

1344

DUNNAM, 1985

530-01-248

SEP 26 1985

Joseph J. D'Lugosz, Hydrologist
Geological Investigations Branch
Waste Management Project Office
Nevada Operations Office
U.S. Department of Energy
Post Office Box 14100
Las Vegas, NV 89109

ACTION AKM PD
INFO _____
R.F. _____
AMA _____
AME & S _____
AMO _____

ACCIDENT EXPERIENCE "G" & "N" TUNNELS, NEVADA TEST SITE

As you requested, we have researched the accident experience for the past ten years for "G" & "N" Tunnels at the Nevada Test Site (NTS) and find no accidents that could be considered caused by, or related to, unstable ground, faulty or such geologically related conditions. In fact, I don't recall over the past 20 years any incidents or accidents that could be directly attributed to geological conditions.

To support our finding, I am attaching copies of (11) injury reports that are connected to the above tunnels and period. These represent the most serious (disabling) injuries. The details of a December 30, 1975, injury to a Sylvian B. Gilbert, Fork Lift Operator, is not available since Mr. Gilbert terminated employment and his personnel file is inactive. It is known that Mr. Gilbert suffered a fractured right leg, and since he was a fork lift operator, in all probability his accident occurred at the portal where fork trucks are utilized.

Only one case relates to an incident that is peculiar to mining or tunneling. It occurred on August 2, 1983, to Felix E. Romero when a slab of rock fell out of the back (ceiling) and struck him. It must be pointed out, however, that Mr. Romero was in the process of rock bolting the unsupported portion of the tunnel that had been mined the previous shift. Rock bolting is part of the standard procedure for tunnel support and, while every effort is made to bar down (pry loose) loosened slabs to lessen the danger, some do go undetected. This is recognized as a hazard of the trade.

ACTION _____
CC: D'LUGOSZ
CC: _____
CC: _____

Joseph J. D'Lugosz
530-01-248
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If I can be of further assistance, please contact me at 295-7400.

ORIGINAL SIGNED BY
COLLIN W. DUNNAM

Collin W. Dunnam, Manager
Occupational Safety & Fire
Protection Services

CWD:QWG:MT02H:pg

Enclosures
As stated

H. D. Edwards THRU W. G. Flangas

C. W. Dunnam Original Signed
(W. DUNNAM

August 8, 1983

LOST TIME INJURY - [REDACTED]

[REDACTED] was injured when he was struck and knocked to the ground by a slab of rock which fell out of the back in the N17 drift of U12H in Area 12.

FINDINGS:

1. Occupational Safety was notified on the Las Vegas pager at 1756 hours.
2. [REDACTED] was standing on a 10' step ladder when the slab fell and struck him. As he fell, his head hit the boom of the jumbo; he then landed on his back on the bottom of the drift.
3. [REDACTED] was with a crew rockbolting a portion of the drift that had been left unsupported by the day shift. (Eight to ten feet of ground was unsupported.)
4. The ground in the area was known to be "slabby". After the drift was opened and the ground sat unsupported, it began to pop under pressure and slabs broke away and fell.
5. [REDACTED] was taken on a stretcher from the accident location to the portal, where he was turned over to Medical.

CONCLUSIONS:

1. The direct cause of this injury was the fall of the slab.
2. The open drift was left too long before ground control was attempted.

RECOMMENDATIONS:

1. Miners, shifters, tunnel walkers, and supervision should be reoriented with CFR30, Part 57, Section 57.3-22, "Miners shall examine and test the back, face, and rib of their working places at the beginning of each shift and frequently thereafter."
2. All open ground should be supported by rockbolts as soon as possible after an area is exposed.

H. D. Edwards THRU W. G. Flangas
August 8, 1983
LOST TIME INJURY [REDACTED]
Page 2

3. Safety meetings should be held frequently using this accident and proper ground control as a subject.

Please let me know by August 22, 1983, what action has been taken on our recommendations.

