
West Virginia Office of Miners' Health, Safety and Training

July 1, 2010

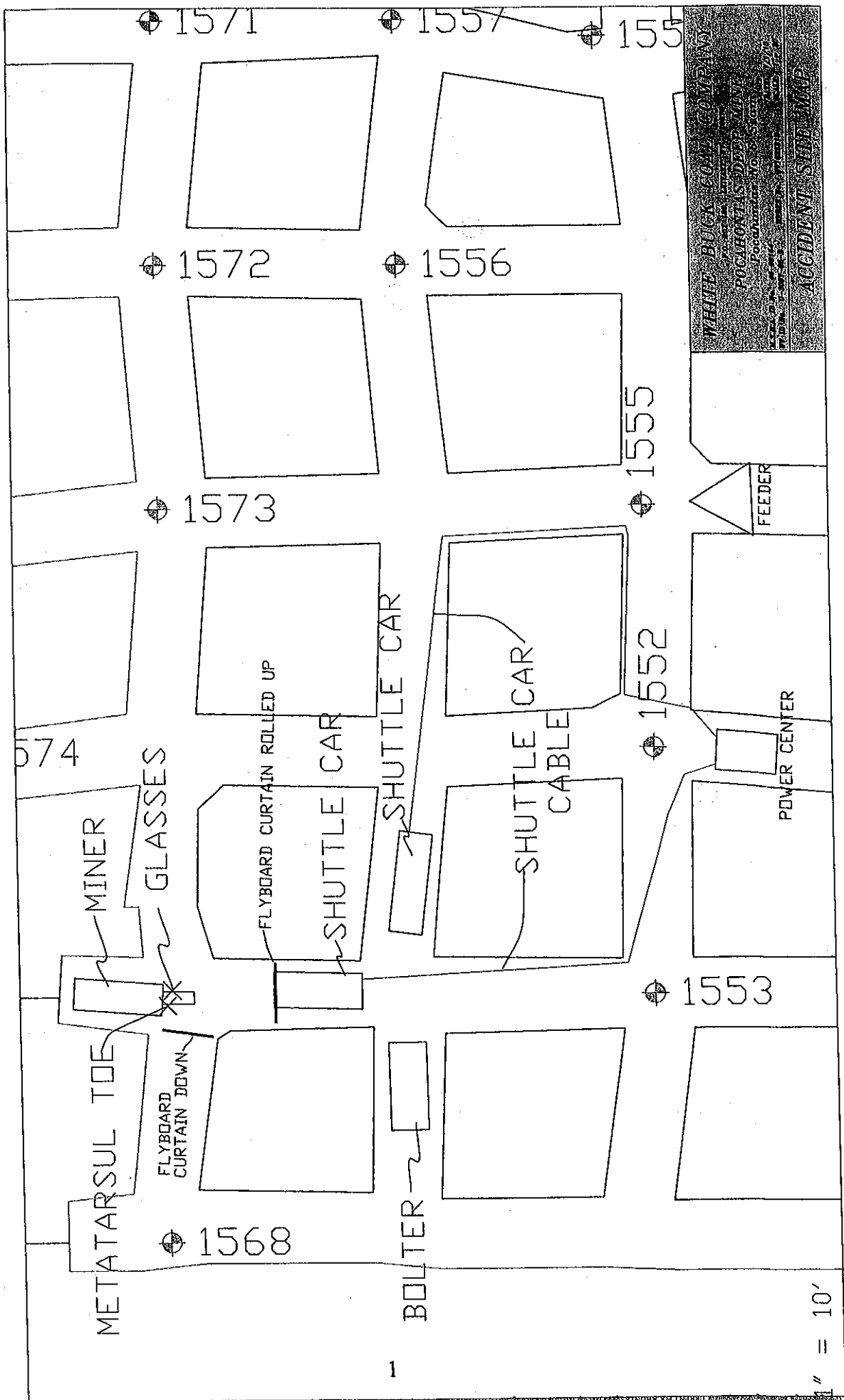
Report of Investigation
Underground Coal Mine Fatality
(Haulage Accident)

