West Virginia Office of Miners' Health, Safety & Training

May 18, 2017

Report of Investigation

Coal Mine Fatality

Struck Against Roof

Pinnacle Mining Company, LLC

Pinnacle Mine

Permit Number U00020483A

Region 2

891 Stewart Street

Welch, West Virginia 24801

Eddie Collins, District Inspector 337

John O'Brien, Inspector-at-Large 192

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TIMELINE

05/18/2017

11:00 p.m. approximately	accident occurred
	Jeff Davis (Dispatcher, Pinnacle Mine) notified of accident
11:09 p.m.	call placed to 911 (Wyoming County)
11:13 p.m.	STAT Ambulance Unit dispatched to scene
11:29 p.m.	STAT Unit arrived at scene

05/19/2017

12:23 a.m.	STAT Unit enroute to Welch Community Hospital
12:33 a.m.	STAT Unit arrived at Welch Community Hospital
12:50 a.m.	Mr. Luches Rosser was pronounced dead at Welch Community Hospital

GENERAL INFORMATION

The Pinnacle Mining Company, LLC, Pinnacle Mine, Permit #U00020483A is located in Wyoming County on Route 16 near Pineville, West Virginia. The mine currently employs three hundred ninety-nine (399) miners divided up over three (3) shifts over a twenty-four (24) hour day. This mine has two (2) continuous miner sections and one (1) longwall section that produces coal from the Pocahontas 3 seam with an average height of approximately forty-eight (48) inches. This is a belt haulage mine that produces coal on the evening and midnight shifts with the day shift being a maintenance shift. The miners are transported in and out of the mine by track rail with trolley. The majority of the miners enter and exit the mine by way of an elevator at the 8 Haulage Shaft, while the remaining miners utilize the Pinnacle side slopes.

DESCRIPTION

On May 18, 2017 at approximately 11:00 p.m., Mr. Luches Rosser and Mr. Tracy Lester were traveling from the sizer area along the 8 Haulage track toward the shaft bottom on the No. 43 electric motor. Mr. Rosser was operating the No. 43 electric motor between No. 39 break and No. 43 break on the 8 Haulage track when, according to Mr. Lester, the trolley pole came off of the trolley wire and the No. 43 electric motor began to slide. Mr. Lester stated that Mr. Rosser turned, stood up, and placed the trolley pole back onto the trolley wire. When Mr. Rosser returned to his seat he turned his head in the direction of travel and struck his head on a Heizman metal I-beam causing him to lose his hard hat. Mr. Rosser then attempted to place his hard hat back on his head when he struck his head against a second Heizman metal I-beam and immediately slumped over. Mr. Lester, who was in the passenger seat, leaned forward to try and stop the motor. When the motor came to a stop, Mr. Lester discovered that Mr. Rosser was unconscious and unresponsive. Mr. Lester began flagging the No. 13 Jeep that was traveling in front of him. The occupants of the No. 13 Jeep, Chris Dotson and Matt Muncy, saw Mr. Lester flagging, turned their trolley pole and trammed back in his direction. Mr. Lester informed them that Mr. Rosser struck his head on the mine roof and was now unconscious. The three (3) miners, Mr. Dotson, Mr. Muncy and Mr. Lester, traveled toward the No. 43 motor where Mr. Rosser was located. Mr. Dotson stated that Mr. Rosser had a faint pulse. Mr. Dotson, Mr. Muncy and Mr. Lester then worked to remove Mr. Rosser from the No. 43 electric motor and place him on the mine floor. Mr. Muncy began to perform C.P.R. on Mr. Rosser. Mr.

Dotson attempted to revive Mr. Rosser by placing ammonia capsules underneath Mr. Rosser's nose but did not get a response. No.36 cutdown manbus then arrived on the scene with Mr. Calvin Roark, Mr. Cody Thompson and Mr. Terry McGinnis. Mr. Dotson, Mr. Muncy and Mr. Lester moved Mr. Rosser from the mine floor onto the duck bill end of the No. 36 cutdown manbus. The No. 36 cutdown manbus departed the scene en route to the shaft bottom where EMS personnel were waiting. EMS personnel continued CPR on Mr. Rosser en route to the mine surface where an ambulance was waiting. Mr. Rosser was loaded in the ambulance and transported to Welch Community Hospital where he was pronounced dead on May 19, 2017 at 12:50 a.m.

