West Virginia Office of Miners' Health, Safety and Training

JULY 27, 2012

Report of Investigation
Underground Coal Mine Fatality
(Machinery Accident)

Coal River Mining, LLC
Fork Creek No.10 Mine
Permit Number U-5005-09

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

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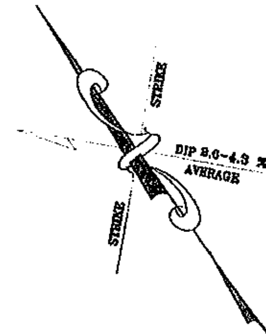
Curtain
Gurney Kit on Bottom
and First Aid Kit stacked on top
Miner Cable

Miner Cable
Miner Cable

Air Splint
1st aid Packing
Burn Sheet 2
Miner Cable
Air Regulators
First aid Packing
Splint
O2 Mask
Open First Aid Pack
Flat Screwdriver
Miner Boom Rear
Glove 1
Glove 2
Miner Cable
Teather on cable unconnected
Clothes Marks On Rib
Rub Marks On Rib
Back Board Strap
Rub Marks On Rib
Rub Marks On Rib
Victim Location
Rub Marks On Rib
Rub Marks On Rib
Teather connected to loop 2
Teather connected to loop 4
Teather connected to loop 3
Rear edge of miner
Miner Cable
Rear of Cats on Miner
Slew Marks
Slew Marks
Slew Marks
Front of slew Marks
Front of Cats on Miner
Front of Pan on Miner
Cable & H2O under Pan
Front of Ripper Head
Cable & H2O Loop
H2O Line
Cable
Miner Cable
Cable & H2O Loop
Water Line Loop
Cable Loop

Packing Material
Nasal cannula
Breathing Mask
Burn Sheet 1
First Aid Supplies
First Aid Wrench
Bandages
Neck Brace
Gurney Kit on Bottom and First Aid Kit stacked on top
Curtain (Location taken at anchor point)
Miner Boom Rear
Remote Box
Teather Connected to Boom
Victim Hard Hat
Teather connected to loop 1
Rear edge of miner
Front of Ripper Head



Fatality Survey
Fork Creek No.10 Mine
1st South East Mains MMU002-0 Section
MSHA ID # 46-09325
(Post - Accident Location)

Scale: 1"=10'

Date: 7-27-2012

1811

General Information

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

Coal River Mining, LLC, was issued a permit to operate the Fork Creek No.10 mine on October 8, 2009 and remains active to this day. The mine has six drift openings into the Stockton seam which normally operates five (5) days per week. Currently, the mine employs a total of 103 persons. Coal is mined on two advancing continuous miner sections producing coal on day and evening shifts and maintenance work is performed on the owl shift. The average mining height is approximately 132 inches. The owl shift employees on the No.2 section were classified as move crew workers performing duties such as belt installation, power moves, roof and rib bolting, equipment moves for maintenance and set up for the day shift production crew.

A fatal machinery accident occurred at approximately 4:00 a.m. on Friday, July 27, 2012 at Coal River Mining, LLC, Fork Creek No.10 Mine (U-500509) located near Alum Creek in Boone County. The accident occurred on the No. 2 working section in the crosscut between No. 4 and No.5 entries near survey station No. 1819. Mr. Johnny Mack Bryant II, 35 years of age, received fatal crushing injuries while assisting the move crew foreman move a Joy JM6462 12.CM 12 continuous miner. Mr. Bryant was in a blind spot at the rear of the continuous miner when he was struck by and pinned against the mine rib and the end of the miner boom.

The Lincoln County Emergency Services Authority, Station 20, Unit 44 was notified of the accident at 4:19 a.m., and responded to the mine accident. The Lincoln County Ambulance Authority transported Mr. Bryant to Thomas Memorial Hospital where he was pronounced deceased at 5:52 a.m., by the emergency room physician.

