

APPENDIX III

FATAL ACCIDENTS: Since the inception of the Project in the Spring of 1943, until September 1946, twenty-four (24) fatal accidents have occurred. The following history of these incidents was taken from hospital records, reports of investigation boards, and the safety division files:

1) STEVEN ROCHES - - A bulldozer operator for M. M. Sundt Construction Company was the first fatality of the Project. At O243, 11 February 1943, he was engaged in clearing loose rock and dirt from the road bed as part of the operation of widening the access road to the Project. As was normal practice in these operations about thirty minutes previous to the time of the accident the hillside was blasted and a group of laborers experienced in this type of work had been sent above the blasting to pry loose any movable material which might fall as a result of the blasting charge. Approximately ten minutes after this careful check had been made and the all clear signal had been given, Mr. Roches took his bulldozer in to complete his job. Apparently the vibrations of the machine caused a piece of rock to fall pinning the deceased beneath it while he was still seated in the tractor,

An investigation Board composed of Captain H. L. Shepard, Mr. Franklin F. Flare, and Mr. Edward G. McIntosh met at 1100, 11 February 1943.

Their findings completely absolved M. M. Sundt Construction Company of any blame, as prudent safety precautions had been taken during the operations. However, they recommended that in the future, blasting operations be completed during daylight hours; even though the area had been well lighted by artificial lights at the time of the accident, it

was deemed wiser to carry on these operations during the day.

II) GEORGE HERMAN HOLTARY - - On 1 March 1943, at 1130, Mr. George Herman Holtary, a diesel motor mechanic employed by the U. S. Sundt Construction Company, was assembling one of the three units of the new power plant. He entered the crank case housing, against the superintendent's orders, to install one of the pistons. As he attempted to jack up the crankshaft to provide more working space forgetting that instead of it moving only a few inches, gravity would cause a 180° revolution. He was caught between the unbalanced crankshaft and the crankshaft housing with the pressure of the 13,000 pound crankshaft against his abdomen and the small of his back. It required about ten minutes to release him. He was immediately sent in the waiting ambulance to Santa Fe, but died enroute.

A Board of Investigation was appointed 2 March 1943, composed of Captain H. L. Shepherd, Mr. Frank DeLusa, and Mr. Franklyn F. Flores. They found that the deceased had acted with over-confidence, carelessness, and had disregarded Mr. W. H. Crockett's orders; that it was unnecessary to enter the crank case to install the pistons as it was customary to do this operation from outside, that U. S. Sundt Construction Company and its supervisory personnel be absolved of any blame since all proven safety precautions had been taken. They recommended that in the future employees remain outside such engines, subject to dismissal for failure to comply.

III) GEORGE J. EDWARDS - - On 4 July 1943, 1/5 George J. Edwards, ASN-32583836, age 45 years, while walking to the MCC Club fell into a drainage ditch injuring his back. He was not found until early next morning when he was taken to the MP Detachment infirmary and given first aid.

At 0900, 5 July he was sent to Burns General Hospital for treatment. There he was found to have a punctured kidney and as a result of this, he died 19 July 1943. He was given a military funeral in Santa Fe where he was buried.

Investigation found that he had been inebriated at the time of his accident. The autopsy showed that death was due to a punctured kidney sustained from the fall.

IV) JOSE ZENTAYA - - On 2 November 1943, Jose Zentaya aged 39 years, an employee of M. M. Smith Construction Company, was digging the acid sewer ditch from "D" Building, thirty feet southwest of "C" Building. The ditch was not reinforced with shoring although it was approximately eight feet deep. Mr. Zentaya was told by the foreman to stop digging and get out of the excavation. The foreman concluded he would obey, but either he failed to understand the warning or deliberately disregarded it for he didn't leave his work. The ditch caved in covering the victim with approximately six feet of earth. Although action was immediate in an effort to recover his body, he was dead when removed.

An Investigation Board found that some sort of bracing or reinforcing material should have been used and recommended that in future excavations this be done.