White Buck Coal Company
Pocahontas Mine
Permit Number U00300705A

Region IV Office
550 Industrial Drive
Oak Hill, West Virginia 25901
Gary S. Snyder, Inspector-at-Large

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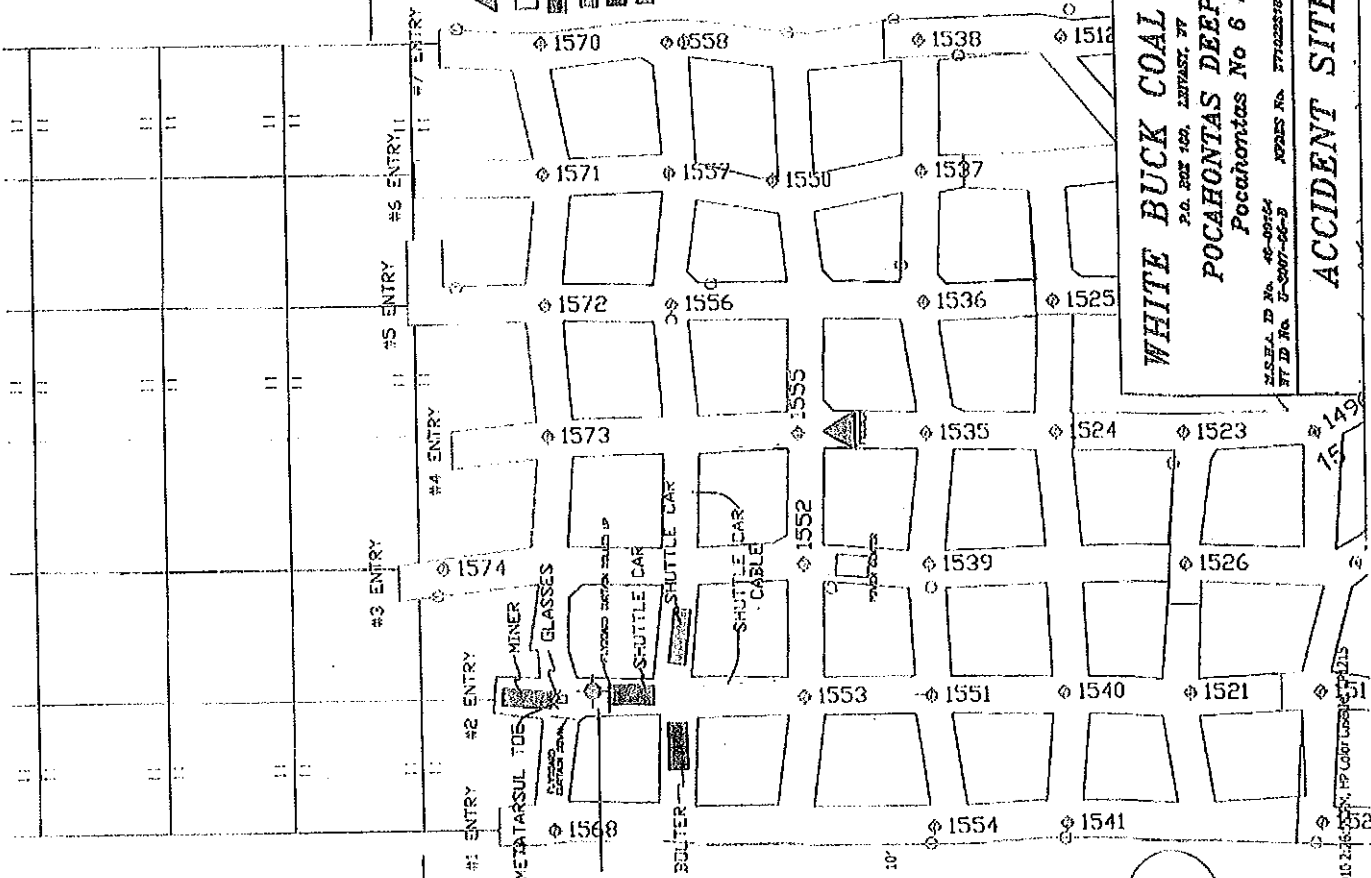
WENTZ-BUCKS FOM COMPANY
 POCAHONTAS DEEP SHAFT
 POCAHONTAS, VA
 ACCIDENT SITE MAP