The Mine and Industrial Accident Emergency Operations Center was notified of the accident at 4:35 a.m., by Mr. David Griggs, the mine tracking and communications dispatcher at Fork Creek No. 10 Mine. Mr. John Kinder, Inspector-at-Large, Region 3, West Virginia Office of Miners' Health, Safety and Training was notified of the accident at 4:49 a.m., on July 27, 2012. A joint investigation with Company Officials and the Mine Safety and Health Administration was started immediately.

Description

The owl shift move crew for the No.2 section, supervised by Mr. Kevin Parsley, move crew foreman, entered the mine at 11:00 p.m. on Thursday July 26, 2012. The crew traveled via a track mounted personnel carrier to the No.2 section and arrived at approximately 11:15 p.m.

The scheduled work activities performed prior to the accident progressed normally with mark-up and installation of belt hangers and chains, installation of roof and rib supports, cleaning, rock dusting and supplying the section. At the beginning of the shift, face equipment was moved outby the last open crosscut to facilitate cleaning and rock dusting. The move crew foreman, Mr. Parsley, assisted by move crew leader Mr. George Higenik, moved the right side continuous miner from the No. 5 entry left crosscut face down No. 5 entry into the next crosscut outby between No. 5 and No. 4 entries where the miner was backed in, boom first and parked during the dinner break for maintenance. While tramming to this area, approximately 200 feet of cable slack, attached to four cable slings was secured to the end of the miner boom on the operators' side. These four cable slings were removed from the boom hook to facilitate servicing by the greaser, Mr. Rubin Caroll. The move crew assembled at the section power center and ate dinner from approximately 3:20 a.m. to 3:50 a.m. During this time, the greaser, Mr. Rubin Carroll serviced the right side miner.

At approximately 3:50 a.m., according to a written statement provided by Mr. Parsley, move crew foreman, Mr. Bryant, and move crew member, Mr. Brian Wall were initially instructed to assist move crew foreman Mr. Parsley as he prepared to move the right side miner. In the interim, Mr. Wall was instructed to place the Johnson Industries battery powered mantrip on charge before assisting with the moving of the miner. Mr. Parsley re-attached four (4) rope slings on the miner boom hook in preparation to move the continuous miner back another (10) feet to pick up the fifth and last rope sling of miner cable slack next to the ventilation control (check curtains) installed across the cross cut. Mr. Parsley told Mr. Bryant that when he moved the miner back to this area the 5th rope sling could be attached to the miner boom, so he told Mr. Bryant to get out of the way. Mr. Parsley stated that Mr. Bryant traveled back through the ventilation control (check curtains) away from the continuous miner out of his sight.

Mr. Parsley proceeded to walk to the cutter head end of the continuous miner to operate the miner and proceeded to tram the continuous miner toward the No. 4 entry to pick up the fifth loop of cable slack. As the miner started to move, the cable slack slid under the loading pan of the miner. Mr. Parsley stopped the miner and threw one (1) loop of miner cable slack over away from the pan, without de-energizing the machine when he bent over to move the second loop of cable slack away from the pan he accidently knocked the power to the miner by tripping the panic button on the remote box. Mr. Parsley re-started the miner from the remote box and proceeded to tram the miner toward the ventilation control (check curtain) watching the cable slack at the gathering pan area.

While moving the machine, Mr. Parsley heard Mr. Bryant yell his name. Mr. Parsley stated that he could not see Mr. Bryant's location from where he was standing and took steps forward toward the middle of the crosscut opening and saw Mr. Bryant holding the rope sling in his hand while pinned between the outby crosscut rib and the end of the continuous miner boom. Immediately, Mr. Parsley moved the continuous miner boom away from Mr. Bryant according to testimony by either moving the miner or swinging the boom. Mr. Parsley yelled for help and immediately ran to contact Mr. Griggs the dispatcher (mine tracking and communications person) for him to call for an ambulance and contact Mr. Rodney Nelson the third shift mine foreman for assistance.