CWD:AJL:cah

cc: H. D. Cunningham, M/S 555

1. PATIENT'S HOME ADDRESS [REDACTED]	2. UNION AFFILIATION Leborer	3. DATE OF REPORT 6-2-83
4. PATIENT'S HOME TELEPHONE [REDACTED]	5. HOME TELEPHONE (ALAMO) [REDACTED]	6. COST CENTER 543-014 MINER
7. FULL NAME & ADDRESS OF EMPLOYER Reynolds Elect & Engr Co Inc P.O. Box 14400 Las Vegas, Nv 89114	8. SOCIAL SECURITY NO. [REDACTED]	

9. LOCATION IF DIFFERENT FROM MAIL ADDRESS - EMPLOYER	10. MARITAL STATUS [REDACTED]	11. SEX [REDACTED]
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12. OCCUPATION Miner	13. SHIFT Night	14. STATE IN WHICH HIRED Nv	15. HOW LONG EMPLOYED WITH COMPANY IN NEVADA 1 yr	16. PATIENT'S BIRTH DATE [REDACTED]
18. PLACE OF ACCIDENT N Tunnel	SPECIFIC LOCATION	AREA 12	NTS <input checked="" type="checkbox"/> NTS LV <input type="checkbox"/>	18. DATE OF ACCIDENT 6-2-83

21. DESCRIBE ACCIDENT: Name body part(s) injured and the object or substance involved. Describe events and specific actions which resulted in the injury or occupational disease.

While hooking up a flat car to a engine on the train my finger got caught by the pin on the hookup.

22. DID INJURED REPORT ACCIDENT TO MEDICAL AT ONCE YES NO (EXPLAIN)

23. DID HE REPORT ACCIDENT TO HIS SUPERVISOR NO YES NAME Cecil Reed DATE 6-2-83 TIME Immediately

24. WERE THERE WITNESSES TO ACCIDENT NO YES (Give Names) Name unknown

25. DID ACCIDENT OCCUR ON COMPANY TIME AND WHILE AT REGULAR WORK NO YES

26. DID ACCIDENT OCCUR ON EMPLOYER'S PREMISES NO YES

27. LIST NUMBER OF PERSONS, INCLUDING AGES, RESIDING IN USA WHO ARE DEPENDENT UPON YOU FOR SUPPORT

NO. OF DEPENDENTS [REDACTED] AGES [REDACTED] SPOUSE'S FIRST NAME [REDACTED]

28. I CERTIFY THE ABOVE IS A TRUE STATEMENT IN ORDER TO OBTAIN THE BENEFITS OF THE NEVADA INDUSTRIAL INJURY & OCCUPATIONAL DISEASES ACTS. (Patient's Signature) [REDACTED] Date 6-2-83

29. PLACE OF FIRST TREATMENT Area #12 Medical	DATE 6-2-83	31. HOUR IN 0025 OUT 0030	32. OSHA RECORDABLE <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES
PLACE OF SECOND TREATMENT Mercury Medical	DATE 6-2-83	IN 0120 OUT 0200	DATE RECORDABLE 6-3-83

DO NOT FILL IN BELOW WHEN REFERRING PATIENTS TO OTHER N.T.S. MEDICAL FACILITY

33. DIAGNOSIS (Give Type) Wound, contusion & laceration of rt. middle & ring finger	34. TREATMENT 1. examined 2. hemorrhage controlled 3. 75mg Demerol IM 4. Ice packs
--	--

35. X-RAY TAKEN: YES NO FINDINGS: At SNMH

36. FROM THE INFORMATION RECEIVED ABOVE CAN YOU DIRECTLY CONNECT THIS ACCIDENT AS JOB INCURRED NO YES

37. REFERRED OFFSITE TO (Physician's Name & Address) [REDACTED] Las Vegas Nv

38. DID ANY PREVIOUS INJURY OR DISEASE CONTRIBUTE TO THIS INJURY NO YES (Explain)

39. TREATED BY (Physician's Name & Address)

40. DOES THIS INJURY APPEAR TO HAVE POSSIBLE FUTURE COMPLICATIONS NO YES (Explain) Unknown

41. HOSPITAL (Name & Address)

42. DEGREE OF DISABILITY	FULL DUTY DAYS	LIGHT DUTY DAYS	NO DUTY DAYS	43. DATE LAST WORKED 10 days	44. DATE RETURNED TO WORK
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Reynolds Electrical & Engineering Co., Inc.

MEMORANDUM

To H. D. Edwards THRU W. G. Flangas *WGF*
From C. W. Dunnam *C.W. Dunnam*
Date October 8, 1982
Subject EYE INJURY [REDACTED]

[REDACTED] in the extensometer drift, G-Tunnel Complex, [REDACTED] sustained an injury to his right eye when he was struck by the end of a wire hanger. The hanger was used to hold a two-inch air hose and a one-inch water hose to the rib of the drift.