#2 UNIT

MMU-006-C

MMU-005-C

- ▲ FALLPIECE
- POWER CENTER
- ▨ SHUTTLE CAR #1
- ▨ SHUTTLE CAR #2
- ▨ BELTER
- ▨ MINER
- ◊ VICTIM



DATE OF ACCIDENT: 7/1/2010
 APPROXIMATE TIME: 8:30 AM

WHITE BUCK COAL COMPANY
 P.O. BOX 429, ZAVAST, WY 26076
POCAHONTAS DEEP MINE
 Pocahontas No 6 Seam
 DATE: 7/1/10
 SCALE: 1" = 10'

MINERAL INT. NO. 44-0004
 STATE REG. NO. 15-0007-06-0
 XREFS NO. 771022512

ACCIDENT SITE MAP

**Report of Investigation
Underground Coal Mine Fatality
White Buck Coal Company
Pocahontas Mine, Permit Number U00300705A**

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.

Wilbert Ray Starcher, an employee of White Buck Coal Company, was fatally injured in an accident at approximately 8:30 a.m., on July 1, 2010. Mr. Starcher was working as the Section Electrician on the No. 2 working section when he was struck and run over by a Joy shuttle car.

The Mine and Industrial Accident Emergency Operations Center was notified of the accident at 8:33 a.m. by Quinwood Ambulance and again at 8:44 a.m. on July 1, 2010 by Steve Redden, Superintendent of White Buck Coal Company's Pocahontas Mine. The West Virginia Office of Miners' Health, Safety and Training was notified of the accident by the Mine and Industrial Accident Emergency Operations Center at 8:38 a.m. A joint investigation with the Mine Safety and Health Administration was started immediately.

DESCRIPTION

The White Buck Coal Company, Pocahontas Mine is located on Anjean Road near Rupert, West Virginia in Greenbrier County. The underground mine has two working sections mining in the Pocahontas #6 coal seam. This coal seam is approximately 44 inches thick with average overall mined height of approximately 6 to 6 1/2 feet. The mine has 77 employees and operates five (5) days a week and every other Saturday. Normally, the day and evening shift are production shifts with the midnight shift conducting maintenance activities and performing section belt and power moves.

On July 1, 2010, thirty (30) employees of the White Buck Coal Company started underground at approximately 6:30 a.m. Eleven (11) employees traveled to the No. 2 working section. When the crew arrived at the section power center, the Section Foreman, Franklin D. McMillion, read a portion of the roof control plan to the crew. One roof bolter crew was assigned to add supplemental roof support in an area that had been cited by an MSHA Inspector the previous day. Mr. McMillion examined the working faces and returned to the power center and instructed the rest of the crew to begin their work activities for the day.

Jameson G. Lilly, Continuous Miner Operator, started production in the working face of the No. 2 entry, which was nearly flush with the last open crosscut. Jacob Hinkle and Jeremiah Armstead, Roof Bolter Operators, began work at the roof bolter located in the second crosscut outby the face, between the No. 2 and No. 1 entry, performing pre-operational checks on their machine. The No. 2 Joy shuttle car, operated by Zack Simmons, traveled up the No. 4 entry from the feeder and entered the No. 2 entry through the second crosscut outby the face when production started. The No. 1 Joy shuttle car, operated by Justin Tinney, traveled the crosscut from the feeder and into the No. 2 entry toward the continuous miner.