Mr. Nelson was at the section 5A belt head located a short distance from the No. 2 section when Mr. Nelson heard Mr. Parsley yell for help on the mine phone. Mr. Nelson ran to the accident scene and found Mr. Bryant face down on his stomach beside the rib next to the miner boom. Mr. Bryant was unconscious, unresponsive and had no pulse. Mr. Nelson was joined by Mr. Nick Hensley and Mr. James Bryant, both of whom are certified Emergency Medical Technicians, who administered medical assistance to the victim. Mr. Daniel Gillispie, Mr. Chase Workman and Mr. John Maynard arrived with a stretcher and first aid supplies. Mr. Bryant was placed on a stretcher and carried to the end of the track where he was laid on a track mounted "gopher" personnel carrier and transported to the surface. CPR was continued on Mr. Bryant. Upon arrival on the surface, Mr. Bryant was removed from the mantrip and laid on the concrete surface at which time, Mr. Hensley, EMT, placed an Automated External Defibrillator (AED) on Mr. Bryant and registered "no shock advised, continue CPR." Lincoln County EMS Ambulance Service transported the victim to the Thomas Memorial Hospital where Mr. Bryant was pronounced deceased at 5:52 a.m. by the Emergency Room Physician.

Conclusion

On July 27, 2012, Mr. Johnny Mack Bryant, II a member of the third shift move crew, received fatal crushing injuries when he positioned himself in the "red zone" of the continuous mining machine to place a cable sling onto the miner boom and was pinned between the coal rib and the boom of the continuous miner.

Findings of Fact

1. The operator's remote control unit, used in conjunction with the Joy JM6462 12 CM 12 Continuous Miner, was in a good condition and was fully functional.

2. The Joy JM6462 12 CM 12 continuous miner is designed so that the machine will not tram or operate on start-up if either of the two tram levers on the Matrix LTD TX3 remote control unit is stuck or placed in an operational position.

3. The remote control unit is designed with a "tram enable" switch. This switch must be activated before the machine will tram. If tramming is not initiated within three (3) seconds, the "tram enable" switch must be recycled.

4. Representatives from the Mine Safety & Health Administration, MSHA'S Technical Support Group from Pittsburgh, PA., and the West Virginia Office of Miners' Health, Safety and Training extensively tested the continuous mining machine and the remote control unit. All switches and control functions performed properly without any defects observed.

5. The environmental condition of the mine floor in the crosscut between No. 4 and No. 5 entries, at the time of the accident, was dry with firm bottom. No irregularities of obstructions were observed, and only a minimal change in elevation existed between entries. During testing of the continuous miner, the machine did not stray off course or display any other unexpected movement.

6. As the continuous miner was moved out of the No. 5 entry crosscut face back to the outby crosscut between No. 4 entry and No. 5 entry, the miner was trammed, boom first, with the cable loops attached to the tail hook.

7. The miner operator positioned himself in front of the machine while tramming in reverse, tail first, through the crosscut where the fatal accident occurred. Mr. Parsley and Mr. Bryant discussed the next move, to position the miner back another ten feet to pick up the last cable loop of slack and Mr. Parsley cautioned Mr. Bryant to position himself out of the way and saw Mr. Bryant walk through the curtains toward No. 4 entry away from the miner.

8. Based on investigative findings at the accident scene and testimony from Mr. Parsley, move crew foreman, Mr. Parsley did not have a direct line of site to Johnny Mack Bryant, II from where Parsley stood while operating the miner, because of the curvature of the rib line between the operator and the victim prior to the accident.

9. As Mr. Parsley began to tram the miner, he became distracted by the miner cable gathering under the loader pan of the machine and stopped tramming the miner to move the cable out of the way. Without de-energizing the miner, the operator bent over to move two loops of cable away from the pan and inadvertently de-energized the machine.

10. According to physical evidence and testimony from Kevin Parsley, Parsley restarted the miner and trammed the machine away from the cable and heard Mr. Bryant yell his name.

11. According to testimony after hearing Mr. Bryant yell his name, Mr. Kevin Parsley stopped tramming and took steps forward toward the middle of the crosscut opening so he could see Mr. Bryant. Mr. Parsley saw Mr. Bryant holding the cable sling while pinned between the miner boom and the outby rib of the crosscut with his back to the rib.

