

**State of West Virginia  
Office of Miners' Health, Safety & Training  
205 Marion Square  
Fairmont, West Virginia 26554**

**May 11, 2005**

**Fatal Power Haulage Accident  
(Underground Coal Mine)**

**Consolidation Coal Company  
Shoemaker Mine  
Permit No. D-4791**

**Region One  
Brian Mills, Inspector At Large  
Colin D. Simmons, District Mine Inspector  
Alan A. Lander, Safety Instructor**

## TABLE OF CONTENTS

*	<b>General Information</b>	<b>3</b>
*	<b>Description</b>	<b>3, 4</b>
*	<b>Findings of Fact</b>	<b>4, 5</b>
*	<b>Conclusion</b>	<b>5</b>
*	<b>Recommendation</b>	<b>6</b>
*	<b>Enforcement Action</b>	<b>6</b>
*	<b>Acknowledgement</b>	<b>6</b>
*	<b>Appendix</b>	<b>7</b>

## GENERAL INFORMATION

A fatal power haulage related accident occurred at approximately 1:15 P.M. on May 11, 2005 at the Consolidation Coal Company, Shoemaker Mine. The accident occurred on the 14-A Longwall section where blocking material was being delivered by a scoop in the number one entry. Mr. Clyde Willis, age 47, was fatally injured when struck by the Eimco scoop. He was walking approximately five to six feet ahead of the scoop.

Mr. Mike Sinozich, Chief Safety Inspector, notified Colin Simmons, District Mine Inspector with the Office of Miners' Health, Safety and Training, of the accident at approximately 3:45 P.M. that afternoon. A verbal order was issued to control the area until an investigation was completed. A joint investigation with the Mine Safety and Health Administration, the United Mine Workers of America and mine management was started immediately.

## DESCRIPTION

The Consolidation Coal Company, Shoemaker Mine is a drift and shaft mine. It produces coal in the Pittsburgh seam and is located near Dallas, in Marshall County. Mining is conducted with one longwall unit and two continuous miner units. Employees and supplies are transported by rail. Coal is removed from the working sections via a conveyor belt to a central loading facility and then is transported by mine cars to the outside.

On Wednesday, May 11, the day shift production crew and timbering crew, for the 14-A section, entered the mine at approximately 8:00 A.M.. The timbering crew was under the supervision of Mr. William Coen, Longwall Coordinator. The longwall production crew was under the supervision of Mr. Charles Beaver. The longwall timbermen crew consisted of Michael Young, Jeffrey Phillips and Clyde Willis (victim). The crews traveled underground and arrived on the section at approximately 8:45 A.M. The timbermen's assignment that shift was to set posts in the number two and number one entries of the 14-A section in advance of the retreating longwall. The longwall face was at approximately 35+50.

After arriving on the 14-A section, the timbering crew removed the vehicles parked at the mantrip station, to the number 19 switch along the 14-A section supply track. This was to clear the end of the supply track for a car of post. The section supply track is located in the number two entry. Mr. Willis and Mr. Phillips moved a car of posts to the end of the supply track with a locomotive. They proceeded to load a lift of post (approximately 32) onto the duck bill of the #192 scoop, parked in the clearance side crosscut at 25 Block. Mr. Young pulled the supply car outby with the locomotive. Mr. Phillips then moved the scoop across the tracks and through the airlock doors. They proceeded up the number one entry to deliver the posts. Mr. Willis opened and closed the airlock doors for Mr. Phillips. Upon delivery of the posts the crew continued posting in the number two entry, working outby toward the number 30 crosscut. At approximately noon, they informed Mr. Coen that they had a steering problem with the #192

scoop and were out of blocking materials needed in the number one entry. He instructed them to park the defective scoop and to use the #11 scoop that was on charge in the number 25 crosscut. The three crew members then took lunch.

At approximately 12:45 P.M. the crew finished their lunch and began to load blocking material on the duck bill of the #11 scoop. Mr. Young pulled the supply car out by approximately thirty feet to clear the number 25 crosscut. Mr. Willis opened and closed the airlock doors for the scoop. Mr. Young locked the locomotive down and walked up the number two entry to the last open crosscut. Mr. Phillips was operating the scoop in the number one entry, with Mr. Willis walking approximately five to six feet ahead. The scoop's operating compartment was located on the right side and Mr. Willis was walking near the left rib line. Mr. Phillips stated that he could only see Mr. Willis's cap light against the left rib. He was watching the right rib in order to keep the scoop in the center of the entry. He looked back toward Mr. Willis and could no longer see his light. He immediately stopped and backed up the scoop. He then heard Mr. Willis moaning. Mr. Phillips saw miners cap lights down the number one entry and yelled and signaled to them for help. The maintenance crew that was going to work on the number 192 scoop immediately went to help. Mr. Young, who was standing in the last open crosscut between the number one and two entries, heard the cries for help and went to summon help from the longwall crew working in the number three entry.

