

REPORT OF FATALITY

JANUARY 16, 2014

METTIKI COAL, LLC (WV)

METTIKI E MINE

PERMIT #U00200104

REGION ONE

14 COMMERCE DRIVE, SUITE ONE

WESTOVER, WEST VIRGINIA 26501

EDWARD PEDDICORD, INSPECTOR-AT-LARGE

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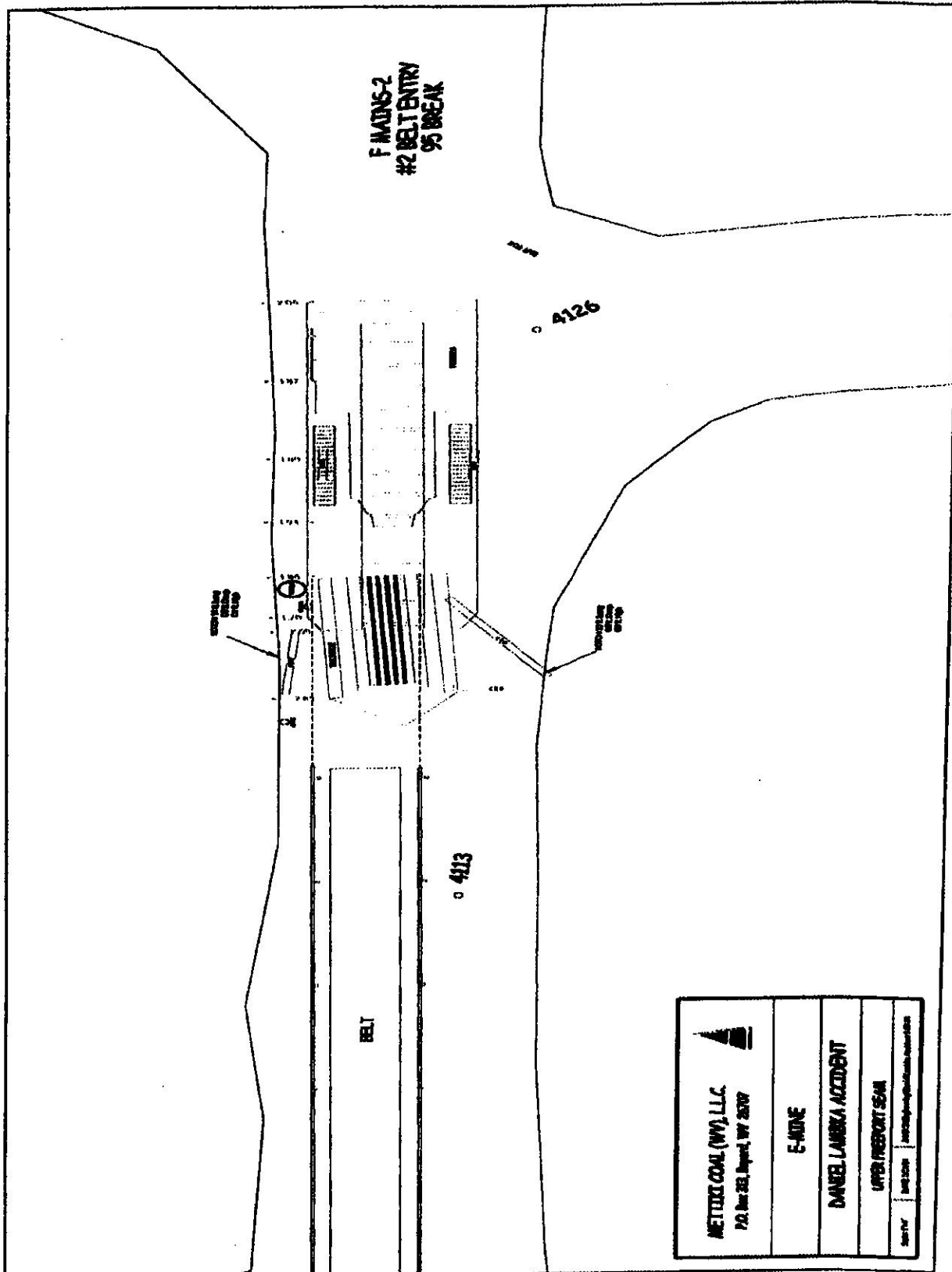
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** The scale referenced is not accurate due to the map being minimized to fit the format of this report.

GENERAL INFORMATION

The Mettiki Coal, LLC (WV), Mettiki E Mine, Permit #U00200104 is located near Davis, Tucker County, West Virginia. The underground mine employs 223 miners. The Upper Freeport seam is accessed by the E Mine slope located at the mine portal. The mine produces approximately 2 million tons of coal annually from two (2) continuous miner units and one (1) longwall unit. Coal is transported from the working sections in the mine via conveyor belts to the surface. Diesel and battery powered vehicles are used to transport supplies and mine personnel.

