July 31, 2012

Report of Investigation
Underground Coal Mine Fatality
(Crushing)

ICG Beckley, LLC
Beckley Pocahontas Mine
U-3011-95A

Region IV Office
550 Industrial Drive
Oak Hill, WV 25901
McKennis P. Browning, Inspector-at-Large
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SKETCHES
Re-Creation of Fatal Accident
Per First Responder Advisory

ICG Beckley, LLC
Beckley Pocahontas Mine
U-3011-95A
Re-Enactment of Fatal Accident
ICG Beckley, LLC
Beckley Pocahontas Mine
U-3011-95A
Vertical Scale is Exaggerated by a Factor of 4.

Grade Measurements of No. 3 Entry roadway.
Report of Investigation

Underground Coal Mine Fatality
ICG Beckley, LLC
Beckley Pocahontas Mine
WV Permit Number U-3011-95A

GENERAL INFORMATION

This report is based on an investigation conducted in accordance with Chapter 22A, Article 1, Section 14 of the mining laws of the state of West Virginia.

A fatal accident occurred at approximately 12:45 p.m. on July 31, 2012, at the ICG Beckley LLC, Beckley Pocahontas Mine located at Eccles in Raleigh County.

The accident occurred on the No. 2 working section, in the No. 3 entry along the section travelway/supply roadway, near survey spad No. 8769.

Greg Byers, 43 years of age received crushing injuries when he was caught between the operator’s compartment of the No. 8 scoop and the coal rib. Mr. Byers expired on July 31, 2012, due to the injuries he had sustained during the accident.

The West Virginia Office of Miners’ Health, Safety and Training was notified of the accident by Steve Toler, safety director, at the ICG Beckley Pocahontas Mine at 1:18 p.m. A joint investigation with the Mine Safety and Health Administration started immediately.

The ICG Beckley LLC, Beckley Pocahontas Mine is located at Eccles, West Virginia in Raleigh County. The deep mine has two air shafts and one slope and normally operates 7 days a week. This mine currently has 287 employees. Coal is extracted from the Pocahontas No. 3 seam, which has an average thickness of 43 inches. The average mining height is approximately 60 inches. Currently advance mining is accomplished with 3 “super” sections.

DESCRIPTION

On July 31, 2012, the employees of the A-2 crew led by Johnathan Moorefield, section foreman, and Roy Smith, assistant section foreman, entered the mine at 6:15 a.m. The crew traveled by rubber-tired vehicle and arrived on the No. 2 working section at approximately 6:45 a.m.
The shift progressed normally with mining and bolting cycles alternating between the left and right sides of the 8 entry section. Ventilation work, rock-dusting and supplying of the section were performed as needed throughout the shift.

At approximately 12:30 p.m. Greg Byers was instructed by the section foreman Johnathan Moorefield to change the batteries on the No. 8 Scoop. Greg Byers proceeded to the No. 8 scoop charging station, located out-by the No. 2 section dumping point in the No. 3 entry, near survey spad No. 8769.

At approximately 12:40 p.m. David Thompson was operating the No. 11 scoop in the left return on the No. 2 working section performing rock dusting duties. Upon completion of his duties, David Thompson exited the No. 2 working section and began to travel out-by, batteries first, in the No. 3 Entry. He traveled 7 crosscuts out-by the No. 2 section dumping point.

As the No. 11 scoop operated by Mr. Thompson traveled into the intersection at cross cut No. 5 near survey spad No. 8769 where the No. 8 scoop charging station is located, the batteries on the No. 11 scoop struck the bucket of the No. 8 scoop which was protruding out into the intersection 6.5 feet due to the location of the charger in the charging station. When Mr. Thompson realized that he had struck the No. 8 scoop he turned the No. 11 scoop away from the No. 8 scoop. Mr. Thompson’s actions moved the No. 8 scoop pinning Greg Byers (who was in the process of changing the No. 8 scoop batteries) between the operator’s compartment of the No. 8 scoop and the mine rib.

When Mr. Thompson realized that Mr. Byers was pinned between the No. 8 scoop compartment and the mine rib, he called the No. 2 section foreman Johnathan Moorefield and informed him that help was needed at the No. 8 scoop charging station. Mr. Thompson then plugged the No. 8 scoop batteries up; reset the main breaker; energized the pump motor; and moved the No. 8 scoop away from the mine rib to free Mr. Byers.

At this time, Johnathan Moorefield, No. 2 section foreman, and Brian Farley, No. 2 section electrician, had arrived at the accident scene. Mr. Moorefield called for EMTs and supplies, Mr. Farley assisted David Thompson (EMT) in moving Mr. Byers out into the No. 3 entry.