CONCLUSION

On May, 18, 2017, Mr. Luches Rosser, evening shift shuttle car operator, received fatal injuries while operating the No. 43 motor on the 8 Haulage mine track when his head struck a metal I-beam located just inby 42 crosscut.

FINDINGS OF FACT

1. A post-accident inspection of the No. 43 motor showed that the motor was in proper operating condition. The mine track and trolley wire appeared to be properly maintained.
2. No warning light, reflective sign or tape was installed at the abrupt and sudden change in the overhead clearance, approximately sixty (60) feet inby 42 crosscut where the accident occurred.
3. No record of being task trained to operate an electric trolley motor was produced.
4. Mr. Luches Rosser was employed at this mine for two (2) months and twelve (12) days.
5. The accident occurred when Mr. Luches Rosser was traveling to the surface upon completion of his shift.
6. In the direction of travel, there is an 0.76% grade from 45 break to 41 break.

ENFORCEMENT ACTION

The following actions were taken as a result of the investigation.

A non-assessed control order was issued in accordance with Chapter 22A, Article 2, Section 68 of the West Virginia Code to preserve the accident scene after the recovery of the victim and until the investigation of the accident site by OMHS&T personnel had been completed.

One special assessed notice of violation was issued to Pinnacle Mining Company, LLC during this investigation.

1. 22A-1-36(b)-The operator did not demonstrate that Luches Rosser received adequate training regarding the provisions of the comprehensive mine safety program; specifically, the provisions dealing with track haulage and the prohibition against standing upright in the operating deck of a locomotive while it is in motion. A form indicating Luches Rosser received annual refresher training on March 6, 2017 was the only record provided to the OMHST. Listed below is program component #4, safe work practices and conditions, as listed in Pinnacle Mine's CMSP.

   Supervisors promote safe work practices and conditions through compliance with state laws, rules and regulations, and company policies concerning the protection of employees and property. It is the duty of the miners to comply with these state laws, rules and regulations, and company policies concerning safe work practices, procedures and conditions. Safe work practices and conditions are further promoted through the effective use of training, task training, safety meetings, safety huddles, special contacts, contacts, planned and impromptu observations, and safety audits.

Two notices of violation were issued to Pinnacle Mining Company, LLC during this investigation.

1. 22A-2-37(f)- The agent of the mine operator failed to maintain the 8-Haulage mine track and provide a marking of warning lights or reflective signs or tapes for an abrupt or sudden change in the overhead clearance at a location 60' inby Break No. 42 where the mine roof is eighty and one half (80 ½) inches from the top of the rail and the abrupt or sudden change drops thirty-one and one half (31 ½) inches. This only allowed fifty (50) inches to

fifty-three (53) inches of clearance from the top of the rail to the beams through this area.

2. 36-19-4.2- The agent of the mine operator failed to provide the Director in writing within 24 hours of an injury that occurred resulting in the loss of life on 5-18-17.

RECOMMENDATIONS TO PREVENT REOCCURENCE

The following has been included in Component #3 of the Pinnacle Mine Comprehensive Mine Safety Program.

The following plan of action will be taken along 8 Haulage Extension Track in order to help prevent future accidents in that area;

1. A highly visible, reflective sign reading "STOP, Low Top Ahead, Proceed With Caution" will be conspicuously located at cross cut #38 and at cross cut #45 along the 8 Haulage Extension Track. Reflectors and flashing lights will be placed at areas in between the signs to further identify the area. A highly visible, reflective sign reading "STOP, Low Top Ahead, Proceed With Caution" will be installed at approximately 152 break on West Mains Track. This sign will indicate there is low clearance to the end of the West Mains track.
2. A highly visible, reflective sign and/or reflective material will be installed approximately 2-3 breaks inby and outby other areas of the mine that have an abrupt change in the mine roof that could result in overhead clearance that post a hazard to miners riding or operating a track mounted vehicle. Reflectors or flashing lights will be placed at all areas in between the signs where abrupt changes causing low clearance hazards occur.
3. Training will be conducted and recorded with all employees on the Track Haulage Procedure. Training will be certified by employee signature. This will also be added to the comprehensive safety plan and implemented in the Annual Refresher class, Experienced Miner training and New Miner training.

ACKNOWLEDGEMENTS

The West Virginia Office of Miners' Health, Safety and Training gratefully acknowledges the cooperation of: the employees of Pinnacle Mining Company, LLC, the UMWA and the Mine Safety and Health Administration.