West Virginia Office of Miners' Health, Safety and Training

May 17, 2012

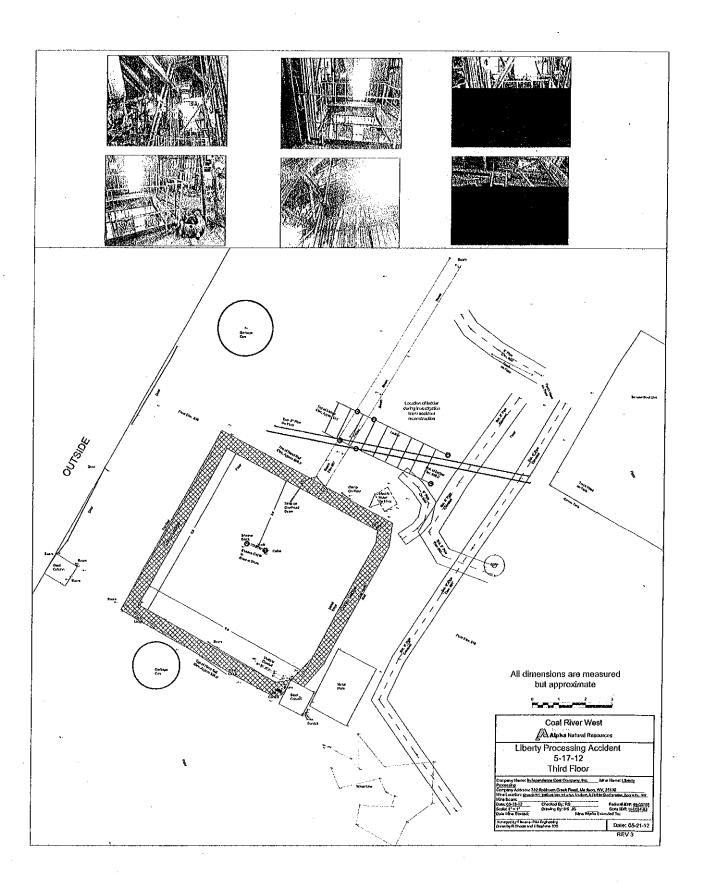
Report of a Fatality by Fall to a Lower Level Liberty Processing

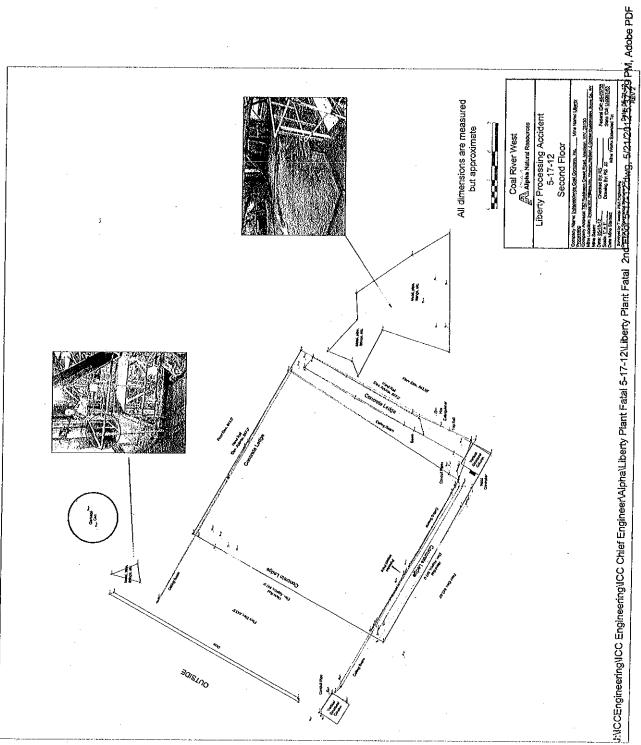
Independence Coal Company
Liberty Processing
L-699