[REDACTED] was attempting to lower the hoses and unhooked one end of the hanger. The hoses fell and the hanger flipped out and the end struck him in the eye.

FINDINGS:

1. The accident was reported to Occupational Safety.
2. [REDACTED] was performing a routine job.
3. [REDACTED] was not wearing eye protection.
4. [REDACTED] was a shifter at U12-G.
5. The hanger and hoses were approximately 6½ feet above the bottom of the drift.

CONCLUSIONS:

The weight of the falling hoses caused the free end of the U-shaped hanger to flip out in one quick motion.

Eye protection (safety glasses) would have prevented the end of the hanger from hitting [REDACTED] eye.

RECOMMENDATIONS:

1. Supervisors should enforce Safety Code P-9 in all underground areas and surface support areas of every tunnel complex.
2. A safety meeting should be held as soon as possible, reviewing the cause of this injury and possible prevention through use of proper eye protection.
3. Safety meetings on Safety Code P-9 and the advantages of eye protection should be held at frequent intervals.

Please let me know by October 25, 1982 what action has been taken regarding these recommendations.

Reynolds Electrical & Engineering Co., Inc.

MEMORANDUM

To H. D. Edwards THRU W. G. Flangas *WGF*
From C. W. Dunnam *C.W. Dunnam*
Date January 5, 1982
Subject LOST TIME ACCIDENT - [REDACTED]

[REDACTED] in Area 12 at "N" Tunnel's No. 10 Bypass Drift, [REDACTED] rotary driller helper, FOD-DOD, fractured five (5) ribs and his right foot.

[REDACTED] had just finished cleaning out the mud tank and had walked over to the drill rod. He was standing beside [REDACTED] driller, watching the drilling operation. [REDACTED] for some unknown reason, reached over and came in contact with the rotating drill rod. At this point, the coveralls [REDACTED] was wearing began to wrap around the drill rod, pulling him towards it. When the slack in the coveralls was taken up, [REDACTED] began rotating with the rod. [REDACTED] made approximately two (2) revolutions around the rod before [REDACTED] got to the controls on the drill to shut it off.

At this point, [REDACTED] mine inspector who was present, freed [REDACTED] from the drill rod by cutting off his coveralls. While [REDACTED] went for help, [REDACTED] then got up and walked over to a core box, where [REDACTED] had him lay down until help arrived.

RECOMMENDATIONS

1. Working around moving shafts/rods should be discussed in safety meetings.
2. Drillers should make each drill helper aware of hazards on operating drills. This should be covered at the start of each shift.

CWD:FAS:sjb

cc: H. D. Cunningham
Central Files

Reynolds Electrical & Engineering Co., Inc.

MEMORANDUM

To W. G. Flangas THRU H. Runnels *HR*
From C. W. Dunnam *C.W. Dunnam*
Date March 16, 1976
Subject DISABLING INJURY [REDACTED]

On [REDACTED]
mechanic foreman in FOD/DOD, sustained an amputation of the tip end of his left middle finger.

FINDINGS

[REDACTED] was showing [REDACTED] (both of FOD/DOD) how to operate the concrete blending machine. [REDACTED] was standing on the opposite side of the machine out of their view. [REDACTED] stopped the machine and [REDACTED] reached into the measuring wheel to see if there was any material in the wheel. At this time, the machine was started thus catching [REDACTED] left middle finger between the measuring wheel and the housing.

CONCLUSION

The concrete blending machine was not tagged and locked-out in conformance with REECO Safety Code P-13.

Please let me know by March 30, 1976, what corrective action has been taken to prevent recurrence of similar incidents.

CWD:DRE:cm



Reynolds Electrical & Engineering Co., Inc.

MEMORANDUM

To W. G. Flangas THRU *W. G. Flangas*
 From G. W. Dunnam *G. W. Dunnam*
 Date February 2, 1978
 Subject PERSONAL INJURY [REDACTED]

On Thursday, [REDACTED] in the by-pass drift at U12N tunnel, a twenty-five foot section of 4" concrete placement hose ruptured while under pressure during a pump-cleaning operation, causing the hose to strike [REDACTED] both miners assigned to FOD/DOD. [REDACTED] sustained injuries to both ankles as a result.

