# Report of Fatality
# Bull Dozer Accident
# Surface Coal Mine
# December 29, 2017

Revelation Energy, LLC
S7 Surface Mine
Permit Number S00303991A

Region IV Office
550 Industrial Park Drive
Oak Hill, West Virginia 25901
McKennis P. Browning, Inspector-at-Large

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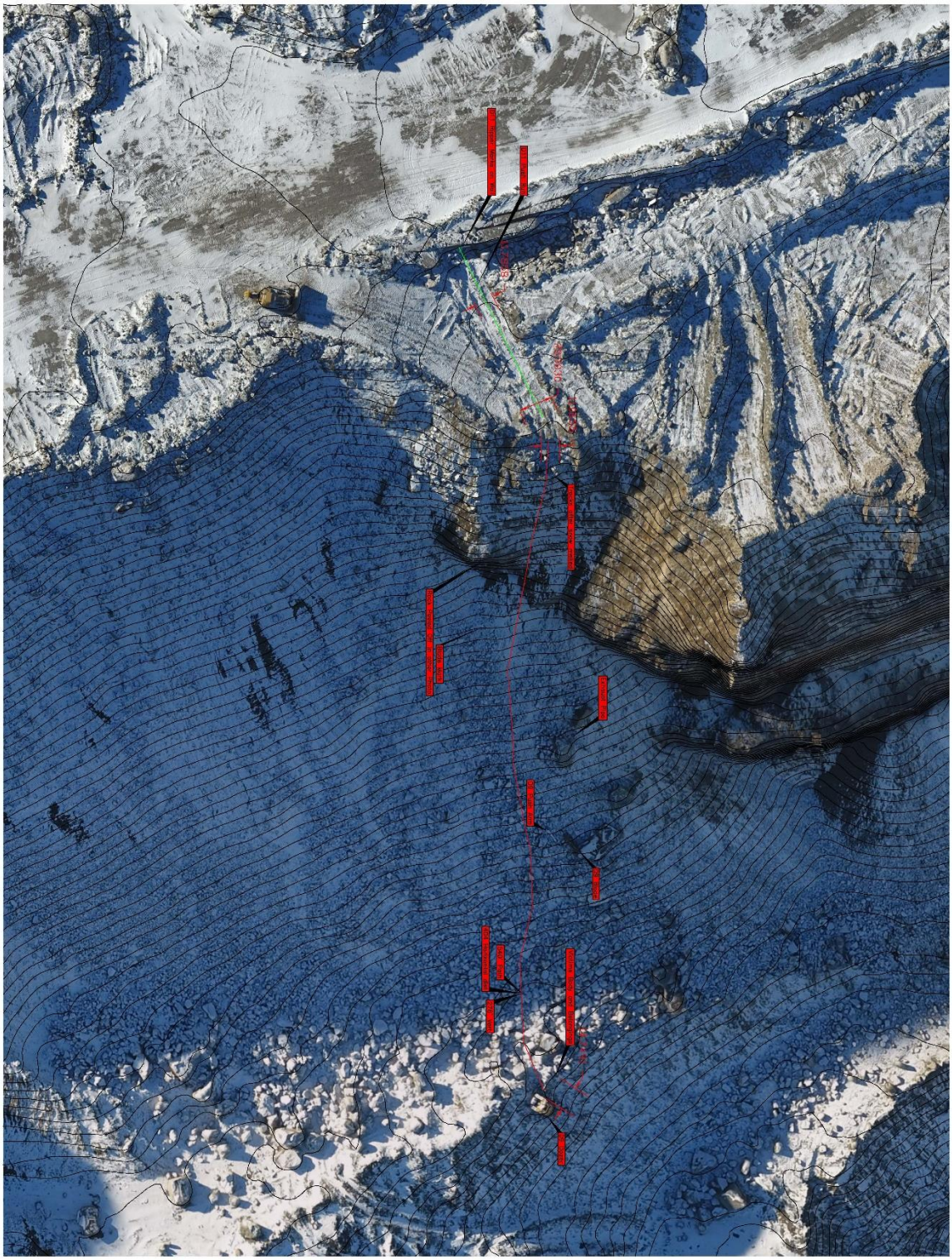
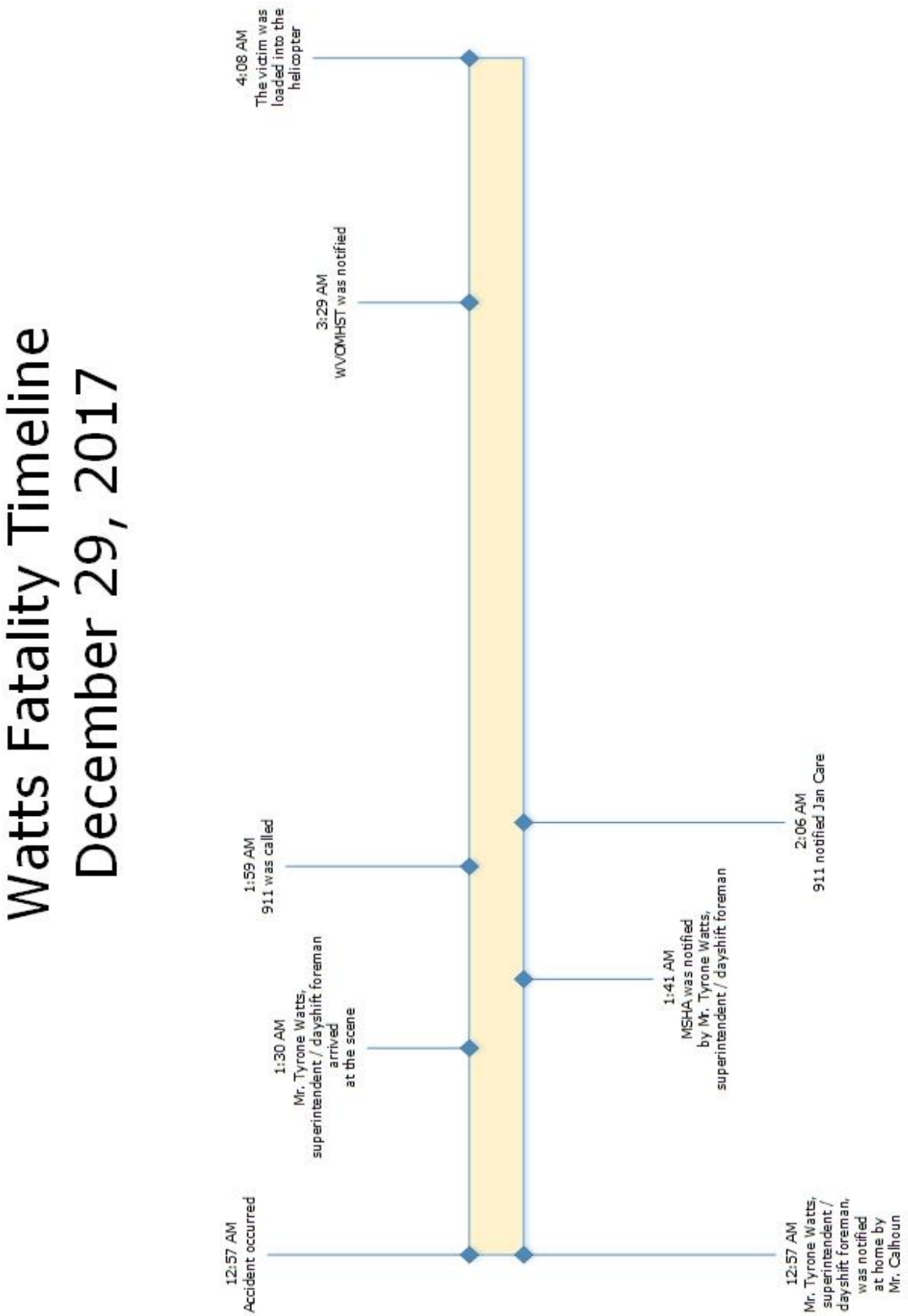
# MAPS