V) Pfc. FREDERICK (NMI) CALBRAITH - - On 4 November 1943, Pfc. Frederick Calbraith, ASN-32685686, a member of the Military Police Unit, was accidentally shot with an Army service rifle, M-1, calibre .30. Pvt. Michael Wasko of the same organization had been engaged in cleaning his rifle in one of the barracks in the military area. Unknown to him, a cartridge was in the chamber of the rifle which was discharged as Pvt. Wasko

closed the bolt and snapped the trigger. Pfc. Galbraith was asleep in one of the beds adjoining the one on which Pvt. Wasko was seated. The bullet entered Galbraith's left thigh and, because of the close range, inflicted a severe wound. Immediate medical aid was administered and Galbraith was moved to the Burns Hospital in Santa Fe, where he died from severe shock as a result of the wound.

After a complete investigation of the unfortunate incident by Captain Ralph Carlisle Smith, Pvt. Wasko was charged with manslaughter and was tried by General Court-Martial at this station. The accused was found guilty of manslaughter and of carelessly discharging a firearm. The Reviewing Authority of the Eighth Service Command reversed the decision of the court on the first charge on the Specification Sheet. Pvt. Wasko was found not guilty of manslaughter, but guilty of carelessly discharging a firearm. His sentence was suspended.

VI and VII) FREEM LOVATO & FILLICOW VIGIL - - On 20 November, 1943, a one-and-a-half-ton (1½) Chevrolet dump truck was being used to transport twenty-eight (28) laborers to lunch from one of the construction projects. All were War Department employees. As the truck approached one of the gate entrances, the accelerator pedal stuck, causing the motor to race. The driver applied both the foot and the emergency brakes, neither of which was effectual in stopping the truck. He then attempted to slow the vehicle by shifting into a lower gear. In the ensuing excitement the driver did not think of turning off the ignition. Another car was stopped at the gate for routine pass inspection and the driver of the truck attempted to steer his vehicle between the gate post and the standing car. The vehicles collided, the truck overturned, and Lovato

and Vigil were injured in the overturning. They died shortly after admission to the Post Hospital.

The accident was investigated by a Board of Officers consisting of Lt. Col. Ashbridge, Major S. L. Stewart, Captain Peur de Silva and Mr. Edwin Brooks. The Board found that the accident was caused by a latent defect in the brake mechanism which existed at the time of manufacture and which could not have been foretold, combined with the sticking of the accelerator pedal; that from the system of motor maintenance practiced in the Technical Area, sole responsibility for the faulty condition of the vehicle could not be fixed on any one person; that pressure on construction forces to meet deadline requirements resulted in lax enforcement of safety precautions; that Mr. Lovato died from laceration of the leg; that Mr. Vigil died from laceration of the brain; and that there had been no delay in providing medical attention since the injured persons were receiving treatment within fifteen (15) minutes after the accident.

The Board recommended that Motor Pool personnel be increased so that a weekly inspection of vehicles could be accomplished; that one shop be established for first and second echelon repairs, and a separate shop for third and fourth echelon repairs; that one person in the Technical Area should be made responsible for all vehicles assigned to the Technical Area on a permanent basis; that a program of safety education be initiated by Tech Area and Post Safety Officers; and that a stricter enforcement of traffic regulations be adopted.

VIII) FRED WOLCOTT - - This man was employed by Powdermilk Brothers Contractor, and was engaged in clearing a wooded area upon which

the "F" site buildings were to be erected. Trees had been felled and piled, and were being dragged from the area by a bulldozer. The deceased had hooked a long cable from a tree to the bulldozer he was operating and was attempting to "spring" the tree. In so doing, the tree snapped and started to fall in the direction of Kalcott. He made no attempt to get out of his tractor or to protect himself from the falling tree. Witnesses to the incident stated that Kalcott appeared to be "frozen" to the seat of his tractor. He was struck on the head by the uppermost branches of the tree and was instantly killed. The cause of death was diagnosed as brain and internal chest injuries. Kalcott died at OMS, 9 May 1944. The body was removed to the Memorial Chapel Funeral Home in Santa Fe, New Mexico.

After investigation by insurance investigators the dependents of the deceased were paid \$16.00 a week for 600 weeks by Lowdermilk's insurance carrier, the Mountain States Mutual Casualty Company, Albuquerque, New Mexico.

II) ELMER RANDEL BOWEN, JR. - - On the afternoon of 1 July 1944, Elmer Randel Bowen, Jr. aged 10 $\frac{1}{2}$ years, son of civilian employees of the operating contractor, was drowned when a canoe in which he was riding capsized in the heating pond at this station.

