

**UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION**

COAL MINE SAFETY AND HEALTH

**REPORT OF INVESTIGATION
Surface Coal Mine
Fatal Powered Haulage Accident
November 28, 2006**

at

**Spring Creek Coal Company Mine
Spring Creek Coal Company
Decker, Big Horn County, Montana
ID No. 24-01457**

Accident Investigators

**Phillip Gibson
Coal Mine Safety and Health Inspector**

**William Younkin
Coal Mine Safety and Health Inspector**

**Robert Montoya
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Technical Support Mechanical Engineer**

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Mining Engineer**

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PHOTO OF ACCIDENT SCENE
Caterpillar 789B Haul Truck
Pit 3 West



VICTIM LOCATED UNDER LEFT REAR DUAL TIRES

OVERVIEW

On Tuesday, November 28, 2006, at approximately 1:05 a.m., Mario J. Corriveau, a 50-year old haul truck operator, was fatally injured at the Spring Creek Coal Company mine in a powered haulage accident. Corriveau had dumped a load of coal waste material from a Caterpillar 789B haul truck he was driving in the Pit 3 West area and called on the radio to report that the parking brakes on the truck would not release. A mechanic responded and found the truck resting against a berm with the bed up and the engine running. Corriveau was found crushed beneath the left rear dual tires. There were no witnesses to the accident, thus the actual events causing Corriveau to be crushed under the tires are not exactly known.

The accident occurred when the frozen parking brakes released unexpectedly allowing the truck to roll forward downgrade into the berm. Corriveau was either thrown from the truck and was struck and crushed by the left rear dual tires or he was on the ground and struck and crushed by the tires. The accident occurred due to an ineffective program to ensure that truck operators set the parking brake before exiting the cab of the truck. This allowed Corriveau to exit the truck cab and not return the parking brake toggle switch to the "on" position after the switch had been put in the "off" position to move forward to finish dumping the load. Management did not have effective maintenance procedures to ensure that water was drained from and not allowed to accumulate in the air tank/system and caused the freezing problem that was experienced at the time of the accident when the parking brakes would not release.

GENERAL INFORMATION

The Spring Creek Coal Company mine is a surface coal mine operated by Spring Creek Coal Company. It is located near Decker, Big Horn County, Montana. The mine extracts coal from the Anderson-Deitz seam utilizing two draglines for overburden removal. The coal is loaded by shovels and front-end loaders into 190-ton haul trucks. The seam averages 80 feet in thickness and the overburden is approximately 65 feet thick.

At the time of the accident, the mine produced 45,000 tons of coal per day and employed 176 miners. The mine operated seven days per week, using two 12-hour production shifts and two maintenance shifts per day. The principal officers for the mine at the time of the accident were: Lane Vanderhoef, Production Supervisor; Marc Ostrem, Acting Mine Manager; Kean Johnson, Manager, Site Health and Safety; Erik Strom, Manager, Site Technical Services; and Brad Orr, Manager, Site Maintenance.

Prior to the accident, the last Mine Safety and Health Administration (MSHA) regular inspection was completed on September 8, 2006. The non-fatal days lost (NFDL) incidence rate for the mine from January to September, 2006, was 0.78. The National incidence rate for surface coal mines for the same period was 1.47.

DESCRIPTION OF ACCIDENT

Mario J. Corriveau, haul truck operator, began the night shift at 7:00 p.m., November 27, 2006. He operated a Caterpillar 789B 190-ton end-dump haul truck, Company No. 503. Corriveau traveled to Pit 3 East where Cliff Swinyer, shovel operator, was loading coal with shovel No. 301. Corriveau and two other haul truck operators proceeded to haul coal from the No. 301

shovel to the truck dump located near the train loadout facilities. During the shift, Corriveau received a load of waste to be dumped in the Pit 3 West waste dump area. He entered the pit on the highwall side, turned the truck around and backed up to the middle pile in the dump area. As per procedure, it appears that Corriveau put the transmission in neutral and applied the park brake. He raised the bed to dump the waste material. Normally, Corriveau would then release the park brake and the truck would roll forward as the load feathered off. However, this time the parking brake would not release and at approximately 1:00 a.m., November 28, 2006, Corriveau called the maintenance shop to report the parking brake problem.

At approximately 1:10 a.m., James Leno, mechanic, arrived to find truck No. 503 resting on the spoil side berm approximately 100 feet from the waste piles. The truck was leaning at an angle with the engine running and the bed in the raised position. Leno radioed for Corriveau but did not receive a response. When he could not contact Corriveau, Leno called Lane Vanderhoef, production supervisor. Vanderhoef responded to the scene with a spotlight accompanied by Paula Hovey, road grader operator. When the victim was located a Mine Emergency Response Team (MERT) was summoned. Leno shut down the truck engine with the emergency "kill" switch on the front bumper, leaving the bed in the raised position. Jonathan Miles, MERT member, checked the victim. At approximately 2:15 a.m., Lee Hamilton, shovel operator, and Swinyer accompanied the local ambulance service and personnel to the accident scene. The ambulance personnel evaluated the situation. The victim was pronounced dead at the accident scene by the county coroner.