Industrial Safety has completed a preliminary investigation. A group consisting of representatives from FOD/DOD and Industrial Safety is investigating the incident in more detail.

FINDINGS

1. A concrete pour had been made in the by-pass drift prior to the incident. The hose ruptured after the pour had been completed and while operations were underway to clean the remaining concrete from the pump and from one section of hose used in the pour.
2. [REDACTED] a shifter who was working on the crew that made the pour, states that the twenty-five foot section of hose which ruptured had not been used to make the pour.
3. The section of concrete placement hose which ruptured had been coupled to a section of hose already attached at the pump and used on the pour. The additional length of hose was added in order to reach the Moran car so the remaining concrete could be pumped back into the car.
4. The concrete pump being used was #77531 "Pump-It" Model 100N. The pump has less than eighty hours of use.
5. The concrete pump is set to 4,000 p. s. i. of hydraulic pressure which would deliver a maximum discharge pressure at the pump of 700 p. s. i. The relief valve on the pump is set at 5,000 p. s. i. of hydraulic pressure making discharge pressure in excess of 900 p. s. i. impossible.
6. The 4" concrete placement hose is rated by the manufacturer at 500 p. s. i. working strength and 2,000 p. s. i. bursting strength.

*Copy
 Aeylan
 and
 Dale
 Sarge
 Famer*

W. G. Flangas THRU D. L. Fraser
February 2, 1978
PERSONAL INJURY...
Page 2

7. The discharge nozzle on the concrete pump has a 6-1/2" diameter. Two metal reducing fittings were attached to the pump to obtain the required 4" diameter coupling for the hose.
8. A Safety Engineer was at the location minutes after the incident occurred, but was not informed that there was an injury involved. Upon returning to the location, all involved equipment and personnel had been moved.
9. Concrete hose is normally stored inside the tunnel away from sunlight. The hose is several years old however visual inspection revealed no signs of undue or excessive wear or abuse.
10. FOD/DOD has written guidelines for safe concreting procedures to be followed in making a pour and cleaning the equipment and hoses.
11. The section of hose which ruptured had not been inspected prior to use to locate a possible blockage.

CONCLUSIONS

1. There may have been an obstruction in the hose itself which caused excessive pressure buildup in the system.
2. Due to the fact that the ruptured section of hose had not been used for the pour and was not slicked up, the viscosity of the concrete may have been too great to allow the concrete to flow easily. The resulting friction inside the hose coupled with the pressure moving the concrete may have created enough excess pressure to rupture the hose.

RECOMMENDATIONS

1. When incidents like this occur, Industrial Safety should be notified immediately and the area should be secured so that a timely investigation can be conducted.
2. FOD/DOD guidelines for safe procedures in concrete pouring, as written August 21, 1970, should be followed.

Please let me know by February 24, 1978 what action has been taken regarding these recommendations.

H. D. Edwards THRU W. G. Flangas

for C. W. Dunnam ORIGINAL SIGNED BY
F. J. STEPHENSON, JR
March 7, 1984

LOST TIME INJURY [REDACTED]

On [REDACTED] in the main drift of U12n, [REDACTED] a tunnel walker assigned to F00-D00, was seriously injured when he was struck by a derailed flatcar-mounted Bean grout pump.

FINDINGS:

1. The accident was reported to and investigated by Occupational Safety.
2. The train was traveling into the tunnel.
3. The train consisted of four pieces of rolling stock in the following order (front to rear): car #501015, with Bean grout pump #74459 permanently mounted; flatcar #72701; locomotive #72151; and man car #72796.
4. The locomotive operator was [REDACTED] and the sweeper was [REDACTED].
5. The frame of the pump car was 5 ft. wide and 12 ft. long. The wheelbase was 60 in. long. The rear coupler, coupled with the flatcar, was not the proper coupler for the hitch (see attached Inspection Report). The top of the broken coupler pin was found on the left side of the drift about 5 ft. from the point of impact with the water pipes and where Gray was struck. This coincides with the position of the Bean pump car coupler at the time of impact. The remaining part of the pin was found in the coupler and was bent in the bottom section.
6. The Bean pump car derailed to the right, and the right front corner struck the 30 in. vent pipe running along the right side of the drift at Station 13+90. The right front corner of the pump car caught against a vent pipe connection and jammed the pipe flat against the rib. The rear of the car swung to the left, hit Gray on the right leg, impinged the leg between the corner of the car and the chilled water line, where it came to a stop. The front of the flatcar derailed and swung to the left with the rear of the pump car. The rear of the flatcar swung to the right and derailed with the front of the locomotive. The rear wheels of the locomotive stayed on the rails.