Shortly before 8:30 a.m. and toward the end of mining cycle in the No. 2 entry, Mr. Tinney stopped his shuttle car and briefly spoke to Mr. Hinkle, who was located at the front of the roof bolting machine. Mr. Tinney stated that he saw Wilbert Starcher, Electrician, standing at the front of the roof bolter talking to Mr. Hinkle. The No. 2 shuttle car was being loaded at the time. Mr. Tinney re-entered the shuttle car when the No. 2 shuttle car appeared to be loaded and was leaving the continuous miner. As soon as he saw the No. 2 shuttle car clear the intersection of the No. 2 entry, he proceeded toward the continuous miner. Around this time, Mr. Hinkle stated that he saw Mr. Starcher walk into the No. 2 entry and toward the miner.

The No. 1 shuttle car traveled to the continuous miner and was loaded. As the shuttle car was leaving the miner, Mr. Lilly noticed a light dragging on the mine floor and saw that the shuttle car was apparently dragging a person. He flagged and shouted at Mr. Tinney to stop. The men found that Mr. Starcher had been run over and was being dragged, face-down, by the shuttle car. Mr. Lilly told Mr. Tinney to go get help. Zach Simmons, who had just arrived in the No. 2 shuttle car and was waiting to go to the continuous miner to be loaded, noticed that the No. 1 shuttle car had stopped. He saw Mr. Tinney running away from the miner, so he went to investigate. He observed what had taken place, so he ran to the mine phone and called outside to report the accident. He then returned to the accident site to assist. Mr. Hinkle and Mr. Armstead, who were at the roof bolter, had already arrived at the accident site to help free the victim.

Franklin McMillion, Section Foreman, and Teddy Alderman, Mine Foreman who was also on the section, learned of the accident and immediately went to the scene. The shuttle car is equipped with a hydraulic service jack on the right front corner. The men decided to use it to raise the shuttle car and free Mr. Starcher. The jack was extended to the mine floor but would not adequately raise the shuttle car. A 6-inch by 6-inch square timber was brought to the scene and placed under the foot of the service jack. This allowed the shuttle car to be raised higher. Mr. Starcher's foot was caught between a chain flight and a cross member, but he was soon freed and removed from underneath the shuttle car. Vital signs were checked, but none were ever detected. Mr. Starcher was placed on a backboard, taken to the section's track-mounted mantrip and transported to the surface.

Upon arrival at the surface, the victim was transferred to a waiting ambulance. Mr. Starcher was transported to the Greenbrier Valley Medical Center, where he was pronounced dead at 10:00 a.m. by R.W. Foster, D. O.

FINDINGS OF FACT

1. Wilbert Ray Starcher was working as the electrician on the No. 2 working section. This was the first day he had been assigned to this particular job. He had previously been working as an outby electrician. The electrician previously assigned to this section had retired on June 30, 2010.
2. Shortly before the accident, Mr. Starcher was located at the front of the roof bolting machine, which was parked in the crosscut between the No. 2 and No. 1 entry just outby the operating continuous miner. He was last seen leaving this area and walking up the No. 2 entry toward the continuous miner.
3. The available equipment maintenance records did not indicate that any problems existed with the No. 1 Joy shuttle car.
4. The roadway in this area was generally wet and muddy with approximately two inches of mud existing in this area and throughout the section. This mine floor was relatively flat, but slight dips also existed at the accident scene.
5. A fly board was previously installed on the roof just outby the area where the continuous miner was operating. The fly board was approximately 29 feet outby the back of the continuous miner. Translucent fly pads were installed on this board to assist in ventilation control. It was reported that the continuous miner operator had rolled-up one fly pad on the right side of the No. 2 entry to improve his visibility of the shuttle cars as they approached the continuous miner.
6. A sideboard had been added to the No. 1 shuttle car that inhibited the view of the operator. This sideboard was installed to a height that only allowed approximately $\frac{3}{4}$ to 1 inch of clearance between it and the bottom of the canopy. The other two shuttle cars being used on the section had differently constructed sideboards. None of the three shuttle cars had sideboards of the same design.
7. An inspection of the No. 1 Joy shuttle car, Model 10 SC-32 / Serial No. 16916, by the WV OMHS&T and MSHA Technical Support Group showed no defects, other than the added sideboard, affecting safe operation of the shuttle car.
8. The seam thickness at this mine is approximately 44 inches. The overall height in the area of the accident was approximately 6 – 6 $\frac{1}{2}$ feet.