DESCRIPTION

On January 16, 2014, at approximately 9:05 p.m., Daniel K. Lambka, 20 years of age, was fatally injured while assisting with the installation of the F Mains #2 conveyor belt and the positioning of the Oldenburg Stamler Feeder. This accident occurred in the #2 entry, at cross-cut #95, on the F Mains working section. Mr. Lambka had a total of two and one half (2.5) years of mining experience with four and one half (4.5) months at the Mettiki E Mine.

On January 16, 2014, at 9:14 p.m., the Mine and Industrial Accident Rapid Response System was notified that an accident had occurred at the Mettiki E Mine. West Virginia Mine Inspectors; Allen Nestor and Tadd Rankin were informed by John Meadows, Assistant Inspector at Large of the West Virginia Office of Miners' Health, Safety and Training and were instructed to go directly to the Mettiki E Mine. A joint investigation with the Mine Safety and Health Administration and Mettiki Coal, LLC (WV) began immediately.

On January 16, 2014, at approximately 3:00 p.m., a crew of men traveled from the E Mine portal to the F Mains Section to begin their regular job duties and the installation of the F Mains #2 Section conveyor belt. This crew consisted of Mettiki Coal, LLC (WV) employees; Rodney Rosier Jr., Jonathan Zinn, Dylan Simmons, Randy Murphy, Aaron Friend, Vince Sisler, Jason Smith, Kenneth Friend, Anthony Glover, Mike Waybright, Charlie Bostick, William DeMoss, Jerry Adams, Bobby Morgan, Matt Rodeheaver and Daniel Lambka, under the supervision of Douglas Corbin, underground mine foreman.

The miners working on the belt installation trammed the feeder off the tailpiece and spliced in the additional piece of belt. They attached the scoop to the tailpiece then pulled the belt and tailpiece inby one block. The miners then installed the ridged structure and set the tailpiece by positioning wooden (5"x7") posts, installed on an angle from the inby end (tail roller end) of the tailpiece into the outby notches in the ribs, near the mine floor.

The belt was started and ran for approximately 20 seconds when miners noticed movement of the tailpiece and feeder. They immediately instructed Mr. Morgan, who was located at the conveyor belt switch to deactivate the conveyor belt by pulling the pull cord. The outby end of the anchoring post positioned from the inby end (tail roller end) of the tailpiece on the tight side had come out of the notch in the rib. This allowed the outby end of the tailpiece to shift toward the walk side of the conveyor belt and the inby end of the tailpiece to move forward. This movement of the tailpiece caused the front of the feeder to shift toward the tight side of the belt entry rib where the victim was positioned. The front of the feeder was attached with chains to the rear of the tailpiece which contributed to the movement of the front of the feeder. This sudden and unexpected movement of the front of the feeder resulted in Mr. Lambka being pinned between the solid coal rib and the feeder.

Miners immediately dispersed to get medical supplies and equipment to assist Mr. Lambka. Mr. Corbin was performing a pre-shift examination of the section. Upon his arrival at the accident location, he instructed Mr. Rosler to help him cut the conveyor belt in two outby the tailpiece in order to relieve tension from the belt. An Auxier shuttle car, located nearby, was hooked to the feeder and an attempt was made to pull the feeder from the rib but the chain broke. Mr. Simmons then attempted to tram the feeder away from the rib to free the victim, but the feeder would not move. In the final attempt to move the feeder, the shuttle car pulled the feeder sideways with a larger chain in conjunction with the tramping of the feeder. This enabled the miners to move the feeder and free Mr. Lambka.

Miners relocated the victim to the inby end of the feeder and immediately started to render medical assistance. They began CPR and oxygen was administered but Mr. Lambka was unresponsive. Calls were made to the surface to secure transportation and to alert others of

the accident. Mr. Lambka was secured for transport and miners continued treatment while traveling to the surface. Once on the surface, Mr. Lambka was transferred to the care of Tucker County EMS, where the decision was made by Medcom to stop CPR. The Tucker County Medical Examiner/Coroner pronounced the time of death at 10:08 p.m. on January 16, 2014. Mr. Lambka was then transported to Davis Memorial Hospital in Elkins, West Virginia.

FINDINGS OF FACT

1. Daniel Lambka received a West Virginia Underground Miner Certification, #1-19876, on February 29, 2012.
2. Mr. Lambka received experienced miner training from Mettiki Coal, LLC (WV) on September 17, 2013.
3. Mr. Lambka's job title was general inside labor.
4. The afternoon shift at this mine is the non-production shift.
5. A conveyor belt take-up system is not always utilized on development.
6. A conveyor belt take-up system was recently installed in the F Mains #2, 48 inch conveyor belt. The 48 inch belt was supported by 60 inch structure. The belt was approximately 5,100 feet in length.
7. The F Mains #2 conveyor belt drive and take-up is manufactured by The Continental Conveyor and Equipment Company.
8. The F Mains #2 conveyor belt take-up was inspected after the accident and was found to be operating properly. The pressure to activate the hydraulic take-up unit was approximately 800 psi and deactivates at approximately 940 psi.
9. The conveyor belt structure is suspended from the mine roof with chains.
10. The conveyor belt is offset toward the tight side to accommodate clearance for the secondary escapeway.
11. The conveyor belt tailpiece weighs approximately 4 ton and is manufactured by Fairfax Machine and Welding, Inc.