Several canoes had been taken over by the Government from the Los Alamos School and were placed under the supervision of the Recreational Department. They were made available to Post residents as a recreational diversion, but as a precaution only adults and persons able to swim were allowed to use them. Signs were posted, and notices in the Bulletin prohibited swimming in the pond. Paddles for the canoes were kept in the

adjacent fire station so that firemen on duty were put on notice in the event of an emergency. Life preservers were kept at the Fire Station and a life preserver cushion was in the canoe which capsized.

The Bowen boy was accompanied by an older boy who was employed at the Project, and who procured the paddles from the fire station. In this instance, apparently the normal safety precautions were relaxed as neither of the boys was able to swim. As was characteristic of their youth, the boys attempted to paddle fast, and the canoe overturned when they executed a sharp turn. Within a very few minutes after the alarm was given, capable swimmers were attempting to recover the body of the Bowen boy. The body recovered, all known methods of artificial respiration were put into play by four (4) Project doctors, several nurses and enlisted personnel, Oxygen, adrenalin, and other drugs were administered. The effort at resuscitation was persisted in for two (2) hours, but without success.

A complete investigation of the incident was made by Captain Ralph Carlisle Smith, after which he recommended that all boats be removed from the pond site and that guards be instructed to enforce a prohibition against canoeing. This was effected and has remained in force.

X) ERNESTO FRESQUES - - On 6 July 1944, Ernesto Fresques, of Santa Cruz, New Mexico, a truck driver employed by Robert McKee Construction Company, was instantly killed when a pile of steel reinforcing mesh fell upon him. The deceased had driven his truck beside the pile of steel, some of which was to be loaded upon his truck. Two (2) fellow laborers were on top of the pile of steel and one (1) was on the cab of the truck. They were experiencing difficulty in moving the steel because of bent

edges and improper stacking. Ernesto Presques was standing between the pile of steel and his truck. A section of the pile suddenly toppled over upon the truck, pinning Presques against the truck. He was instantly killed, the cause of death being determined as laceration of heart and lungs. The insurance company investigated the accident and the dependents of the deceased (his wife and one child) were paid four thousand dollars (\$4000.00) by the McKee Company's insurance carrier.

XI) HORACE RUSSELL, JR. -- On 30 July 1944, Horace Russell, Jr. aged 26, a research chemist employed by the Operating Contractor was riding his horse in one of the canyons near the Project. While galloping the horse over rough terrain, Mr. Russell was thrown from the saddle and suffered a head injury. A riding companion summoned an ambulance from the Post Hospital, where the injured man was taken. Because of symptoms of severe brain injury, the patient was moved the same day to Bruns General Hospital at Santa Fe, in attendance of Captain James F. Nolan and two (2) nurses. Major C. L. Robertson, MC, Chief of Neurosurgical Service, Brooke General Hospital, San Antonio, Texas was flown to Bruns to examine Mr. Russell. But the injured man died 5 August 1944, in spite of everything medical science could do. The final diagnosis was laceration of the brain.

Investigation of the incident, and settlement of personal affairs was accomplished by Captain Ralph Carlisle Smith, and Mr. David Dow of the Technical Area. The investigating officers report found that at the time of the accident, Mr. Russell was engaged in personal activity off the site; that he had received prompt and expert medical attention from the U. S. Army, and that there was no evidence of negligence on the part of

any person concerned.

XII) PFC. HUGO B. KIVISTO - - On 3 December 1944, Pfc. Hugo Kivisto, ASN-36360191, a member of the Provisional Engineer Detachment, was fatally injured while driving an Army vehicle, a 1942 Federal cab-over-engine type. The deceased was traveling over a section of dirt road with poorly graded surfaces in the vicinity of Santa Cruz, New Mexico, and lost control of the vehicle while rounding a hazardous curve which had been the scene of several previous accidents. The truck plunged over an embankment and Pfc. Kivisto was pinned under the cab after attempting to jump clear. The diagnosis of death was multiple hemorrhages of the brain, multiple contusions and lacerations of the head, and possible suffocation.

1st Lt. Joseph F. Carroll was appointed investigation officer. His approved findings indicated that the death occurred in the line of duty and not as a result of deceased's misconduct.