H. D. Edwards THRU W. G. Flanagan
March 7, 1984
LOST TIME INJURY [REDACTED]
Page 2

7. [REDACTED] was walking toward the portal on the left side of the drift. The light string was on the right side of the drift. Generally, those working underground are oriented toward walking on the lighted side.
8. There was a 16 in. rise in the track between Station 12+36 and 12+66. At Station 13+05 there was a low spot in the left rail of the track, approximately 4 in. below the right rail. The track was 36 in. wide from center-to-center of the rails. At the point of impact the right rail was 22" from the vent line. This placed the corner of the pump car 10 in. from the vent line when the wheels were on the track.
9. The drift was 9 ft. wide from the vent pipe to the water and air service pipes on the left side.
10. At the time of the investigation, the train had been backed up 10 ft. to release [REDACTED] and clear a way for him to be removed from the accident scene.
11. [REDACTED] supported [REDACTED] until the pump car was moved, freeing his leg. He then applied a tourniquet to [REDACTED] leg and gave him first aid until a stretcher was brought in and [REDACTED] was transported out of the tunnel.
12. An inspection of the locomotive, flatcar, and Bean pump car was ordered by Occupational Safety. Results of the inspection are attached.
13. The motorman and the tunnel walker ([REDACTED] the injured party) indicated that the train speed was not excessive. A WSI security inspector who witnessed the accident stated that, "The train seemed to be going too fast." He also stated that the Bean pump car was weaving prior to the derailment.

CONCLUSIONS:

1. The direct cause of the injury was the derailed pump car pinning Gray's leg against the 8 in. chilled water line.
2. The most likely accident scenario was as follows:
 - a. The sharp rise in the track and an already defective coupling caused the pump car to start weaving.

H. D. Edwards THRU W. G. Flangas

March 7, 1984

LOST TIME INJURY [REDACTED]

Page 3

- b. The low spot in the track allowed first the front wheel and then the back wheel on the left side to dip down.
 - c. This action caused the wheel on the right front of the pump car to become light and increase the swaying action.
 - d. As the right front wheel lifted high enough to clear the wheel flange, the swaying action pushed the front of the car to the right.
 - e. When the front of the car moved just 10 in. to the right, the corner caught the connecting rings on the vent line, causing the car to swing into the vent line.
 - f. The rear of the car was forced to the left, carrying the front of the flatcar with it.
 - g. When the front of the pump car contacted the right rib, it stopped abruptly and the rear continued to swing until it contacted the pipes on the left rib.
 - h. The car then stopped completely.
 - i. The flatcar coupler jammed into the pump car coupler, shearing the top of the pin.
 - j. The rear of the flatcar swung to the right as the front stopped against the pump car.
 - k. The rear of the flatcar derailed to the right and caused the front of the locomotive to derail to the right also.
3. Contributing factors were as follows:
- a. Track condition - Track conditions, especially the low spot in one track and the 16 in. rise in approximately 30 ft., were major contributing factors.
 - b. Train composition - Pushing two cars, with the heavier car leading, apparently helped create the forces which initiated the swaying and eventual derailment.

M. D. Edwards THRU W. G. Flanagan
March 7, 1954
LOST TIME INJURY - [REDACTED]
Page 4

- c. **Coupler condition** - The undersized and worn coupler and pin probably contributed to the weaving of the Bean pump car and created the forces which resulted in the derailment.

[REDACTED] was not walking on the lighted side of the tunnel, in conflict with instructions generally provided to underground workers. As an experienced underground supervisor [REDACTED] was not required to be on a specific side of the drift. His position was certainly not a factor in the derailment. He could have been injured walking on either side of the tracks. While [REDACTED] position was not apparently a contributing factor in this accident, the reason for his choosing the "nonrecommended" side is not clear.

5. The physical evidence and testimony fail to establish that the speed of the train was excessive or was a significant contributing factor, albeit the chances and consequences of derailment obviously increase with speed.