EMTs Roy Smith, Jonah Clark, Yubrenalm Isabelle, Jeff Varney, and Rodney Smith arrived at the accident scene with supplies.

EMTs assessed Mr. Byers’ injuries and treated him for shock, administered oxygen and prepared him for transport via diesel powered rubber tired mantrip. The five EMTs traveled from the accident scene and arrived on the surface with Mr. Byers at 1:45 p.m.

Jan Care Emergency Services was waiting on the surface and transported Mr. Byers to Raleigh General Hospital. Mr. Byers was then transported by Healthnet to CAMC General Hospital in Charleston WV, where he expired from injuries sustained during the accident.
FINDINGS OF FACT

1. Gregory A. Byers was employed as a scoop operator on the No. 2 section at the Beckley Pocahontas Mine.

2. Gregory A. Byers had been operating the No. 8 Fairchild scoop and was in the process of changing batteries on the No. 8 scoop at the scoop charging station.

3. The No. 8 scoop charging station is located outby the No. 2 section in the cross cut between the No. 2 and No. 3 entries at spad No. 8769.

4. The No. 3 entry is used as the main supply roadway as well as the entry designated for the transportation of employees of the No. 2 section.

5. The crosscut located at the No. 8 scoop charging station overall height is approximately 72 inches and the average width is 19 feet 6 inches.

6. The No. 8 scoop charging station in the crosscut is located at the top of an incline in the No. 3 entry haulage roadway that starts approximately 50 feet inby the charging station and crests at the inby corner of the charging station.

7. The placement of the stopping and the No. 8 scoop charging station in the crosscut forced the No. 8 scoop bucket to protrude 6 to 7 feet into the No. 3 roadway. This placement at the No. 8 scoop bucket partially obstructed the No. 3 entry haulage roadway of the No. 2 section.

8. The No. 11 scoop was traveling outby from the No. 2 section, batteries first in the No. 3 entry haulage roadway. The No. 11 scoop was traveling up the incline, with extraneous materials (3 bags of rock dust) located on top of the No. 11 scoop. The placement of the bags of rock dust on top of the No. 11 scoop limited visibility and prevented the operator from observing the bucket of the No. 8 scoop which was protruding into the No. 3 entry haulage roadway.

9. The left rear battery tray arm of the No. 11 scoop struck the front left corner of the No. 8 scoop bucket. This action moved the No. 8 scoop resulting in Mr. Byers being pinned between the mine rib and the operator’s compartment of the No. 8 scoop.

10. After the control order was issued, surveyors entered the accident scene to perform mapping work prior to the investigation beginning.
CONCLUSION

On July 31, 2012, Greg Byers, scoop operator, received crushing injuries when he was pinned between the mine rib and the operator’s compartment of the No. 8 scoop. Mr. Byers expired on July 31, 2012, as a result of injuries sustained during the accident.

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 in order to preserve the scene of the accident and to complete the investigation.

The West Virginia Office of Miners’ Health, Safety and Training issued 12 violations arising out of its investigation of the accident on July 31, 2012. Eight (8) violations were regularly assessed under case No. 274-0056-2012. Four (4) violations were specially assessed. The following notices of violation were issued to ICG Beckley, LLC. Beckley Pocahontas Mine Permit No. U-3011-95A.

REGULAR ASSESSMENTS

1. Notice of Violation: 121477. Title 36, Series 10, Section 3.1. The mine ribs are not being supported or controlled along the right rib at the No. 8 scoop charging station.

2. Notice of Violation: 121478. Title 36, Series 10, Section 3.1. The mine roof is not being controlled or supported in the last open crosscut in the No. 1 entry on the No. 1 section. A portion of the mine roof has broken loose and is being supported by the line curtain.

3. Notice of Violation: 121479. Chapter 22A, Article 2, Section 4 (a). The approved base plan for methane and dust control is not being complied with in the No. 7 left on the No. 3 section that was cut into intake air. The approved plan, page 3, paragraph 16 states: Except in adverse conditions, or special mining projections, the final cut through of crosscuts into entries or entries into crosscuts will be accomplished from the intake side toward the return side so that the air courses over and away from the continuous miner operator.

4. Notice of Violation: 121480. Title 36, Series 10, Section 3.1. The mine roof is not being supported or controlled in No. 6 entry on the No. 3 section in that a roof bolt has broken off.

5. Notice of Violation: 121481. Title 36, Series 10, Section 3.1. The mine-roof is not being supported or controlled in No. 6 entry on the No. 3 section in that a roof bolt has broken off.
6. Notice of Violation: 121483. Title 36, Series 18, Section 4.1. The No. 2 scoop on the No. 1 section is not being properly maintained in that the rub rail which protects the control panel is missing.