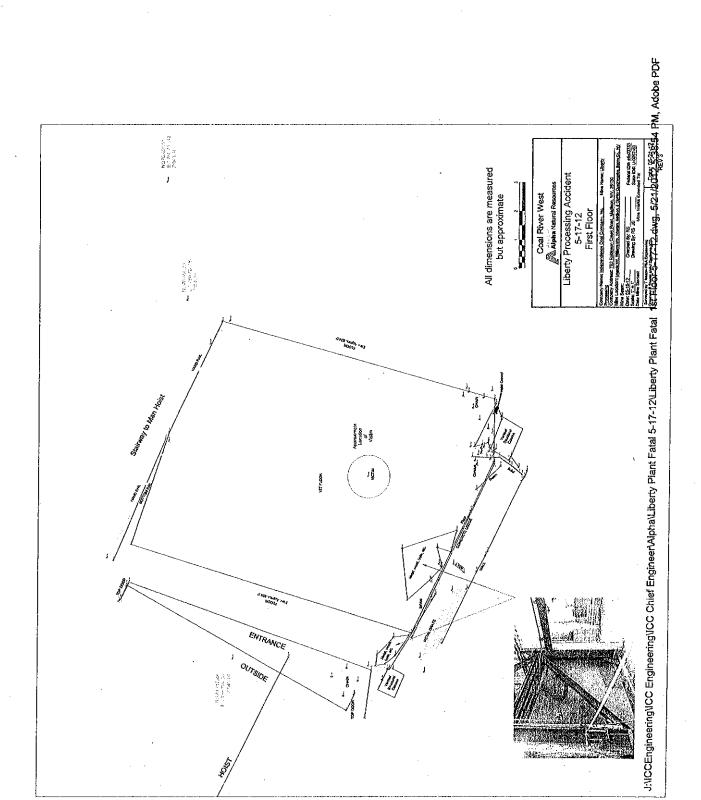
Region III 137 Peach Court, Suite 2 Danville, WV 25053 John Kinder, Inspector-at-Large

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General Information

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

Independence Coal Company was permitted to operate Liberty Processing on July 15, 1996. The plant is located on Robinson Creek Road off state Rt. 85 near Uneeda, Boone County, West Virginia.

Liberty Processing has a total of 45 employees and operates three (3) shifts per day. The plant has two coal processing facilities, Plant "A" and Plant "B". The accident occurred at the "A" plant.

The victim, Clyde Dolin, was 57 years of age and had 39 years of surface experience and 13 years at this preparation plant facility.

Mr. Dolin, an employee of Independence Coal Company, Liberty Processing, was fatally injured in an accident which occurred at approximately 11:52 a.m. on May 17, 2012. Mr. Dolin was working as a mechanic on the third floor of the "A" plant when he fell through the hoist well to the basement floor.

The Boone County 911 Emergency Service Authority was notified of the accident at 11:53 a.m., and the Industrial Accident Emergency Operations Center was notified of the accident at 11:58 a.m., by Bob Richmond, plant control room operator for Independence Coal Company. 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 12:04 p.m. A joint investigation with the Mine Safety and Health Administration and mine management began immediately.

Description

On May 17, 2012, mechanic Clyde Dolin began his shift at 7:00 a.m. at Liberty Processing. The facility is divided into two separate processing plants, "A" and "B". The "A" plant is the oldest part of the facility and where the fatal accident occurred. The "B" plant is the newer portion of the facility. A project of removing old support structures in the "A" plant was underway and began several months prior to the accident. On the 3rd floor, a section of old 12 inch trolley beam extended over the edge of the hoist well, created an obstacle for hoisting materials to the 3rd floor.

Removing this portion of the trolley beam was included in the ongoing project of removing old support structures in the "A" plant. The victim, Mr. Dolin, and two co-workers, Brandon Geer and William Mark White, decided to begin the project. Mr. Geer assisted Mr. Dolin by raising the well hoist up to Mr. Dolin's level so he could place the well hoist hook in the eye of the sling that Mr. Dolin was tying to the old beam. Mr. Geer was positioned across from Mr. Dolin's left, on the other side of the hoist well operating the hoist at the time of the accident. Mr. White prepared the cutting torches and connected them to the acetylene and oxygen regulators installed on the three and a half 3 ½ floor directly behind Mr. Dolin at the time of the accident.