RECOMMENDATIONS:

1. Develop and implement a written, auditable program for track inspection and maintenance.
2. Develop and enforce written procedures for train operations to include, but not be limited to:
 - a. Train composition - To cover limitations on number and type of cars, and placement of cars in the train relative to each other and the locomotive; i.e., appropriate restrictions on pushing cars, placement of heavy cars, etc.
 - b. Train inspection and maintenance - With emphasis on running gear and couplers.
3. Verify that the lighted side of the drift is the recommended side for walking in and out of "H" Tunnel. If the lighted side is not the desired side, orientations to underground workers should be changed. If the lighted side is the desired side, all personnel, including REECo tunnel supervision, should walk on the lighted side.

H. D. Edwards THRU W. G. Flanagan
March 7, 1984
LOST TIDE INJURY [REDACTED]
Page 5

4. Conduct a safety meeting on proper makeup and operation of trains for all personnel involved.

Please let me know by March 21, 1984, what action has been taken regarding our recommendations.

OWD:AJL:ck

Enclosure
As stated

cc: H. D. Cunningham, w/encl., W/S 555

H. D. Edwards THRU W. G. Fleegas
Original Signed By W. G. Fleegas
C. W. Dunn

March 23, 1984

LOST TIME INJURY - [REDACTED]

On [REDACTED] in Area 12 at "G" Tunnel, a lost load from a flatcar resulted in a lost time injury to [REDACTED] a miner assigned to F00/D00. [REDACTED], motorman, and [REDACTED] sweeper, were transporting two 40 ft. sections of rail into the tunnel, when one of the rails swung to the right and contacted the right rib. The other end of the rail lodged itself between the frame and body of the muck car that [REDACTED] was riding in and upended it. In the course of these happenings, the door of the muck car opened and closed, catching [REDACTED] left foot and fracturing two metatarsals.

FINDINGS:

1. Accident was reported to and investigated by Occupational Safety.
2. The two flatcars were connected with a drawbar, so that the cars would be separated enough to support the rails.
3. [REDACTED] acting as the sweeper, was riding in a muck car at the front of the train, which is the proper position for this job.
4. The two rails being transported were not secured to the flatcar by any means.
5. Excessive speed does not seem to be a contributing factor.
6. Minor damage was incurred to the left vent line and to the right side of the track.

CONCLUSION:

It has been concluded that had the rails been secured on the flatcar by a binder, chain, or any other acceptable means, this accident could have been prevented.

H. D. Edwards THRU W. G. Flanagan
March 23, 1984
LOST TIME INJURY [REDACTED]
Page 2

RECOMMENDATIONS:

1. The tunnel superintendent should instruct his personnel on the procedures for loading, securing, and inspecting all loads going into the tunnel by train.
2. The tunnel superintendent should also review with his personnel the procedures for:
 - a. Tunnel Train Inspection and Operation
 - b. Tunnel Pedestrian Traffic
 - c. Tunnel Track Inspection
3. A disciplinary action policy should be formulated to ensure that the motorman and swamper comply with Safety Code T-16, paragraph 15, similar to the responsibility placed on truck drivers and crane operators.

Please let me know by April 6, 1984, the action taken in regard to the above recommendations.

CRD:FAS:ck

cc: Executive Office, N/S 555

H. D. Edwards THRU W. G. Flangas

C. W. Turner: Original Signed
C.W. DUNHAM

May 17, 1983

LOST WORK DAY CASE [REDACTED]

On [REDACTED] an extra heavy duty driver assigned to FOD-000, suffered a fracture of the facial bones when the handle of a chain binder struck him.

[REDACTED] had made a delivery to the Area 12 N-Tunnel portal area and was in the process of releasing the chain binders that secured the load to the truck. [REDACTED], in opening the binder, failed to stand clear as the binder lever sprung open. The handle portion struck him in the face, causing the fracture and laceration. He was immediately given medical attention but was referred to Sunrise Hospital. Subsequent examinations determined that surgery was indicated.

CONCLUSION:

It is obvious that [REDACTED] failed to stand in the clear when he opened the binder. Apparently, he performed the task without considering the dangers that he was well aware of.

RECOMMENDATION:

This case should be a subject of a safety meeting of those who have occasion to use load binders, cheater bars, and come-alongs.