7. Notice of Violation: 121484. Chapter 22A, Article 2, Section 40 (15). The No. 5 fletcher twin boom roof bolter on the No. 1 section is not being maintained in permissible condition. The O ring is missing from the rear area light. 0.30 percent methane was detected at this site.

8. Notice of Violation: 121485. Chapter 22A, Article 2, Section 25 (a). The approved roof control plan is not being complied with on the No. 1 section in the No. 5 entry in that a roof bolt and plate are missing.

**SPECIAL ASSESSMENT’S**

1. Notice of Special Assessment: Case No. 274-0057-2012 (NOV. No. 121482) Title 36, Series 30, Section 4.1. The section roadway on which section haulage equipment travels is not being maintained in a safe condition and free of hazards on the No. 1 section. The stopping and scoop charger located at spad No. 8622 are situated in a manner which causes the scoop to protrude into the section equipment haulage roadway. This condition creates an imminent danger. Under §22A-1-21 (b) (2) (a). This condition violates a health or safety provision or safety rule and is of a serious nature and involves an imminent danger.

2. Notice of Special Assessment: Case No. 274-0058-2012 (NOV. No. 121487) Title 36, Series 30, Section 4.1. The section roadway on which section haulage equipment travels is not being maintained in a safe condition and free of hazards on the No. 2 section. The stopping and scoop charger located at spad No. 8769 are situated in a manner which causes the scoop to protrude into the section equipment haulage roadway. This condition creates an imminent danger. Under §22A-1-21 (b) (2) (a). This condition violates a health or safety provision or safety rule and is of a serious nature and involves an imminent danger.

3. Notice of Special Assessment: Case No. 274-0059-2012 (NOV. No. 121486) Title 36, Series 18, Section 4.1. The No. 11 A.C. Fairchild scoop in service on the No. 2 section is not being maintained in a safe operating condition. Extraneous materials (three bags of rock dust) are stacked on top of the No. 11 scoop, limiting visibility of the scoop operator. Under §22A-2-21 (b) (2) (d). This condition violates a health or safety provision or safety rule and is of a serious nature and involved a fatality.

4. Notice of Special Assessment: Case No. 274-0060-2012 (NOV. No. 121491) §22A-1-21 (b) (2) (a). Following a mine accident resulting in a fatality, evidence at the accident
scene was disturbed after recovery of the victim. Prior to an investigation by the WV Office of Miners’ Health, Safety and Training and after a control order was issued, surveyors for the operator entered the accident scene to perform work prior to OMHST’s investigation. The violation of OMHST’s control order by the operator is a violation of a health or safety provision, is of a serious nature, involves a serious injury that resulted in a fatality.

RECOMMENDATIONS

In accordance with Chapter 22A, Article 1, Section 36, of the West Virginia State Mining Laws: An Addendum to the Comprehensive Safety Program for ICG Beckley LLC, Beckley Pocahontas Mine (Permit No. U-3011-95A) shall include a charging station policy.

ACKNOWLEDGMENT

The West Virginia Office of Miners’ Health, Safety and Training gratefully acknowledges the cooperation of the employees and management of the ICG Beckley, LLC, Beckley Pocahontas Mine and the Mine Safety and Health Administration during the investigation.

APPENDIX

- Mine Information Sheet
- Victim Information Sheet
MINE INFORMATION

COMPANY  ICG Beckley, LLC

MINE NAME  Beckley Pocahontas Mine

WV PERMIT  U-3011-95A  MSHA PERMIT NO. 46-05252

ADDRESS  279 Wolf Run Road, Eccles

COUNTY  Raleigh  PHONE NO.  304-929-4280

DATE PERMIT ISSUED  10-14-2008

WORKING STATUS  Producing

LOCATION  Eccles

UNION  NON-UNION  ✓

DAILY PRODUCTION  7,000 Tons  ANNUAL PRODUCTION TO DATE  600,000 Tons

TOTAL EMPLOYEES  287

NUMBER OF SHIFTS  3

COAL SEAM NAME AND THICKNESS  Pocahontas 3  48” – 52”

ACCIDENT INCIDENT RATE  2.85  LOST TIME ACCIDENTS  3

TYPE OF HAULAGE  Coal

WVOMHST INSPECTOR  Bobby Harper

DATE OF LAST INSPECTION  07-30-2012

NOTIFIED BY  Elmer Billups

NOTIFICATION TIME  1:48 p.m.

CMSP – ANNIVERSARY DATE  04-15-2013

CMSP – CONTACT PERSON  Steve Toler