# TIMELINE


Watts Fatality Timeline
December 29, 2017
12:57 AM
Accident occurred
1:30 AM
Mr. Tyrone Watts, superintendent / dayshift foreman arrived at the scene
1:59 AM
911 was called
3:29 AM
WVOMHST was notified
4:08 AM
The victim was loaded into the helicopter
1:41 AM
MSHA was notified by Mr. Tyrone Watts, superintendent / dayshift foreman
2:06 AM
911 notified Jan Care
12:57 AM
Mr. Tyrone Watts, superintendent / dayshift foreman, was notified at home by Mr. Calhoun

# REPORT OF FATALITY

## BULL DOZER ACCIDENT INVESTIGATION
## REVELATION ENERGY, LLC
## S7 SURFACE MINE
## WV PERMIT NUMBER S00303991A

## GENERAL INFORMATION

This report is based on an investigation conducted in accordance with Title 56, Series 3, Section 12 of the West Virginia Code of State Rules.

Mr. Thurman A. Watts (victim), an employee for Revelation Energy, LLC, was fatally injured in a dozer accident at approximately 12:57 a.m. on December 29, 2017. Mr. Watts (victim) was operating a (unit number D-13) Caterpillar D9T dozer, pushing overburden over the highwall that had been previously shot to uncover the Winifrede Ryder coal seam, when he traveled too close to the edge of the highwall and the ground under the dozer appeared to have given way causing the dozer to fall off the highwall. Mr. Watts (victim) died from injuries he sustained during the accident.

The West Virginia Office of Miners' Health, Safety and Training, Region IV office, was notified of the accident by the Mine and Industrial Accident Emergency Operations Center at 3:29 a.m. on December 29, 2017. A joint investigation with the Mine Safety and Health Administration (MSHA) and management of Revelation Energy, LLC was started immediately.

## DESCRIPTION

The Revelation Energy, LLC, S7 Surface Mine is located near Pax, West Virginia, and is situated in Fayette County, West Virginia. The surface mine normally operates two (2) shifts and has twenty-two (22) employees; fourteen (14) employees on the day shift and eight (8) employees on the night shift. The employees normally work a ten (10) hour shift. The day shift schedule is 6:00 a.m. to 4:00 p.m. and the night shift schedule is 5:00 p.m. to 3:00 a.m.

The night shift started normally for the equipment operators on December 28, 2017. Mr. Watts (victim) began his shift at approximately 5:00 p.m. at the parking lot located at the bottom of the hill. The night shift foreman, Mr. Denver Calhoun, transported Mr. Watts (victim) and another dozer operator, Mr. Larry Dotson, to the dozers that they were going to be operating that evening.

Mr. Watts (victim) and Mr. Dotson arrived at the Winifrede Ryder pit area and performed a walkaround of the area where they were going to be operating the dozers during the upcoming shift. After the walkaround was complete, the men performed the required pre-operational check of their dozers and began pushing the overburden off the highwall. The shift appeared to

be a normal working shift. The men engaged in normal conversation throughout the start of the shift over the CB radio. The men stopped to take lunch at approximately 11:00 p.m. while their dozers were being fueled. After lunch the men returned to normal operations. Mr. Dotson was reported to be shoving overburden off the highwall while Mr. Watts (victim) shoved material from the right side of Mr. Dotson. Mr. Watts (victim) was operating partially parallel to the highwall on his right side. Mr. Dotson stated that after he shoved overburden off the highwall he started backing up to get another push. Mr. Dotson was looking at the rear perimeter of the machine while in reverse. Mr. Dotson stated in testimony that when he turned back around to look forward, the other dozer operated by Mr. Watts (victim) was gone.