Mr. Dolin selected a fourteen foot top section of a separated twenty four foot extension ladder, manufactured by Werner, to access the trolley beam. Mr. Dolin climbed up the ladder approximately six feet from the plant floor to reach the trolley beam location with the hoist well positioned on his left side. Mr. Dolin reached to his left to knot tie the eye-to-eye nylon sling to the end of the old trolley beam. As he reached over, the ladder began to slide toward his left causing the right ladder rail to rise above the floor. Mr. Dolin and the ladder cantilevered over the hoist railing falling into the hoist well. Mr. Dolin held onto the ladder and remained in contact with the ladder to the basement floor.

Immediately after the accident, co-workers Norman Roberts and Roger Hamilton were the first to arrive to aid Mr. Dolin. They untangled his feet and removed the ladder. First-aid was administered by the plant foreman, James Maynard, and emergency medical technician, James Noble. Mr. Nobel, an employee of the Allegiance mine, was dropping mine samples off to the dust lab when he became aware of the accident. The plant foreman, Mr. Maynard, administered CPR and Mr. Noble checked Mr. Dolin for breathing and a pulse, and neither was detected. Others arrived with a stretcher and first aid supplies. An Automated External Defibrillator (AED) was placed on Mr. Dolin and registered "no shock advised, continue CPR." Mr. Dolin was carried from the plant floor to the bed of a one ton flatbed Ford truck and continued CPR for 2 to 3 minutes until the Boone Ambulance Authority arrived and took over administering CPR and transported Mr. Dolin to Boone Memorial Hospital where he was pronounced dead at 1:01 p.m. by Dr. Chanaa.

Conclusion

Mr. Clyde W. Dolin was fatally injured when he fell from an elevated work position on the 3rd floor of the plant to the basement floor. Mr. Dolin fell a total of three plant floor levels, through

the area of the plant known as the hoist. Mr. Dolin fell because the ladder he was using was not secured against movement and he was not tied off with a safety vest or lanyard type harness.

Findings of Fact

- 1) Mr. Clyde W. Dolin had a total of thirty nine years of mining experience and had worked for Independence Coal Co., Liberty Processing a total of thirteen years as a mechanic. Several of the employees commented that Mr. Dolin was highly respected by his coworkers and looked up to him for his knowledge and experience. Mr. Dolin was preparing to remove a portion of an old trolley beam from an elevated work position six feet off the 3rd floor surface a few feet from the hoist well area of the Liberty plant "A" side
- 2) A two inch angle iron was mounted to the end of the old beam and extended up to the bottom of the 4th floor structure. The angle iron was detached from the 4th floor anchorage and the old beam moved from side to side. The 3rd floor also moved from vibration when the plant was in operation.
- 3) Mr. Dolin used the top section of an extension ladder that according to the manufacturer, was not designed to be used without the bottom section. The ladder did not have feet or skid pads on either end. The ends of the ladder rails were rounded on both ends.
- 4) Mr. Dolin did not secure the ladder against movement nor did he use proper personal protective equipment for fall protection (safety vest or lanyard type harness) to perform the task.
- 5) Mr. Dolin had two safety harnesses with lanyards in his tool box located on the 5th floor of the processing plant.
- 6) Inspection of ladders used in the "A" and "B" plant revealed the presence of five extension ladders that were damaged and not maintained in good condition. Two ladders were in fact separated top portions of extension ladders that had no feet or skid pads installed. One ladder was cut off to six and a half feet long and did not have feet or skid pads installed.
- 7) Debris, in the form of two, two inch rolling stock, (metal pipes) measuring ten feet long, were present under or near the ladder used by Mr. Dolin prior to the accident. Also, an old electric motor, an eight inch pipe elbow and a six inch pipe clamp used to patch holes and leaks were lying between the ladder position and the hoist well opening that created tripping, stumbling hazards at the accident scene.