Mr. William Coen, Longwall Coordinator and EMT; Mr. Douglas Blair, mechanic and EMT in training; Mr. Charles Beaver, Longwall Foreman and EMT; General Mine Foreman Mr. Ronald Kovaski, EMT all responded to the accident site. Mr. Kovaski stated the victim told him he got rolled under the scoop. After assessing the injuries, it was decided to remove the victim from the mine as soon as possible. Tri State Ambulance was waiting at the Golden Ridge Portal and transported him to the Wheeling Medical Park Hospital. He was stabilized and then Life Flighted to the Allegheny General Hospital in Pittsburgh, Pennsylvania. At approximately 8:15 P.M., Mr. Willis died during the surgery to correct injuries suffered in his accident.

## **FINDINGS OF FACT**

- 1) The victim was struck by an Eimco battery powered scoop, Model 585, Serial number 70550034. The company number assigned to the scoop was #11.
- 2) The victim was walking five to six feet in front of the scoop being trammed in the number one entry.
- 3) The scoop was loaded with blocking material to be used with the super post being set in the number one and two entries. The cap boards measured 7-1/2 inches wide by 16 inches long. Wedges measured 10 inches wide by 13-1/2 inches long.
- 4) The duck bill being utilized on the Eimco scoop measured 64 inches wide by 94 inches long.

- 5) Blocking material was stacked approximately 32 inches high in the center, and approximately 20 inches high, on both sides of the duck bill.
- 6) A measurement could not be taken as to how high the duck bill was raised off the mine floor while tramming up the entry. The scoop had been repositioned and the duck bill was on the mine floor at the time of the inspection. Through testimony, it is estimated the duck bill would have been raised approximately two feet off the mine floor. Mr. Phillips stated during the interview that he could see over the load "somewhat".
- 7) The scoop had traveled approximately 381 feet in the number one entry prior to the accident.
- 8) The victim had been trained the prior month in the safe operation of the scoop and proper procedure for setting posts.
- 9) The scoop operator, Jeffrey Phillips had been trained the prior month in the safe operation of the scoop and correct procedure for setting post. Safe Observation slips provided for Mr. Phillips, since September 2002, revealed he was a safe and experienced operator.
- 10) Task Training for both Mr. Willis and Mr. Phillips was conducted on April 13, 2005.
- 11) Height in the number one entry was approximately 97 inches high. Entry width was approximately 15 feet 3 inches.
- 12) An inspection of the #11 scoop revealed no deficiencies or violations.
- 13) An inspection of the number one entry revealed no obstructions in the tram way. Visibility was not hindered from any dust in suspension. The roadway had been dampened. The entry had sloughage along both ribs and two tire tracks in the mine floor.
- 14) Mr. Young stated he didn't know why the victim was in front of the scoop and believed he may have seen him walk in front of scoops before.

## **CONCLUSION**

While delivering blocking material in the number one entry on the 14-A Longwall Section, at 32+14, the victim received multiple serious injuries when he was struck by an Eimco scoop. At approximately 8:15 P.M., Mr. Willis died during the surgery to correct these injuries. The victim was positioned in close proximity to a moving piece of equipment.

## RECOMMENDATIONS

Mine management shall submit to the West Virginia Office of Miners' Health, Safety and Training a modification to their Comprehensive Mine Safety Program to address the safe operating procedures for off track mining equipment. (See Appendix)

Mine Management shall hold safety meetings with all mine personnel to discuss the safe operation of off track mining equipment to prevent a recurrence of the accident.

## ENFORCEMENT ACTION

The following enforcement action was taken as a result of the investigation.

A non assessed control order was issued in accordance with West Virginia Administrative Regulation Title 36 Series 19 Section 7.1

A violation was issued that directly attributed to the cause of the accident.  
**Title 36, Series 30, Section 4.6** Based on information obtained during an investigation of a fatal accident on the 14-A section it was revealed that Mr. Clyde Willis was struck by a battery powered scoop that was being operated in a manner that did not assure his being a safe distance away from and out of the equipment's path of travel.

