ROOF FALL FATALITY
(UNDERGROUND MINE)

SEPTEMBER 13, 2012

CONSOLIDATION COAL COMPANY
BLACKSVILLE #2 MINE
PERMIT NO. D-5744

REGION ONE-WESTOVER
14 COMMERCE DRIVE, SUITE ONE
WESTOVER, WEST VIRGINIA 26501
EDWARD PEDDICORD, INSPECTOR-AT-LARGE
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GENERAL INFORMATION

The Consolidation Coal Co., Blacksville #2 Mine, Permit No. D-5744 is located near Wana, in Monongalia County, West Virginia. The underground mine employs 513 miners. The Pittsburgh No.8 seam is accessed by one hoist located at the Wana portal in West Virginia and one elevator at the Kuhntown portal located in Pennsylvania. The mine produces approximately 4 million tons of coal annually from four (4) continuous miner units and one (1) longwall unit. Coal is transported from the working sections in the mine via conveyor belts to the Wana skip shaft. Coal is then transported to the surface by the hoisting skip. Battery/trolley powered rail mounted vehicles are used to transport supplies and mine personnel.

DESCRIPTION

On September 13, 2012 at approximately 3:30 p.m., Mr. William E. Mock, 61 years of age, was fatally injured by a piece of falling roof rock. At the time of the accident, he was attempting to cut/remove a permanent support (roof bolt) that was installed through a wooden plank. The accident occurred at Main North Haulage, between #116 & #117 blocks. Mr. Mock had a total of thirty-eight (38) years of mining experience; with three years at the Blacksville #2 Mine.

At 3:55 p.m. on September 13, 2012 Mr. Edward Peddicord, Inspector-at-Large for Region One of the Office of Miners’ Health, Safety and Training was notified by the Mine and Industrial Accident Emergency Operation Center of the accident. Mr. James Stuckey and Mr. Barry Fletcher (District Inspectors) were contacted by Mr. Peddicord and instructed to go directly to the Blacksville #2 Mine. A joint investigation with the Mine Safety and Health Administration, United Mine Workers of America and Consolidation Coal Company was started immediately.

At the beginning of the shift, Mr. William Mock and Mr. Douglas Ice Jr., general inside laborers, received their instructions via the outby employees work list, dated September 13, 2012. The employees were directed by this work list to travel to the Main North Haulage to raise the trolley wire from block #44 to #46 ¾ block and to work on the bonding at #133 block
overcast. In the early afternoon, Mr. Antonio DiDomenico, supervisor, instructed Mr. Mock to go to #117 side of #116 block along Main North Haulage before the end of the shift to remove an exposed bolt that was hanging near the trolley wire and trim the end of a plank board near this location. Mr. Mock called the dispatcher at approximately 2:00 p.m. and requested permission to dispatch to #116 block. Mr. Ice stated that he and Mr. Mock had removed/cut a bolt from the trolley side of the entry and the attached plank which was broken. Mr. Ice placed the plank in the crosscut toward Kuhntown on the conveyor belt side. After this work was completed they were instructed by the dispatcher, at approximately 3:00 p.m., to move their jeep into the Main North Junction, located toward the Kuhntown portal to allow a belt motor crew to pass. Mr. Mock then requested permission to return to #116 block.

Once the jeep returned to #116 – #117 block area, there was no further communication with the dispatcher or other workers until after the accident occurred. Once they returned to the area toward #116 crosscut they attempted to cut the walkway side of a two hole wooden plank to make it a one hole board. The battery operated, reciprocating hand held saw that Mr. Mock was operating became constricted/pinched while attempting to cut the walkway side of the two hole board at this location. Mr. Ice stated that he intended to cut the trolley side bolt that was through the plank with the reciprocating saw but, Mr. Mock told him that he would cut the bolt with the bonder. Mr. Mock positioned himself on the trolley side near the bolt he was removing from the wooden plank. Mr. Ice stated, in the formal interview that he positioned himself near the north end of the BT #24 Jeep, during the removal of the bolt from the trolley side of the plank which resulted in the failure of the mine roof. Mr. Ice stated that Mr. Mock was cutting the bolt with the bonder when he heard a “pop”, then noticed falling roof material. The next thing he saw was Mr. Mock lying on the trolley side rib pinned against the mine floor and rib by a large piece of roof rock. At that time, Mr. Ice called the dispatcher stating “we have a man down” and requested help.

Thereafter, Mr. Ice approached Mr. Mock and upon examination, no pulse was detected. He attempted to free Mr. Mock by placing a hydraulic jack under a portion of the fallen rock that had Mr. Mock pinned. This effort proved unsuccessful. He then attached a
chain holst to the rock and an inby truss bolt north of the scene, again this effort would not lift the rock off of the victim. Mr. Ice was contacting the dispatcher the second time when he saw the lights of co-workers coming toward him from the Kuhntown portal. Numerous workers assisted in the recovery and removal of the victim. These workers confirmed that the victim had no pulse or signs of life upon their arrival, approximately 15 minutes after the accident occurred. Workers lifted the south end of the rock by hand and placed it on the north end of the jeep. A hydraulic jack was utilized to raise the rest of the rock off the victim so he could be removed. Once the recovery was complete the victim was placed on a backboard and transported by battery mantrip, BT #6 to the surface in a timely manner.

A Monongalia County Emergency Service Ambulance had arrived at the Kuhntown Portal waiting to treat the victim. Upon arrival to the surface Mr. Mock was placed in the ambulance and transported to South West Regional Hospital in Waynesburg, Pennsylvania.

FINDINGS OF FACT

1. William Mock received annual refresher training on March 12, 2012.

2. The cutting and removing of permanent roof supports is not a job/task that miners are formally trained to perform at the Blacksville #2 Mine.