- 8) According to testimony, each employee was issued at least one safety harness and given instructions on its use. Employees were responsible for the maintenance and up keep of these devices.
- 9) The hoist well opening on the 3rd floor level is rectangular in shape and measured eighty three inches by seventy eight inches. Hand rails located around all four sides of the opening measured forty two and a half inches high. The opening extended from the basement floor up to the 6th floor of the "A" plant. The total distance from the top of the twelve inch trolley beam where Mr. Dolin was working, down to the basement floor was thirty nine feet and three inches
- 10) No grab hooks or similar facilities to tie off harnesses or lanyards were provided at hoist well landings throughout the plant.
- 11) Testimony from witnesses revealed that the top portion of separated extension ladders were commonly used in the plant to reach elevated work positions and workers were observed standing on ladders in elevated work positions without securing the ladder from movement or wearing safety equipment.

Enforcement Action

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

One (1) violation was issued during the investigation. This is a violation of a health and safety statute, is of a serious nature, and involved a fatality.

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 accident scene and to complete the investigation.

(Violation 107784) Chapter 56, Article 3, Section 43-11 (a) (b). Based on evidence observed and testimony given during an investigation of a fatal accident that occurred on May 17, 2012 at approximately 11:52 a.m., a ladder was used to gain access to an elevated work position that was not securely fastened in place to prevent movement and not maintained in good condition in that the ladder was the top portion of a separated extension ladder that did not have feet or skid pads on either end. A fatal injury occurred when the ladder shifted and the victim fell to the plant basement floor, a distance of thirty nine feet and three inches. A caution label attached to the ladder stated that "This section of ladder is not designed for separate use". This notice of violation is a violation of a health and safety statute, is of a serious nature, and involved a fatality.

A regular safety and health inspection at Liberty Processing was conducted immediately following the fatal accident. Fifteen (15) additional Notices of Violation were issued during the inspection.

Recommendation

In an effort to prevent a re-occurrence of the fatal accident that occurred to Mr. Dolin on May 17, 2012, the following recommendation is made:

1. A revision of the approved Comprehensive Mine Safety Program for Liberty Processing to address ladder safety, fall protection and hoist safety including methods, procedures and practices for using such equipment.

Acknowledgement

The West Virginia Office of Miners' Health, Safety and Training gratefully acknowledges the cooperation of the employees and management of Independence Coal Co., Liberty Processing and the Mine Safety and Health Administration during this investigation.

Appendix

- Mine Information
- Victim Information
- Company Recommendation

MINE INFORMATION

COMPANY	Independence Coal Company						
MINE NAME	Liberty Processi	ng					
WV PERMIT	L-699	MSHA PERMIT NUMBE	R	46-03755			
ADDRESS	782 Robinson Creek Road, Madison, WV 25130						
COUNTY	Boone	PHONE NUMBER	304-369	9-1269			
DATE PERMIT ISSUED July 15, 1996							
WORKING STAT	US	Active					
LOCATION Robinson Creek Road Off Route 85							
UNION		NON-UNION		X			
DAILY PRODUCTIONANNUAL PRODUCTION TO DATE							
TOTAL EMPLOYEES 45							
NUMBER OF SH	IFTS	3					
COAL SEAM NAMES(S) AND THICKNESSES							
ACCIDENT INCI	DENT RATE	1.78 for 2011		LOST TIME ACCIDENTS 1 for the year			
of 2011 and nor	ne in 2012						
		N/A					
WVOMHST INSI	PECTOR	Gregory Raines					
DATE OF LAST INSPECTION March 19, 2012							
NOTIFIED BY <u>Bob Richmond</u> NOTIFICATION TIME <u>11:53 a.m.</u>							
CMSP ANNIVER							
		Lewis W. Shennard Ir					