XIII) PVT. GROVER C. ATWELL - - On 21 July 1945, Pvt. Grover C. Atwell, ASN-35838219, a member of Special Engineer Detachment, and assigned to the hospital as ward attendant died from an overdose of barbiturates taken from the hospital pharmacy. He was discovered dead at 0835, 22 Aug. 1945.

The body was sent immediately to Bruns General Hospital where an autopsy was performed with cause of death established as induction of a chemical, probably one of barbiturates.

Captain Edwin F. Franz was appointed Investigations Officer and arrived at the following conclusions; that the deceased was depressed over his assignment, as there were no indications of financial or family difficulties,

He was declared mentally irresponsible for his actions prior to the time of death, and therefore his "death was in line of duty and not a result of his own misconduct."

XIV) JAMES H. POPPLEWELL - - On 7 August 1945, at 1345, James H. Popplewell, a civilian carpenter was working inside one of the buildings. At the same time, a caterpillar was in process of pushing dirt over the roof. The combined weight of the caterpillar and the dirt proved too great and the heavy machine plunged through the roof pinning Popplewell beneath and causing his instant death.

The autopsy was performed at the Project Hospital proving death had been instantaneous caused by a broken neck and combined strangulation.

A Board of Officers consisting of Major Wm. C. Campbell, President; Captain Edwin Frans and Captain Van. S. Reid, was appointed to conduct a thorough investigation. Their findings based upon many statements, inquiries and cross examinations, placed the blame on the sub-foreman's negligence in giving instructions to push dirt on a structure with a "cat", without ascertaining whether said structure was sufficiently strong; and also for leaving the job while such an operation was being performed. It was recommended that he be dismissed and that a statement of the accident, and Board findings be entered on his Civil Service record.

XV) HARRY E. DAGLIAN - - On 21 August 1945 during experimentation in Omega Building Harry E. Daglian was exposed to too great radiation. As a result he expired 15 September 1945. Complete reports of this case are being written by the Project Health Group, but are not available at this time.

XVI) ASA S. HOUGHTON - - On 27 September 1945, Asa S. Houghton,

a civilian carpenter was going down the hill from the Project toward Santa Fe in his truck at an undetermined rate of speed. According to his statement which corresponded with the statements of eye witnesses, the front wheels of his truck locked causing the vehicle to run off the left side of the road over a 250 foot embankment. The vehicle then turned over five or six times.

He was rushed to the Post Hospital in an ambulance and given immediate treatment. It was discovered that he sustained a broken collar bone, broken ribs and internal injuries which caused his ultimate death 6 October 1945.

No further claims or investigations were forthcoming.

XVII, XVIII, and XIX) MANUEL SALAZAR, ALBERTO ROYBAL and PEDRO BACA - - On the 28 January 1946, Manuel Salazar a janitor employed at the Project was on duty. Two of his friends (also janitors at the Project, but not on duty) Alberto Roybal and Pedro Baca came to visit him, and the three drank a quantity of Ethylene glycol mixed with muscatel wine. They became violently ill at 1900 and were taken to the Post Hospital for treatment. The poisoning was too great to respond to treatment however, and they all died 29 January 1946. The time of death for Manuel Salazar was 1235 hours; for Alberto Roybal at 1445 hours; and for Pedro Baca at 1500 hours. The diagnosis was "Injury to internal organs caused by poison contained in ethylene glycol".

The investigation conducted by the Safety Division and the United States Employee's Compensation Commission proved conclusively that these deaths were not due to injuries sustained in the performance of duty. Therefore, there were no benefits of compensation to the dependents of

the deceased men.

II) LEVI W. CAIN - - About 1704, 5 February 1946 Levi W. Cain, a Post civilian blacksmith was struck by an automobile while crossing the main street at the intersection identified by Post Hq., Bus Depot and Theatre No. 2 parking lot. He was taken by ambulance to the Post Hospital at once for treatment. He was in shock and complained of severe backache. In spite of medical attention, he succumbed 6 February 1946 from fracture dislocation of the spine, with severance of spinal cord.

An Investigation Board consisting of; Major Richard J. Newcomb, President, Captain Theodore F. Huene, 1st Lt. James E. Mills and Mr. Joe W. Austin met on 7 February 1946. Their findings absolved the driver S/Sgt. Alexander V. D. Luft of the car as no excessive speed was involved and it was definitely proven that visibility at this point was extremely poor. Also Mr. Cain was a victim of extensive arthrites which crippled his spine and legs making a fracture more possible.