Another violation was issued that did not directly attribute to the cause of the accident.

## ACKNOWLEDGMENT

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

  
\_\_\_\_\_  
Brian Mills, Inspector-At-Large

June 16, 2005  
Date

  
\_\_\_\_\_  
Colin Simmons, District Mine Inspector

06-15-05  
Date

  
\_\_\_\_\_  
Alan Lander, Safety Instructor

6/15/05  
Date

## APPENDIX

- List of persons providing information or present during the investigation
- Mine Information
- Victim Information
- Drawings
- Modification - Comprehensive Mine Safety Program

## **Investigation / Interviews**

An on-site investigation was conducted on May 11, 2005 of the accident site in 14-A section.

### **WV Office of Miners' Health, Safety & Training**

Colin Simmons	District Mine Inspector
Alan Lander	Safety Instructor

### **Mine Safety & Health Administration**

Allen McGilton	Supervisor
Joseph F. Facello	Mine Inspector
Joseph R. Yudasz	Mine Inspector

### **Consolidation Coal Company**

Jim Latham	Mine Superintendent
Ron Kovalski	General Mine Foreman
Jim Jack	Safety Supervisor
Elizabeth Chamberlin	General Manager Safety
Mike Sinozich	Chief Safety Inspector
Andrew R. Dally	Safety Inspector
William Coen	Longwall Coordinator
Jack Holt	Vice President Safety
Jim Magro	Vice President Operations

### **United Mine Workers of America**

Tom Gessler	Chairman Safety Committee Local 1473
John Cumpston	Safety Committee Local 1473

The following persons were present during one or more of the interviews conducted on May 12, 2005.

### **WV Office of Miners' Health & Safety & Training**

Brian Mills	Inspector At Large
Colin Simmons	District Mine Inspector
Terry Farley	Administrator
Alan Lander	Safety Instructor

### **Mine Safety and Health Administration**

Ronald T. Tulanowski	Mine Inspector
Jerry Vance	Mine Training Specialist
Joseph Yudasz	Mine Inspector



**United Mine Workers of America**

Rich Eddy	International District Vice President
Tom Gessler	Chairman Safety Committee Local 1473
Cliff Ward	Safety Committee Local 1473
John Cumpston	Safety Committee Local 1473

**Consolidation Coal Company**

	Jim Latham	Mine Superintendent
	Elizabeth Chamberlin	General Manager Safety
	Jim Jack	Safety Supervisor
	Mike Sinozich	Chief Safety Inspector
	Roger Fox	Safety
	Helen Churilla	Manager Clinical Healthcare
X	Jeffrey Phillips	Scoop Operator / Timberman
X	William Coen	Longwall Coordinator
X	Ronald Kovalski	General Mine Foreman
X	Terry Hess	Maintenance Foreman
X	Douglas Blair	Mine Mechanic
X	Michael Young	Timberman

X Denotes Persons Interviewed

An onsite inspection of the area was conducted on May 12<sup>th</sup> after the interviews.

**WV Office of Miners' Health, Safety and Training**

Brian Mills	Inspector At Large
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**Mine Safety and Health Administration**

Ronald T. Tulanowski	Mine Inspector
Jerry Vance	Mine Training Specialist
Joseph Yudasz	Mine Inspector

**United Mine Workers of America**

Tom Gessler	Chairman Safety Committee Local 1473
John Cumpston	Safety Committee Local 1473