Mr. Dotson stated that he first thought that Mr. Watts (victim) had backed up to an area where he could not see him. Mr. Dotson called for Mr. Watts (victim) three (3) or four (4) times on the CB radio and then backed his dozer, exited the machine, and looked over the highwall. Mr. Dotson then realized what happened, got back into his dozer and called the night shift foreman, Mr. Calhoun, over the CB radio.

Mr. Calhoun was contacted by Mr. Dotson, at approximately 12:57 a.m. Mr. Calhoun then contacted Mr. Tyrone Watts, superintendent / dayshift foreman. Mr. Calhoun then started searching for Mr. Watts (victim) with Mr. Dotson. Mr. Tyrone Watts, superintendent / dayshift foreman, arrived at approximately 1:30 a.m. and picked up Mr. Dotson. While Mr. Tyrone Watts, superintendent / dayshift foreman, was traveling to the accident site the dozer was located by Mr. Dotson. Mr. Tyrone Watts, superintendent / dayshift foreman and Mr. Dotson then traveled to the location of the dozer. Mr. Tyrone Watts, superintendent / dayshift foreman, stated that they parked about four hundred (400) feet from the dozer and Mr. Dotson jumped out of the truck and started to the machine's location. Mr. Dotson discovered Mr. Watts (victim) lying on the ground approximately fifty (50) feet behind the dozer.

Per Mr. Tyrone Watts, superintendent / dayshift foreman's, written statement, he called MSHA at approximately 1:41 a.m. After that phone conversation he met Mr. Dotson at the dozer where he, (Mr. Tyrone Watts, a certified EMT-M) and Mr. Dotson started administering first aid. Mr. Tyrone Watts, superintendent / dayshift foreman, then called 911 for an ambulance. Per the Jan Care ambulance report, they received the 911 call at 2:06 a.m. After realizing the extent of the injuries, Mr. Tyrone Watts, superintendent / dayshift foreman, called and requested Health Net.

Mr. Tyrone Watts, superintendent / dayshift foreman and EMT-M, stated that Mr. Watts' (victim) pulse was weak. The men then placed a C collar on him and transferred him to a backboard. Three (3) other employees then arrived and they started carrying Mr. Watts (victim) downhill to the ambulance, he was alert and talking to them, but appeared to be having trouble breathing until they were approximately two hundred (200) feet from the ambulance. When they got to the ambulance the EMS personnel started administering CPR and then airlifted Mr. Watts (victim) to CAMC General Hospital. Mr. Watts (victim) was pronounced dead at 5:33 a.m. at CAMC General Hospital.

# FINDINGS OF FACT

1. On December 28, 2017, the second shift mine foreman made his pre-shift examination from 4:30 p.m. to 5:00 p.m. and did not record any hazardous conditions found in the Winifrede Ryder area of the mine.
2. On December 28, 2017, no defects were noted on Mr. Thurman A. Watts' (victim) pre-operational checklist prior to operating the dozer at the beginning of the shift.
3. Mr. Thurman A. Watts (victim) had been task trained on the safe operation of the Caterpillar D9T dozer on December 6, 2017.
4. Mr. Thurman A. Watts (victim) had been employed at this mine for approximately three (3) weeks and had ten (10) years surface mining experience.
5. The dayshift operator of the Caterpillar D9T dozer stated that the dozer was in safe working condition.
6. The accident occurred at approximately 12:57 a.m. on December 29, 2017.
7. Mr. Tyrone Watts, superintendent / dayshift foreman, contacted MSHA at approximately 1:41 a.m. on December 29, 2017.
8. The Jan Care Ambulance report shows that the 911 call was made at 2:06 a.m. on December 29, 2017.
9. The Mine and Industrial Accident Emergency Operations Center was notified at 3:23 a.m. on December 29, 2017.
10. The West Virginia Office of Miners' Health, Safety and Training was notified at 3:29 a.m. on December 29, 2017.
11. OMHST inspectors were unable to immediately inspect the Caterpillar D9T dozer due to safety concerns of the instability and unsafe location of where the dozer came to rest.
12. On March 13, 2018, the Caterpillar D9T dozer was examined. The seatbelt was discovered to be unlatched and did not appear to have sustained any damage. The seatbelt was securely fastened to the Caterpillar D9T dozer cab and the seat was also secured.
13. In addition to other damage observed on the Caterpillar D9T dozer the front and back windscreens were broken out of the operator's cab. The headrest was bent back toward where the rear windscreen should have been.