CWD:QMG:cak

cc: H. D. Cunningham, M/S SSS

1. PATIENT'S NAME [REDACTED]				2. DATE OF REPORT 10-13-75	
3. PATIENT'S HOME ADDRESS [REDACTED]				4. COST CENTER 543-010 MUCK [REDACTED] MC	
5. PATIENT'S ADDRESS AT TIME OF INJURY Same as above				6. SOCIAL SECURITY NO. [REDACTED]	
7. FULL NAME & ADDRESS OF EMPLOYER Reynold's elec. & Eng. Co. Inc. P.O. Box 14400 Las Vegas, Nevada 89114				8. MARITAL STATUS [REDACTED]	
10. OCCUPATION muck machine operator	11. SHIFT d	12. STATE IN WHICH HIRED Nev	13. HOW LONG EMPLOYED WITH COMPANY IN NEVADA 10 yrs	16. PATIENT'S BIRTH DATE [REDACTED]	18. AGE 39
10. PLACE OF ACCIDENT (Specific Location & Area) or (Street, City & State) N tunnel, Area 12., Nevada Test Site			17. DATE OF ACCIDENT 10-13-75		
17. HOUR OF ACCIDENT 0820					
19. DESCRIBE ACCIDENT: Name body part(s) injured and the object or substance involved. Describe events and specific actions which resulted in the injury or occupational disease. " I was caught between the mucking machine and a rib of the tunnel. "					
20. DID INJURED REPORT ACCIDENT AT ONCE <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (Explain)					
21. DID HE REPORT ACCIDENT TO HIS SUPERVISOR <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES (Give Name, Date, Time) Massey					
22. WERE THERE WITNESSES TO ACCIDENT <input type="checkbox"/> NO <input type="checkbox"/> YES (Give Names) [REDACTED]					
23. DID ACCIDENT OCCUR ON COMPANY TIME AND WHILE AT REGULAR WORK <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES			24. DID ACCIDENT OCCUR ON EMPLOYER'S PREMISES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		
25. LIST PERSONS RESIDING IN U.S.A. WHO ARE DEPENDENT UPON YOU FOR SUPPORT					
NAME		RELATIONSHIP		AGE	
[REDACTED]		[REDACTED]		[REDACTED]	
[REDACTED]		[REDACTED]		[REDACTED]	
26. I CERTIFY THE ABOVE IS A TRUE STATEMENT IN ORDER TO OBTAIN THE BENEFITS OF THE NEVADA INDUSTRIAL INSURANCE & OCCUPATIONAL DISEASES ACTS. (Patient's Signature) [REDACTED] Date: 10-13-75					
27. PLACE OF FIRST TREATMENT Mercury Medical facility		28. DATE 10-13-75		29. HOUR 0930-1045	
30. OSHA REPORTA <input type="checkbox"/> NO <input checked="" type="checkbox"/> Y					
DO NOT FILL IN BELOW WHEN REFERRING PATIENTS TO OTHER N.T.S. MEDICAL FACILITY					
31. DIAGNOSIS (Give Type) lac. right lower leg, lac. below (L) patella, general 50 mg. @ A 12, Morphine sulfate 15 contusion to (R) femoral area, fx of anterior lacerations cleansed and dressed. [REDACTED] of left side of pelvis. RAMUS, Contusion R. kidney.			32. TREATMENT		
33. X-RAY FINDINGS RAMUS fracture of anterior [REDACTED] of left side of pelvis			34. FROM THE INFORMATION RECEIVED ABOVE CAN YOU DIRECTLY CONNECT THIS ACCIDENT AS JOB INCURRED <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		
35. DID ANY PREVIOUS INJURY OR DISEASE CONTRIBUTE TO THIS INJURY <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES (Explain)			36. REFERRED OFFSITE TO: [REDACTED]		
37. DOES THIS INJURY APPEAR TO HAVE POSSIBLE FUTURE COMPLICATIONS <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES (Explain)			38. TREATED BY (Physician's Name & Address) [REDACTED]		
39. HOSPITAL (Name & Address) SNMH			40. DATE LAST WORKED 10-13-75		
40. DEGREE OF DISABILITY		FULL DUTY DAYS		LIGHT DUTY DAYS	
NO DUTY		FATAL		41. DATE RETURNED TO	