**Consolidation Coal Company**

Jim Jack	Safety Supervisor
Tom Skrbak	Shift Foreman

MINE INFORMATION

COMPANY Consolidation Coal Company

MINE NAME Shoemaker

WV PERMIT D-4791

ADDRESS RD #1, Box 62-A, Dallas, WV 26036

COUNTY Marshall

DATE PERMIT ISSUED August 12, 1966

WORKING STATUS Active

LOCATION Golden Ridge Portal

UNION 1473 NON UNION \_\_\_\_\_

DAILY PRODUCTION 15,900 ANNUAL PRODUCTION TO DATE 1,457,523

TOTAL EMPLOYEES 461

NUMBER SHIFTS 3

COAL SEAM NAME AND THICKNESS Pittsburgh #8

ACCIDENT TOTAL INCIDENT RATE 3.86 LOST TIME ACCIDENTS \_\_\_\_\_

TYPE OF HAULAGE Belt & Rail

WVOMHST INSPECTOR Colin D. Simmons

DATE OF LAST INSPECTION March 24, 2005

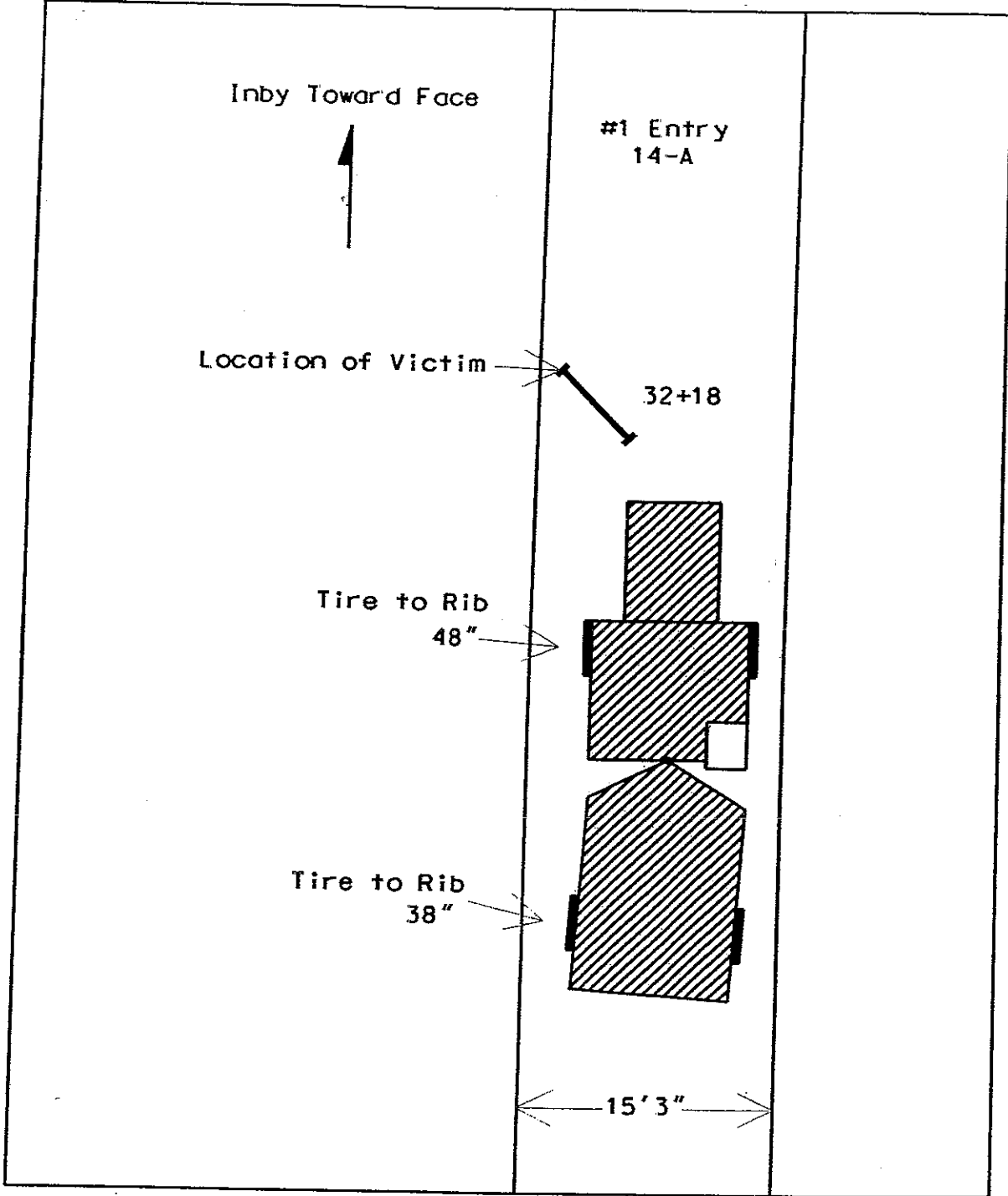
NOTIFIED BY Mike Sinozich

NOTIFICATION May 11, 2005 3:45 PM