# CONCLUSION

On December 29, 2017, normal mining operations were conducted at the Winifrede Ryder area, Revelation Energy, LLC – S7 Surface Mine – West Virginia permit number S00303991A. Mr. Thurman A. Watts (victim), was operating a Caterpillar D9T dozer, and traveled too close to the

edge of the highwall. The ground under the dozer appears to have collapsed causing the dozer to fall off the highwall.

## ENFORCEMENT ACTION

A non-assessed control order was issued in accordance with Title 36, Series 19, Section 7.1 of the West Virginia Mining Laws to preserve the scene of the accident and to complete the investigation.

During this investigation, the West Virginia Office of Miners' Health, Safety and Training issued one (1) special assessed notice of violation and two (2) regular assessed notices of violation to Revelation Energy, LLC.

## RECOMMENDATIONS

In accordance with Title 56, Series 8, Section 9.4 of the West Virginia Mining Rules and Regulations, modifications have been made to Revelation Energy, LLC, S7 Surface Mines' comprehensive mine safety program following the investigation of a fatal accident involving Mr. Thurman A. Watts (victim) that occurred on December 29, 2017. The modifications shall include, but not be limited to, the following:

1. There will be additional safety meetings for each working shift for the first week. These meetings will address the accident and what can be done to prevent future accidents. Meetings will cover the following: PPE use, 3-point contact, blade-to-blade pushing, highwall examinations, weather conditions, and working near the highwall. After the first week, a safety meeting will be held each week for each working shift. A record of all safety meetings will be maintained in the mine office. Each safety meeting will last approximately thirty (30) minutes.
2. Equipment operators will be given additional instructions on safe operating procedures when pushing over highwalls such as; each dozer blade load of material will be deposited at the top edge of the highwall; the material will be bumped over by the next push; this technique shall be demonstrated to all dozer operators; all operators shall be task trained; and a 5000-23 completed for each operator.
3. When operating above a highwall, a berm will be constructed and maintained at or near the top edge of the highwall. The berm will be a minimum of three (3) feet in height or half of the tire of the largest piece of equipment used on the site, whichever is greatest.
4. When operating above a highwall, all equipment operators will be instructed to run equipment perpendicular to the highwall and no one will operate a piece of equipment parallel to the top of a highwall within two (2) blade lengths.
5. Equipment operators will be required to use all safety equipment that is provided such as the following: seatbelts, hardhats, lighting and required PPE. A light plant will be added if

visibility drops within two (2) blade lengths on a D-11 dozer, or the largest dozer operating on the job.

6. Equipment operators will not be allowed to use cell phones while operating equipment, in the event an equipment operator is caught disciplinary action will be taken.
7. Equipment operators will report any unsafe ground conditions to the shift supervisor immediately.
8. All state laws, rules and regulations will be complied with.

## ACKNOWLEDGEMENT

The West Virginia Office of Miners' Health, Safety and Training acknowledges the cooperation of employees and management of Revelation Energy, LLC, S7 Surface Mine and the Mine Safety and Health Administration during this investigation.

## APPENDIX

- Mine Information Sheet
- Victim Information Sheet