REPORT OF FATALITY

FEBURARY 14, 2013

CONSOLIDATION COAL COMPANY
LOVERIDGE MINE
PERMIT NO. D-403

REGION ONE
14 COMMERCE DRIVE, SUITE ONE
WESTOVER, WEST VIRGINIA 26501
EDWARD PEDDICORD, INSPECTOR-AT-LARGE
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Motor trip from 124 to 126 block
Main West Haulage
Accident 2-12-13
Distance between car and estimated original label

Air hose

First Aid Bag

Clamp

Distance between cars is 12 feet

Stretcher bandage
GENERAL INFORMATION

The Consolidation Coal Co., Loveridge Mine, Permit No. D-403 is located near Fairview, Marion County, West Virginia. The underground mine employs approximately 692 miners. The Pittsburgh No. 8 seam is accessed by one hoist located at the Metz portal, one hoist located at the Miracle Run portal and one hoist and slope located at the Sugar Run portal. The mine produces approximately 5.87 million tons of coal annually from three (3) continuous miner units and one (1) longwall unit. Coal is transported from the working sections in the mine via conveyor belts to the Sugar Run slope. Battery, trolley and diesel powered rail mounted vehicles are used to transport supplies and mine personnel.

DESCRIPTION

On February 12, 2013, at approximately 9:30 p.m. Glen Lee Clutter, 51 years of age, was seriously injured and later died as a result of his injuries. At the time of the accident, he was attempting to rerail a loaded Irwin supply car back on the track after the outby end of the car derailed. The accident occurred at West Mains Haulage, between #125 and #126 blocks. Mr. Clutter had a total of thirty-two (32) years of mining experience with nine years (9), five (5) months experience at the Loveridge Mine.

At 9:39 p.m. on February 12, 2013, Edward Peddicord, Inspector-at-Large for Region One of the Office of Miners’ Health, Safety and Training was notified of the accident by the Mine and Industrial Accident Rapid Response System. Danny Burgoyne, District Inspector, was contacted by Mr. Peddicord and instructed to go directly to the Loveridge Mine. A joint investigation with the Mine Safety and Health Administration, United Mine Workers of America and Consolidation Coal Co. began immediately.
At the beginning of the shift, Mr. Clutter and Mr. Scott Shay, general inside laborers/motormen, received instructions to take the #55-20 ton battery/trolley locomotive and the #51-20 ton trolley locomotive from Miracle Run bottom to Sugar Run slope to receive and transport supply cars loaded with longwall materials from Sugar Run slope to the 60 lb. track spur at Miracle Run bottom. The motormen from the Metz portal would receive the cars from Mr. Clutter and Mr. Shay and transport them to 20D longwall set-up section. Upon arrival on Sugar Run bottom, Mr. Clutter and Mr. Shay inspected the eight (8) supply cars and decided to make two (2) trips due to the weight of the cargo being transported on the supply cars. The two locomotives were to be used to transport the trip, one lead locomotive and one tail locomotive. The first trip of four (4) cars was completed without incident as they traveled from Sugar Run to Miracle Run and transferred the cars to the Metz motormen who transported them to the 20D longwall set up. Mr. Clutter and Mr. Shay returned to Sugar Run and retrieved the second trip of four (4) cars. On the second trip, the cars partially derailed between #124 and #126 blocks, on main west haulage. At this time, Mr. Clutter and Mr. Shay notified the dispatcher that they were off track and were beginning to rerail the cars. The outby #51 motor pulled three (3) cars back toward Sugar Run, uncoupling them from the fourth car to provide room to work and rerail the inby supply car. A pneumatic lifting bag was placed on the outby end (Sugar Run) side under the jenny frame and supply car frame. A wooden crib block and a wooden half header board were placed on the top left (wire side) of the lifting bag to fill the void between the car frame and the jenny frame. Once the car was raised, Mr. Clutter positioned himself on the outby end of the car, wire side, and bent over to examine the wheels to determine the correct alignment to rerail the car. When Mr. Clutter raised or aligned the wheels with the slate bar the supply car suddenly shifted approximately four (4) inches. The weight and the movement of the car propelled the slate bar striking Mr. Clutter above the right eye and bridge of the nose. Mr. Shay, who was standing approximately two (2) feet behind Mr. Clutter, asked if he was ok with no response, he immediately called the dispatcher for help and an ambulance. Four (4) employees immediately responded and arrived on the scene of the accident with first-aid material to render assistance. Mr. Clutter was transported to the surface at Miracle Run portal where an ambulance was waiting and life flight was in route. Mr. Clutter was transported by life flight to Ruby Memorial Hospital in Morgantown, WV
where he was pronounced dead at approximately 3:27 p.m. on February 14, 2013, as a result of his injuries.