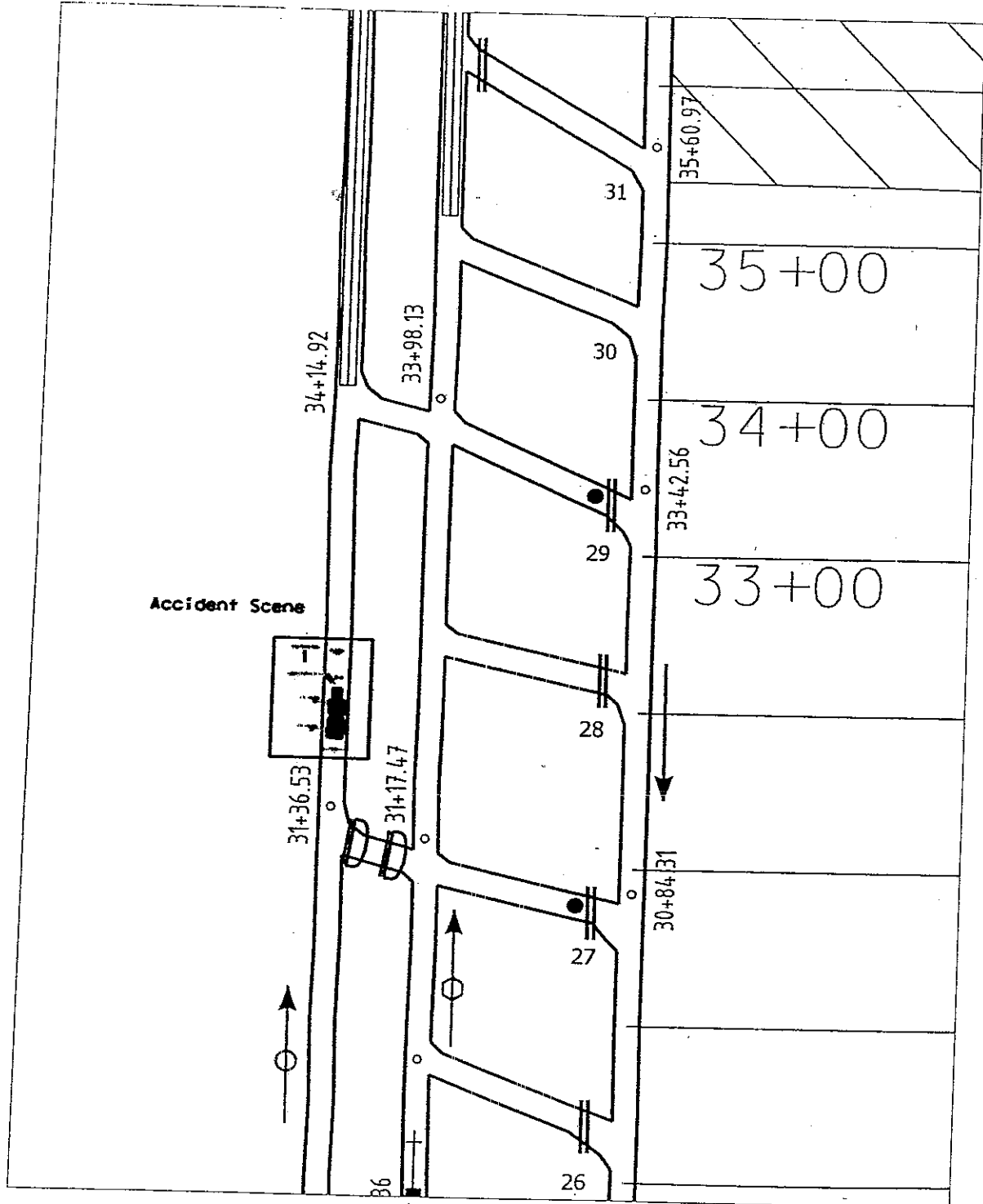
CMSP – ANNIVERSARY DATE March 3, 2006

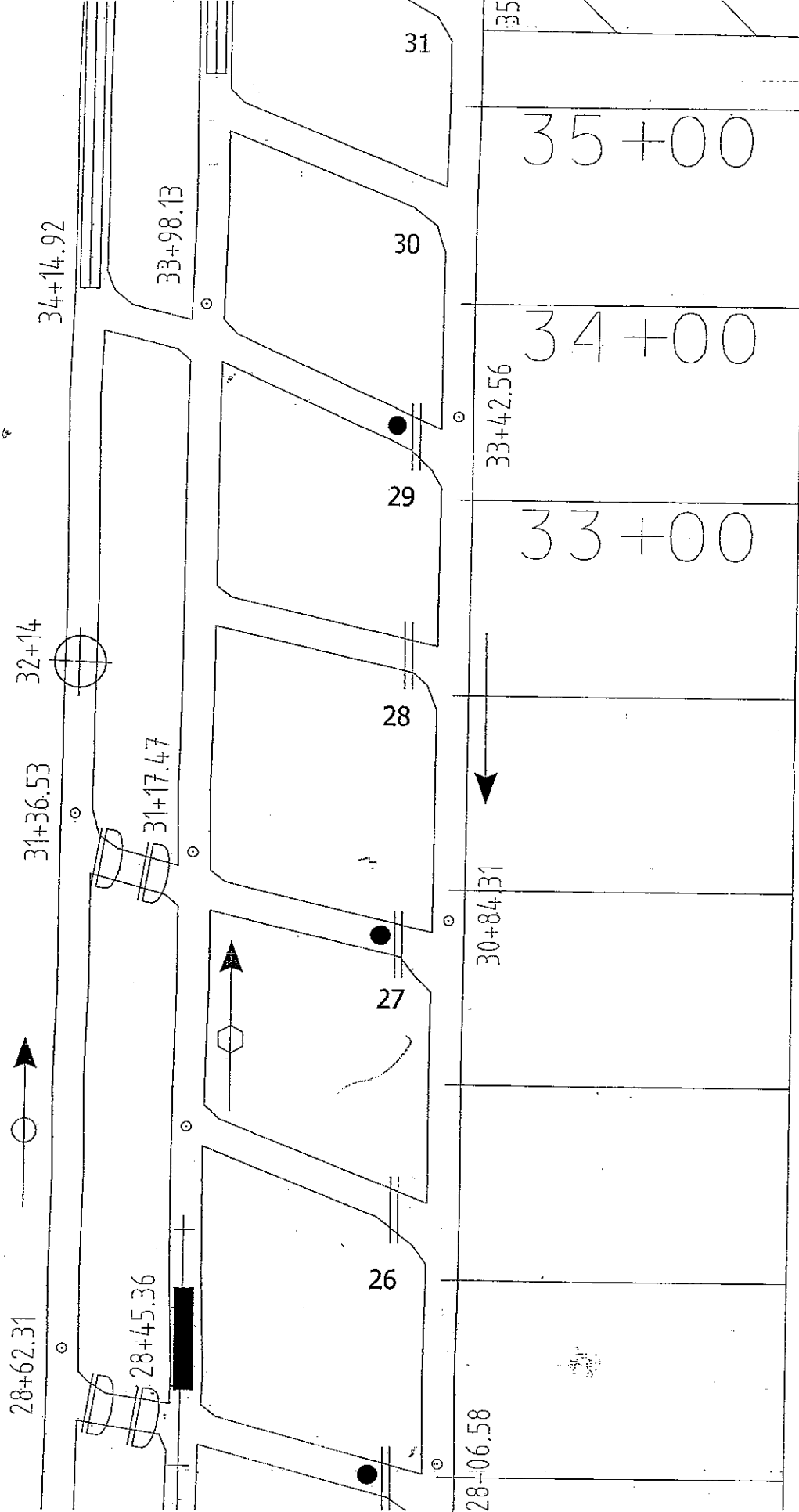
CMSP – CONTACT PERSON James Jack

14-A Accident Scene:



14-A Accident Site:







Consolidation Coal Company  
Shoemaker Mine  
Golden Ridge Portal  
RD #1 Box 62A  
Dallas, WV 26036  
(304) 238-1500  
Fax: (304) 238-1506

Mr. Brian Mills, Inspector at Large  
Office of Miner's Health, Safety and Training  
205 Marion Square  
Fairmont, WV. 26554

May 12, 2005

Mr. Mills,

Shoemaker Mine of Consolidation Coal Company is submitting the following modification to the Comprehensive Mine Safety Program in accordance with 56-8-9.4 as procedures to prevent a reoccurrence of an incident that occurred on May 11, 2005.

## Off Track Mining Equipment

1. Operators of off track mining equipment shall inspect travel ways before operation of their equipment to make sure it is free of hazards.
2. If it is necessary to walk in front of a piece of moving equipment, always walk in direct line of sight of the operator and at a safe distance from the machine.
3. If operating a piece of equipment and another employee is walking in front of you, do not operate this machine unless this individual is in direct line of sight of the operator's compartment and is positioned a safe distance from the machine.
4. Whenever possible, if it is necessary to walk in the same entry and direction as a piece of equipment, do so from behind the machine.

J.W. Latham, III

Superintendent  
Shoemaker Mine