12. The posts used to assist in the anchoring and the installation of the conveyor belt tailpiece are wooden bars. These bars, referred to as "posts", measure 5 inches by 7 inches in diameter, varying in lengths. Wooden header boards and wooden wedges are used at times to assure the ends of the wooden posts are tight once placed into the rib.
13. The anchor posts are installed on an angle from the inby end (tail roller end) of the tailpiece (on each side) into the notches cut into the rib on the outby end of the tailpiece near the mine floor.
14. Once the belt is aligned in order to stabilize the front of the conveyor belt tailpiece, additional posts are installed from the outby end of the tailpiece (on each side) to the rib, near the mine floor.
15. The Oldenburg Stamler Feeder, serial #13746, weighs approximately 45 ton. The feeder was positioned over the F Mains #2 conveyor belt tailpiece at the time of the accident. The feeder was not operating or being trammed and was empty at the time of the accident.
16. The front, outby end of the feeder is normally attached by chains to the rear, inby end of the tailpiece.
17. At the time of the accident investigation, the walk side chain was tight. The tight side chain, near the victim's location, was installed loosely from the feeder through the tailpiece clevis.
18. The feeder crawler (tracks) used for tramping the feeder were placed on a single crib positioned longways, located near the center of the crawler system. The tight side crawler had two rib boards on top of the crib and the walk side had one rib board on top of the crib.
19. The procedures and equipment being used the day of the accident during the installation of the F Mains #2 conveyor belt were similar to those used on a regular basis.
20. Accident site: The height from roof to floor was approximately 12 ½ feet, the width of the entry was approximately 18 feet 2 inches, the mine floor was wet and muddy.

21. No violations or hazardous conditions were noted in any examination book regarding the accident site prior to the accident.
22. Mr. Lambka was fatally injured when the outby end of the Oldenburg Stamler Feeder, positioned at the F Mains #2 conveyor belt tailpiece, pivoted toward the tight side coal rib and pinned the victim between the coal rib and the feeder.

CONCLUSION

Mr. Lambka was fatally injured on January 16, 2014, at approximately 9:05 p.m. The victim was pinned between the Oldenburg Stamler Feeder and the coal rib due to the outby end of the anchoring post installed from the inby end of the tailpiece on the tight side dislodging from the notch in the rib. This allowed the outby end of the feeder which was attached with chains to the inby end of the tailpiece to move. This sudden and unexpected movement resulted in Mr. Lambka being pinned between the solid coal rib and the feeder.

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 is completed.

RECOMMENDATIONS

As a result of a fatality at the Mettiki Coal, LLC (WV), Mettiki E Mine, the following recommendations shall be submitted as a modifications to the Comprehensive Mine Safety Program.

1. The tailpiece will be securely anchored with two inby jacks or posts into the mine rib. In addition, two flag pins inby the tailpiece shall be installed a minimum of three feet into the mine floor and securely anchored by chains to the tailpiece.
2. The notches where the posts will anchor from the rear of the tailpiece into the mine rib will be a minimum of eight inches into the rib.
3. The feeder will be set solidly to the ground and blocked where necessary by cribs or other blocking material from the discharge boom of the feeder to the inby end of the tailpiece.
4. All personnel are to be clear of the conveyor belt tail area and outby the belt tail for at least one block or in a crosscut, at the initial start-up of the conveyor belt.
5. Once the belt has been ensured to be running correctly, the two outby jacks or posts will be set.

ACKNOWLEDGEMENT

The West Virginia Office of Miners' Health, Safety and Training gratefully acknowledges the cooperation of the management and employees of Mettiki Coal, LLC (WV), Alliance Resource Partner, L.P. representatives and the Mine Safety and Health Administration.

MINE INFORMATIONCOMPANY Mettiki Coal, LLC (WV)MINE COMPANY Mettiki E MineWV PERMIT # U00200104 MSHA PERMIT # 46-09028ADDRESS 293 Table Rock Rd. Oakland, MD 21550COUNTY Tucker PHONE NO. 304-259-4912DATE PERMIT ISSUED September 20, 2004WORKING STATUS ActiveLOCATION Rt. 93, 6 miles east of Davis, WVUNION _____ NON-UNION XDAILY PRODUCTION 15,000 tons ANNUAL PRODUCTION TO DATE 240,000 tonsTOTAL EMPLOYEES 223NUMBER OF SHIFTS 3COAL SEAM NAME AND THICKNESS Upper Freeport 8 ½ feetACCIDENT INCIDENT RATE 3.81 LOST TIME ACCIDENTS 7TYPE OF HAULAGE BeltsWVOMHST INSPECTOR Allen NestorDATE OF LAST INSPECTION Regular completed December 10, 2013NOTIFIED BY Jed JonesNOTIFICATION TIME 9:14 p.m. on January 16, 2014CMSP-ANNIVERSARY DATE October 15, 2014CMSP-CONTACT PERSON Terry Hanline