REYNOLDS ELECTRICAL & ENGINEERING, INC. • P. O. Box 14400 • Las Vegas, NV 14 ACCIDENT INJURY REPORT

1. PATIENT'S NAME [REDACTED]		2. UNION AFFILIATION [REDACTED]		3. DATE OF REPORT 2-6-81	
4. PATIENT'S HOME ADDRESS [REDACTED]		5. HOME TELEPHONE [REDACTED]		6. COST CENTER 543-014	
7. FULL NAME & ADDRESS OF EMPLOYER Reynolds Elec & Eng Co Inc P.O.Box: 14400 Las Vegas, Nv 89114				8. SOCIAL SECURITY NO. [REDACTED]	
9. LOCATION IF DIFFERENT FROM MAIL ADDRESS - EMPLOYER				10. MARITAL STATUS 11. SEX [REDACTED]	
12. OCCUPATION miner	13. SHIFT day	14. STATE IN WHICH HIRED NV	15. HOW LONG EMPLOYED WITH COMPANY IN NEVADA 4 months	16. PATIENT'S BIRTH DATE [REDACTED]	17. AGE [REDACTED]
18. PLACE OF ACCIDENT "H" tunnel			19. DATE OF ACCIDENT 2-6-81		20. HOUR OF ACCIDENT 1430
21. DESCRIBE ACCIDENT: Name body part(s) injured and the object or substance involved. Describe events and specific actions which resulted in the injury or occupational disease. "Leaped off a ladder to avoid being hit by a piece of falling steel and landed on a rail with right foot. Fell approximately 2-3 feet." feet.					
22. DID INJURED REPORT ACCIDENT TO MEDICAL AT ONCE <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (EXPLAIN)					
23. DID HE REPORT ACCIDENT TO HIS SUPERVISOR <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES NAME Ron (last name unknown)				DATE 2-6-81	TIME 1431
24. WERE THERE WITNESSES TO ACCIDENT <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES (Give Names)					
25. DID ACCIDENT OCCUR ON COMPANY TIME AND WHILE AT REGULAR WORK <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES			26. DID ACCIDENT OCCUR ON EMPLOYER'S PREMISES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		
27. LIST NUMBER OF PERSONS, INCLUDING AGES, RESIDING IN USA WHO ARE DEPENDENT UPON YOU FOR SUPPORT NO. OF DEPENDENTS [REDACTED] AGES [REDACTED] SPOUSE'S FIRST NAME [REDACTED]					
28. I CERTIFY THE ABOVE IS A TRUE STATEMENT IN ORDER TO OBTAIN THE BENEFITS OF THE NEVADA INDUSTRIAL INSURANCE & OCCUPATIONAL DISEASES ACTS. (Patient's Signature) [REDACTED] Date 2-6-81					
29. PLACE OF FIRST TREATMENT Mercury Medical Facility		30. DATE 2-6-81	31. HOUR IN 1553 OUT 1625	32. OSHA RECORDS <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES DATE RECORDED 2-9-81	
DO NOT FILL IN BELOW WHEN REFERRING PATIENTS TO OTHER N.T.S. MEDICAL FACILITY					
33. DIAGNOSIS (Give Type) CONJUGATED FX. OF RT. CALCANEUS.			34. TREATMENT ACE WRAP ICE PACK TRANSPORTED TO S.H.M.H.		
35. X-RAY TAKEN: <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO FINDINGS: [REDACTED]					
36. FROM THE INFORMATION RECEIVED ABOVE CAN YOU DIRECTLY CONNECT THIS ACCIDENT AS JOB INCURRED <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES			37. REFERRED OFFSITE TO (Physician's Name & Address) [REDACTED]		
38. DID ANY PREVIOUS INJURY OR DISEASE CONTRIBUTE TO THIS INJURY <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES (Explain)			39. TREATED BY (Physician's Name & Address) [REDACTED]		
40. DOES THIS INJURY APPEAR TO HAVE POSSIBLE FUTURE COMPLICATIONS <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES (Explain)			41. HOSPITAL (Name & Address) S.H.M.H. 1600 W. CHARLESTON BLVD. L.V.		
42. DEGREE OF DISABILITY FULL DUTY LIGHT DUTY NO DUTY FATAL	43. DATE LAST WORKED		44. DATE RETURNED TO WORK [REDACTED]		