The Board recommended an overhead walkway at this intersection to eliminate further accidents of this nature.

XI) LOUIS A. SLOVIN - - On 21 May 1946, Louis Slotin was making some extensive experiments in Fajarito Canyon and was exposed to radiation from radio active material to such a degree that his death was caused on 30 May 1946. The Project Health Group is making an analysis of this case which will give complete data.

XIII) LIVIE R. AGUILAR - - At about 1700 hours, 1 July 1946, Livie R. Aguilar who was a truck driver for Zia Company, was coming into Los Alamos from Santa Fe in a 2½ ton Government truck. There were no eye witnesses to the accident and no apparent causes for it, but the truck left

the road and turned over into a pipe line trench pinning him beneath the vehicle and causing almost immediate death.

An ambulance from Los Alamos was summoned at once and his body was carried to the Project Hospital. He was dead upon arrival and the diagnosis was "death from multiple fractures of the facial bones and complete flattening of right side of skull".

An Investigating Board of six members: Lt. Col. Allen K. Fure, President, Captain Jerry H. Allen Jr., Captain Cuggie E. Kyrer, Captain George W. McLaughan, 1st Lt. James B. Mills, and Mr. Chester M. Francis, Their findings showed there was no conclusive evidence of failure on the part of the vehicle, nor that the driver had been under the influence of alcohol, or suffered from abnormal vision or lack of driving skill. They concluded that it had been the responsibility of no one, and that the exact reason for the vehicle to leave the road was unknown. They recommended that emphasis be given to safe operation of vehicles and that supervisors caution their operators to give more constant attention to the operation of their vehicles. No disciplinary action was taken.

XIII) JOSHUA I. SCHWARTZ -- At 1010, 2 August 1946, Joshua Schwartz, of the University of California accompanied by Robert A. Puffines and William E. Bibbs, was engaged in a work project assigned him by Mr. George L. Williams, to trace the air currents in Omega Canyon. He was instructed to use balloons or other non-flammable equipment. Contrary to these instructions he employed a sledge-pot arrangement using potassium chlorate, sugar, red phosphorus and magnesium turnings which exploded, fatally injuring Schwartz and critically injuring his companions.

The guard at this site called the hospital five to seven minutes after

the explosion and the ambulance arrived almost immediately thereafter. First aid was rendered to Huffhines, and all three were taken to the Post Hospital.

A Board of Investigation composed of: Lt. Col. Allen W. Fore, President, Captain Jerry Allen, Jr., Captain Cuggie E. Kyser, Captain George W. McLaughan, 1st Lt. James B. Wills and Mr. Chester M. Francis was appointed. After a thorough investigation they concluded that the explosion was due to inadequate supervision on the part of the A-5 group and Electronics Group supervisory personnel; that Mr. Joshua I. Schwartz had failed to carry out the official orders he had received and had mixed an unauthorized chemical compound; that proper medical attention had been given promptly. They recommended closer supervision; more training in handling explosives and in safety measures; a closer check on the issuance of chemicals; and that no disciplinary action could be taken.

The diagnosis of death was third degree burns of body, plus multiple superficial shrapnel wounds of all burned areas.

(XIV) HERBERT G. SCHWANER - - After completing his job of removing a steel plate at Building 4-5 and replacing the gravel foundation, Herbert G. Schwaner, aged 24 years, drove his bulldozer up a dirt ramp onto the trailer. This was approximately at 1845 hours, 7 August 1946. Apparently he applied the foot brake in an effort to straighten the course of the machine, this action locked the right track causing the machine to topple over pinning the victim beneath. His brother found him about five minutes later, called assistance at once, but Mr. Schwaner was pronounced dead when the doctors arrived.

A Board of Officers consisting of: Lt. Col. Allen W. Fore, President,

Captain Jerry H. Allen, Jr., Captain Coggie E. Kyster, Captain George W. Nottingham, 1st. Lt. James E. Wills, and Mr. Chester H. Francis, was appointed. They found the accident due to the failure of Mr. Schwaner and his official supervisors to devise or provide a safer method of loading ballistics and tractors on to trailers. They recommended the use of steel ramps or well braced earth ramps in this connection. And the use of one helper to aid in aligning the machine as the ascend or descend on to or from a carrying trailer. There was no disciplinary action taken.