12. Mr. Parsley immediately moved the miner away from Mr. Bryant and saw him fall to the mine floor.

13. The state approved roof control plan dated May 21, 2012, page 5, under heading of general safety precautions, item No.11 states "When the continuous miner is being trammed anywhere in the mine, other than when cutting or loading coal, no person shall be allowed on either side of the continuous mining machine (within the turning radius including the boom)".

14. The state approved roof control plan dated May 21, 2012, page 6, under heading of general safety precautions, item No.18 states "The pump motor of the continuous mining machine shall be de-energized during loading or unloading of the trailing cable that supplies electrical power to the continuous mining machine".

Enforcement Action

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

A non-assessed control order was issued in accordance with chapter 22A, Article 2, Section 68 of the WV Code to preserve the accident scene and complete an investigation.

The WV Office of Miners' Health, Safety and Training issued two Special Assessed Notices of Violation to Coal River Mining, LLC, during this investigation. The violations were written as follows:

(Violation No. 31737) Chapter 22A Article 2 Section 25A. Based on evidence observed and testimony received under oath during an investigation of a fatal accident that occurred on July 27, 2012 at approximately 4:00 a.m., the approved roof control plan, dated May 21, 2012, safety precaution No. 11, was not complied with, in that, on July 27, 2012, a Continuous Miner Operator, move crew foreman, stated during testimony "He operated the miner while placing himself in the red zone as he trammed the Joy JM6462 12 CM 12 continuous miner in the four right crosscut, on the No.2 section prior to the fatal accident". This violation is a violation of a health and safety statute, is of a serious nature, and involved a fatality.

(Violation No.31738) Chapter 22A Article 2 Section 25A Based on evidence observed and testimony received under oath during an investigation of a fatal accident that occurred on July 27, 2012 at approximately 4:00 a.m., the approved roof control plan, dated May 21, 2012, Safety precaution No. 18, was not complied with, in that, a move crew miner on the No. 2 section was fatally injured while helping the continuous miner operator install a loop of miner cable slack to the tail boom of the miner. The victim was pinned between the coal rib and the tail of the continuous miner causing fatal injuries. At the time of the fatal accident the pump motor of the continous miner was not de-energized. This violation is a violation of a health and safety statute, is of a serious nature and involved a fatality.

One (1) Individual Personal Assessment (IPA) was issued during the investigation.

Recommendations

In accordance with Title 56, Series 8, Section 8.1 of the WV Mining Laws, the comprehensive mine safety program for the Fork Creek No. 10 Mine shall be modified to include the safety precautions and guidelines submitted by the operator.

Acknowledgement

The West Virginia Office of Miners' Health, Safety and Training gratefully acknowledges the cooperation of the employees and management of Coal River Mining, LLC, Fork Creek No. 10 Mine, the Mine Safety and Health Administration and MSHA's Office of Technical Support during this investigation.

Appendix

- Mine Information
- Victim Information
- Company Recommendations

MINE INFORMATION

COMPANY Coal River Mining, LLC

MINE NAME Fork Creek No.10 Mine

WV PERMIT U-500509 MSHA MINE ID NUMBER 46-09325

ADDRESS P O Box 79 Alum Creek, WV 25003

COUNTY Boone PHONE NUMBER 304-756-2901 or 1281

DATE PERMIT ISSUED October 08, 2009

WORKING STATUS Active

LOCATION Fork Creek off US Route 119

UNION NON-UNION X

DAILY PRODUCTION 2700 Tons ANNUAL PRODUCTION TO DATE 312,296 Tons

TOTAL EMPLOYEES 103

NUMBER OF SHIFTS 3

COAL SEAM NAMES(S) AND THICKNESSES Stockton 132 inches

ACCIDENT INCIDENT RATE 3.32 LOST TIME ACCIDENTS two

TYPE OF HAULAGE N/A

WVOMHST INSPECTOR Mike Pauley

DATE OF LAST INSPECTION June 15, 2012

NOTIFIED BY David Griggs NOTIFICATION TIME 4:35 a.m.

CMSP ANNIVERSARY DATE November 20, 2012

CMSP CONTACT PERSON Terry Chapman