3. The victim was operating the BT #24 battery/trolley powered jeep which was equipped with a 200 amp Goodman bonder that was energized from the jeep batteries. This bonder was being used by the victim at the time of the accident to remove permanent roof support.

4. A DeWalt battery powered reciprocating hand held saw was being used to cut wooden roof planks and metal bolts.

5. The victim was fatally injured when he cut a permanent roof support/roof bolt installed through a two hole plank that was supporting a large piece of mine roof.

6. When the bolt was cut, the plank and roof rock fell pinning the victim against the mine floor and rib resulting in fatal injuries.
7. Neither permanent nor temporary roof support materials were provided on the jeep. Also no permanent or temporary roof support materials were located near the accident site.

8. The two large intact portions of the rock at the accident site were approximately 137” in length, 44” at the widest part and 4”-11” thick.

9. The Trolley wire at the accident scene was guarded.

10. Only Mr. Mock and Mr. Ice were present at the time of the accident.

11. The area of the mine where the accident occurred was developed in March of 1977.

12. The original bolt system installed when the area was initially developed was a three piece system, consisting of two 9’ conventional bolts and one 72” 2 hole wooden plank. The bolts were installed near the end of the wooden planks.

13. The mine roof at the accident site showed visible signs of deterioration from many years of weathering.

14. Additional roof support was installed throughout the years at numerous locations along the Main North Haulage.

15. There were no violations or hazardous conditions recorded in the examination book for the Main North Haulage at or near the accident scene on September 13, 2012.

16. Numerous planks and bolts were observed near the accident site marked with ribbon, including the one that Mr. Mock removed. None of these planks and bolts were noted/identified in the examination book for this area. It was unclear what purpose the ribbons served.

17. The construction book is a book where a record of all outby work performed is recorded along the Main North Haulage and other areas of the mine. This construction book revealed no record of bolts having been removed near or at the accident site in recent weeks.

**CONCLUSION**

The victim was fatally injured when he cut a permanent roof support/roof bolt installed through a two hole plank that was supporting a large piece of mine roof. When the bolt was
cut, the plank and roof rock fell pinning the victim against the mine floor and rib resulting in fatal injuries.

**ENFORCEMENT ACTION**

A non-assessed order was issued in accordance with West Virginia Code Chapter 22A, Article 2, Section 68 to preserve evidence until an investigation by the Office of Miners’ Health, Safety and Training was completed.

A total of five (5) violations were issued during the investigation of this fatal accident: two (2) of which were special assessed violations. The special assessed violations are as follows:

**Title 36, Series 10, Section 14.3(2) exists as follows:** A fatal accident occurred at approximately 3:30 p.m. on September 13, 2012 as a worker was removing permanent roof support which consisted of a nine (9') foot conventional bolt that was placed through one end of a 72” wooden two hole plank. The plank is one piece of a three piece system that consists of the plank and two nine (9') foot bolts installed, one through each end of the plank. The bolt that was cut with a bonder was holding the plank which supported a large roof rock. The large piece of rock fell when the bolt was cut resulting in a fatal injury. Temporary roof supports were not installed prior to removing the permanent roof support (roof bolt). The bolt that was removed which allowed the plank and rock to fall is located at the 33”7” distance on the trolley side as noted on the engineered map provided by mine management. This is a violation of a safety rule, of a serious nature, and involves a fatality.

**Title 36, Series 10, Section 14.1.1 exists as follows:** On September 13, 2012 at approximately 3:30 p.m. the victim was fatally injured when he cut a permanent roof support/bolt that was installed through a two hole plank that was supporting a large piece of mine roof. This work of removing permanent roof support was not supervised by a management person experienced in removing roof supports. This is a violation of a safety rule, of a serious nature, and involves a fatality.
RECOMMENDATIONS

1. A program/policy shall be developed by mine management regarding the manner in which violations, hazardous conditions, mechanical defects and other objects or areas are being identified with ribbons. Fireboss's, inspectors, safety committees and miners often use ribbons to identify these areas or objects as they inspect and travel their work areas throughout the mine. These ribbons which are left hanging for an extended period of time are often confusing and misleading and in most instances not recorded in the fireboss book. The Comprehensive Mine Safety program shall be modified to include this program/policy.

2. Mine Management shall review the requirements of 36-10-14 of the West Virginia mining law 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. Blacksville #2 Mine, Consol Energy Company, Mine Safety and Health Administration, and the United Mine Workers of America during the investigation.
MINE INFORMATION

COMPANY  Consolidation Coal Company

MINE NAME  Blacksville No. 2 Mine

WV PERMIT  D-5744  MSHA PERMIT NO.  46-01968

ADDRESS  P.O. Box 132 Blacksville, WV 26521

COUNTY  Monongalia  PHONE NO.  304-662-2321

DATE PERMIT ISSUED  1969-1970

WORKING STATUS  Active

LOCATION  701 Oak Forest Rd. Holbrook, PA 15341

UNION  x  NON-UNION

DAILY PRODUCTION  19,500 Tons  ANNUAL PRODUCTION TO DATE  1,894,820 Tons

TOTAL EMPLOYEES  513

NUMBER OF SHIFTS  3

COAL SEAM NAME AND THICKNESS  7ft.

ACCIDENT INCIDENT RATE  3.25  LOST TIME ACCIDENTS  13 YTD

TYPE OF HAULAGE  Belts/Skips

WVOMHST INSPECTOR  James Stuckey

DATE OF LAST INSPECTION  Completed 6-27-12

NOTIFIED BY  Mine and Industrial Accident Emergency Operation Center

NOTIFICATION TIME  3:55 p.m. on September 13, 2012

CMSP -- ANNIVERSARY DATE  1-24-2013

CMSP -- CONTACT PERSON  Scott DeVault