a thermal dryer. The victim was preparing to lift sampling equipment with a rope, onto a platform located 134 feet above ground level. As he was removing ice from the platform with his feet, a 24" x 28" section of grating on which he was standing collapsed, causing him to fall to the ground. The grating was severely corroded, and broke where it contacted a support beam, near the exhaust emission stack. Best Practices. Travel-ways and platforms at surface installations shall be of substantial construction and maintained in good condition. Examine travel-ways and platforms both visually and physically before walking or standing on them. Always position yourself in a safe location when removing ice or debris that may conceal a hazardous travel-way condition. Even if areas are not traveled frequently, they should have periodic inspections by a certified person to eliminate hazardous conditions.

VA 12/9/00 On Saturday, December 9, 2000, at approximately 10:50 a.m., a 55 year old truck driver, with 26 years experience, sustained fatal injuries after falling from the bed of a loaded coal truck. The victim had parked his fully loaded coal truck on a haul road approximately two miles below the mine site. He then climbed into the bed of his truck, and began throwing off some of the rock from the top of the load of coal. The victim apparently lost his balance and fell 10 feet from the top of the truck bed onto the haul road, striking his head. There were no eyewitnesses to the accident. Best Practices. Truck drivers should assure that material is properly loaded into the truck bed to preclude the need for climbing into the truck bed to manually rearrange the material. Never climb into a loaded truck bed to manually level or remove material except at a properly designed location or structure where safety belts and lines, or the equivalent, may be used.

AL 5/7/99 An electrician fell through an unguarded 26 inch by 26 inch opening at the top of a 36 inch diameter escape/ventilation shaft on the southeast side of the underground coal storage bunker. The victim was washing the area with a high-pressure hose. There were no eyewitnesses to the accident. The victim was discovered by a co-worker on a platform thirty feet and six inches below the top of the shaft. The victim received multiple injuries and was pronounced dead at the scene by a physician. Best Practices. Protect and guard all openings through which persons or material may fall. Areas where persons are required to work or travel should be kept clear of all extraneous material and other stumbling or slipping hazards. Regulate line pressure on water hoses to a safe and manageable working pressure. Provide training to every person to recognize hazardous conditions in their work area.

KY 9/3/99 A preparation plant mechanic and another employee were using a material hoist to lift a 55-gallon drum to the third floor of the preparation plant. When the mechanic reached out to guide the suspended drum to the third floor, a corroded railing gave way and he fell approximately 50 feet to the ground floor of the preparation plant. Best Practices. Safety belts should be worn at all times where a danger of falling exists. Tag lines or other devices should be used to guide suspended loads during hoisting operations. Metal railings, walkways and stairs should be examined frequently for corrosion or other signs of deterioration.

WV 1/24/96 On Wednesday, January 24, 1996 an employee of a coal company whose occupation was a riverman, was assisting a towboat operator with the capture of a loaded barge at the coal company's river load-out facility. Working from the bow of the towboat, the river man was throwing a line onto the timberhead of the coal barge, when he fell forward into the water between the towboat and the coal barge and sustained fatal crushing injuries.

IL 5/17/96 At about 11:45 p.m., a shift foreman was checking on a shaft sinking crew installing steel plating, doors, and grating over a shaft on the shaft collar. The foreman walked onto the steel structure, traveled across the steel doors over the shaft, and as he stepped off the steel structure towards the shaft collar, the foreman fell into a shadowed opening between the collar and the structure. The foreman fell 140 feet to the work deck located at the shaft bottom.