FINDINGS OF FACT

1. Mr. Clutter received annual refresher training on January 17, 2013.
2. The use of lifting bags to raise derailed supply cars is a common practice at the mine.
3. The victim was operating the #51-20 ton trolley powered locomotive prior to the accident.
4. An approximately 36 in. square Sava pneumatic lifting bag along with wooden crib blocks approximately (5 X 5 X 29½ in.) and a half header board approximately (18 X 4 in.) were used to attempt to rerail the Irwin supply car. The lifting bag was inflated using the compressor of the #55-20 ton battery/trolley locomotive.
5. The metal slate bar that was being used was standard, black in color, 4 ft. 6 in. in length, 1 in. octagon circumference and weighed 12.5 lbs.
6. The distance from the wire side rail to the bottom wire side rib was approximately 31 in.
7. The height of the 85 lb. rail is approximately 5 ½ in. at the accident site.
8. The height from the rail ties to the mine roof was approximately 100 in. at the accident site.
9. The wooden crib used on the lifting bag was approximately 5 in. square and approximately 29 ½ in. in length.
10. The trip consisted of 2 locomotives and 4 loaded Irwin supply cars.
11. The total weight of the Irwin supply cars were: #1 car approximately 68,200 lbs., #2 car approximately 53,000 lbs., #3 car approximately 43,200 lbs. and #4 car approximately 28,200 lbs. (see sketch) The weight of a supply car when empty/unloaded was approximately 28,000 lbs.
12. The track conditions at the accident site were dry and level. The wire side rail rolled out for a distance of approximately 112 ft.
13. The proper track gauge is approximately 42 in. The track gauge where the rail rolled was approximately 44-46 in.
14. The 85 lb. track haulage has been installed/attached with wooden ties and spikes on both sides of the bottom rail flange.
15. The spikes were not properly securing the rail flange to the wooden ties for approximately 112 ft. when measured at the accident scene.
16. No violations or defects were detected during the inspections of the supply cars, locomotives, trolley wire and the haulage clearances.
17. No violations/hazardous conditions at the scene of the accident were recorded in the pre-shift and on-shift examination books prior to the accident.

CONCLUSION

The victim and a co-worker attempted to rerail a loaded supply car. The two miners used a pneumatic lifting bag along with a crib block and a half header board to raise and support the elevated car. Mr. Clutter bent over to examine the wheels to determine the correct alignment. While bending over, Mr. Clutter used a slate bar to raise or align the wheels when the car suddenly shifted and slid across the rail. The weight and the movement of the car propelled the slate bar striking him above the right eye and across the bridge of the nose, resulting in fatal injuries.

ENFORCEMENT ACTION

A non-assessed order was issued in accordance with West Virginia Rules and Regulations Series 36, Article 19, Section 7.1 to preserve evidence until an investigation by the Office of Miners’ Health, Safety and Training was completed.
RECOMMENDATIONS

An enhanced inspection of the gauge and general maintenance of the track rails shall be conducted from the Miracle Run bottom to the Sugar Run bottom. Proper repairs of the rails, ties and spikes shall be performed where required. The company must train or retrain motormen and any other employee who would be expected to use lifting bags for the purpose of rerailing haulage equipment according to the manufacturer's recommendations for safe and proper usage. The company must add an addendum to their Comprehensive Mine Safety Program concerning track haulage safety and review with all employees.

ACKNOWLEDGEMENT

The West Virginia Office of Miners’ Health, Safety and Training gratefully acknowledges the cooperation of the employees and management of Consolidation Coal Co. Loveridge Mine, Consol Energy Company, Mine Safety and Health Administration, and the United Mine Workers of America during this investigation.
MINE INFORMATION

COMPANY   Consolidation Coal Co.

MINE COMPANY    Loveridge Mine

WV PERMIT D-403          MSHA PERMIT NO.  46-01433

ADDRESS   P.O. Box 40 Fairview, WV 26570

COUNTY  Marion             PHONE NO.  304-662-8102

DATE PERMIT ISSUED August 12, 1966

WORKING STATUS      Active

LOCATION    Fairview

UNION        X         NON-UNION

DAILY PRODUCTION             ANNUAL PRODUCTION TO DATE  1.5 million

TOTAL EMPLOYEES  692

NUMBER OF SHIFTS  3

COAL SEAM NAME AND THICKNESS    Pittsburg 8        84 inches

ACCIDENT INCIDENTAL RATE   1.44         LOST TIME ACCIDENTS  2 ytd

TYPE OF HAULAGE    Belts

WVOMHST INSPECTOR   Danny Burgoyne

DATE OF LAST INSPECTION  Regular inspection being conducted at this time.

NOTIFIED BY   Mine and Industrial Accident Emergency Operations Center

NOTIFICATION TIME   February 12, 2013 at approximately 9:39 p.m.

CMSP-ANNIVERSARY DATE   January 23, 2013

CMSP-CONTACT PERSON   Lou Baretta