CONCLUSION

The victim was apparently struck from behind and run over as he was attempting to travel up the No. 2 entry within the shuttle car's path of travel. The operator of the shuttle car was unable to see him as he was approaching the continuous miner to be loaded.

ENFORCEMENT ACTION

A non-assessed control order was issued in accordance with Chapter 22A, Article 2, Section 68 of the West Virginia Mining Laws in order to preserve the scene of the accident and to complete an investigation. The WV Office of Miners' Health, Safety and Training issued eight (8) notices of violation during this investigation. The following notices of violation were issued to White Buck Coal Company, Pocahontas Mine:

Notice of Violation; Chapter 22A, Article 2, Section 37(x):

The No. 1 shuttle car, serial number ET16916, in use on the No. 2 working section has been altered by the addition of sideboards so as to inhibit the view of the operator. A solid metal sideboard is in place between the operator's deck and the cargo area of this shuttle car, with approximately $\frac{3}{4}$ inch gap between the top of the sideboard and the canopy. Also, a solid piece of metal approximately 10 inches high and approximately 16 inches long is welded between the operator's deck and the inby end of this shuttle car. This violates a provision of the West Virginia Code, is of a serious nature and involves a fatality. In addition, it has been determined that this condition creates an imminent danger.

Notice of Violation; Chapter 22A, Article 2, Section 40(6):

Dry insulated platforms are not provided for the area beneath the circuit breakers in use on the left side of the No. 2 section power center. Two of the insulating platforms provided for this area are covered with a mixture of water and wet sludge. The remaining insulating platform provided for the left-side circuit breakers is presently covered with water approximately one (1) inch deep.

Notice of Violation; Chapter 22A, Article 2, Section 4(a):

A minimum quantity of 3,000 cubic feet of air per minute is not provided to adequately ventilate the No. 3 working face of the No. 2 working section. An anemometer reading taken near the end of the line curtain in this working face revealed that only 1,785 cubic feet of air is presently being delivered to this working face.

Notice of Violation; Chapter 22A, Article 2, Section 4(a):

A minimum quantity of 3,000 cubic feet of air per minute is not provided to adequately ventilate the No. 4 working face of the No. 2 working section. An anemometer reading taken near the end of the line curtain in this working face revealed that only 1,980 cubic feet of air is presently being delivered to this working face.

Notice of Violation; Chapter 22A, Article 2, Section 4(a):

A minimum quantity of 3,000 cubic feet of air per minute is not being provided to the No. 5 right working face on the No. 2 working section. An anemometer reading taken near the end of the line curtain revealed that there was inadequate airflow to turn the vanes on the anemometer.

Notice of Violation; Chapter 22A, Article 2, Section 4(a):

A minimum quantity of 3,000 cubic feet of air per minute is not provided to adequately ventilate the No. 6 working face on the No. 2 section. An anemometer air quantity test could not be conducted near the end of the line curtain in this working face, in that a movement of air sufficient to turn the blades of the anemometer is not present.

Notice of Violation; Chapter 22A, Article 2, Section 40(15):

The No. 1 Joy shuttle car, serial number ET16916, in use on the No. 2 working section is not maintained in permissible condition. The gland plugs on both operator side headlights are not tack welded, or otherwise locked in place to prevent them from loosening. No methane is detected on this section at this time.

Notice of Violation; Chapter 22A, Article 2, Section 4(a):

A minimum quantity of 3,000 cubic feet of air per minute is not being provided to the No. 7 working face on the No. 2 working section. An anemometer reading taken near the end of the line curtain revealed that only 2,835 cubic feet per minute was being provided.

RECOMMENDATIONS

In accordance with Title 56, Series 8, Section 9.4 of the WV Mining Laws, the comprehensive mine safety program for the White Buck Coal Company, Pocahontas Mine shall be modified to include the following:

1. Sideboards on all shuttle cars at this mine site will be standardized and will be designed so as to not inhibit the view of the operator.
2. Members on foot will visually or verbally notify the equipment operator before traveling in close proximity to equipment being operated and before crossing the equipment's intended path of travel. Mine management will conduct periodic safe job observations to ensure that these procedures are being followed.
3. All members will be trained in these procedures at the beginning of their shifts prior to resuming production at the mine site. All future new employees will be trained in these procedures before starting their job duties.
4. This procedure will be added to the State Comprehensive Mine Safety Plan for this mine.

ACKNOWLEDGMENT

The West Virginia Office of Miners' Health, Safety and Training gratefully acknowledges the cooperation of the employees and management of White Buck Coal Company and the Mine Safety and Health Administration during this investigation.

APPENDIX

- Mine Information Sheet
- Victim Information Sheet

MINE INFORMATION

COMPANY White Buck Coal Company

MINE NAME Pocahontas Mine

WV PERMIT U00300705A

ADDRESS P.O. Box 180, Leivasy, WV 26676

COUNTY Greenbrier

DATE PERMIT ISSUED November 25, 2008

LOCATION Anjean Road, near Rupert, WV

UNION _____ NON-UNION Yes

DAILY PRODUCTION 2,032 tons

ANNUAL PRODUCTION TO DATE 372,608 tons

TOTAL EMPLOYEES 77 NUMBER OF SHIFTS 3

NAME OF COAL BED Pocahontas #6

SEAM THICKNESS 44 inches

ACCIDENT INCIDENT RATE 4.70 LOST TIME ACCIDENTS 2

TYPE OF HAULAGE Shuttle car / belt

WV OMHST INSPECTOR Byron L. Tucker, Jr.

DATE OF LAST INSPECTION June 29, 2010

NOTIFIED BY Steve Redden, Superintendent

TIME OF NOTIFICATION 8:44 a.m. on July 1, 2010

CMSP - ANNIVERSARY DATE December 2, 2010

CMSP - CONTACT PERSON Larry Roop

VICTIM INFORMATION

NAME: Wilbert R. Starcher

AGE: 60

TOTAL MINING EXPERIENCE: 35 years

AVERAGE NUMBER OF DAYS WORKED PER WEEK: 5-6 (Every other Saturday)

AVERAGE NUMBER OF HOURS WORKED PER WEEK: 45-54

LENGTH OF SHIFTS AT MINE: 9 hrs. TRAVEL TIME TO/FROM WORK: 20 min.

OCCUPATION AT TIME OF ACCIDENT: Electrician

REGULAR OCCUPATION: Electrician

COAL MINER'S CERTIFICATION: N-5754

OTHER CERTIFICATIONS: Electrician NR-2378, Surface Miner 8-3946, Shot Firer

KA-2402, Underground Mine Foreman 33646-82

DEPENDENTS: None

DATE OF ACCIDENT: 1st DAY OF July 2010

AT: 8:30 a.m. O'CLOCK

LOCATION OF ACCIDENT: No. 2 entry of the No. 2 Section just outby the face area

CAUSE OF ACCIDENT: The victim was struck and fatally injured when he entered the

travel path of the No. 1 shuttle car. The accident occurred due to the shuttle car

operator being unable to see the victim.

DATE OF DEATH: 1st DAY OF July 20 10