With the truck bed raised and the truck in a tipping position, an unsafe situation existed. The mine operator conducted a risk and site assessment for conducting the recovery operation. The risk assessment was completed and was approved by William Younkin, Coal Mine Safety and Health Inspector in consultation with MSHA District 9 and company officials. Recovery operations started, however, the truck would not start due to the cold weather and the bed would not come down. The risk assessment was then revised. The recovery continued until the victim was freed from beneath the truck and transported from the mine.

INVESTIGATION OF THE ACCIDENT

Donald E. Gibson, MSHA field office supervisor, Gillette, Wyoming, was notified of the accident at approximately 2:10 a.m., November 28, 2006. Company officials indicated that they initially called the MSHA 1-800 number and reported the accident at approximately 1:50 to 1:55 a.m. Gibson instructed the mine to secure the location of the accident to prevent further injury pending an investigation by MSHA. MSHA personnel were dispatched to the mine. William Younkin, coal mine safety and health inspector, Gillette, Wyoming, arrived at the mine and issued a Section 103(k) order at 2:20 a.m. to ensure the safety of persons at the mine until an investigation could be conducted and the area deemed safe. The MSHA accident investigation team arrived at the mine on November 29, 2006, and began the investigation (refer to Appendix A for a list of persons participating in the investigation). The accident scene was examined, measurements were taken, documents obtained, witnesses interviewed, and tests conducted on the Caterpillar 789B, No. 503 haul truck. The investigation at the mine site concluded on December 1, 2006.

DISCUSSION

Machine Information

The maximum operating weight of the Caterpillar 789B haul truck was 700,000 pounds. The empty weight was 264,100 pounds. The truck was powered by a Caterpillar 3516, sixteen cylinder, 1705 Horsepower (SAE), turbocharged and after-cooled, diesel engine. The truck was equipped with an electronically controlled transmission with six forward speeds, one reverse speed, and a neutral position.

The truck came to rest parked on a berm with the dump body fully elevated. The first persons arriving at the scene reported that the engine was still running following the accident. In addition, the parking brake control was reportedly found in the “off” position and the transmission was in neutral. This was consistent with the control positions found during the investigation. The hour-meter showed 25,859.4 hours.

Efforts to Start the Engine

The first rescuers stated that they shut the engine down with the emergency “kill” switch on the front bumper when they realized that the accident had occurred. The truck has an air starter. During the initial recovery process, mine personnel were unable to start the engine in the severe cold weather. Methanol-based antifreeze was pumped into the primary air tank at that time. Despite this, the engine did not start. Approximately 2½ days after the accident occurred, a second effort was made to start the engine so the truck could be moved to a testing area. The truck’s air system was charged to its operating pressure using an external pressure source. In addition, to permit starting the engine in the severe cold weather, the engine area was pre-warmed using a trailer mounted air heater. The engine started on the first attempt following these preparations.

Service Brake System Design

The 789B haul truck was equipped with individual wet disc, air-over-hydraulic service brakes at each of the four wheels. Cooling oil was circulated through all four service brake disc packs. The truck was equipped with three brake master cylinders that converted air pressure to hydraulic pressure, two for the rear axle and one for the front axle. A makeup tank above the master cylinders supplied the master cylinders. This reservoir was replenished from the hydraulic system used to cool the brake disc packs.

Parking Brake System Design

The parking brake system consists of a spring-applied, hydraulically released system that uses the same wet disc brake packs as the service brake system. The parking brake is activated by a two position toggle switch on the console to the operator’s right.

The air path to release the parking brake consists of the following: air leaves the secondary air tank, goes through the secondary brake air control valve (located inside the heated cab), then through the park brake control valve (inside the cab), then through the secondary brake and

parking brake pressure switch (outside the cab), and finally to the parking and secondary brake valve (outside the cab).

The parking and secondary brake valve is a combination hydraulic and air valve. Hydraulic oil from the parking brake release pump section enters the parking and secondary brake valve. When the parking brake toggle switch is moved to the “off” position, full air pressure is delivered to the parking and secondary brake valve. The air flow pushes down a spool in the parking and secondary brake valve and allows oil flow to release the spring applied parking brake.

When the parking brake toggle switch is moved to the “on” position, the air pressure delivered to the parking and secondary brake valve is shut off, and a spring moves the spool back. This stops the oil flow to the parking brake release chamber and the parking brakes engage by spring force.

A brake retract switch in the operator’s compartment, that operated an on-board secondary/parking brake release electric motor and pump, allowed the operator to release the parking brakes to permit towing a disabled vehicle without the engine running.

Secondary Brake System Design

The secondary braking system operated by applying the spring-applied, oil-released, oil-cooled brake discs on both axles and was controlled by a lever on the left side of the steering column. Pulling the secondary brake handle toward the operator applied the brake. Upon release, the secondary brake control handle spring returned to the brake released position.

Service, Parking and Secondary Brake Holding Ability Tests

The service, parking, and secondary brakes were tested. Each of the three braking systems had the capacity to prevent the truck from moving when the transmission was in first gear and the engine speed was brought to 1200 rpm, which met the specification in the service manual.

Service Brake Over-stroke Indicators

Each of the three master cylinders on the truck was equipped with a pin indicator that will protrude from the end of the master cylinder if a brake system defect causes the master cylinder to over-stroke. None of the over-stroke pins were found to be protruding which indicated proper operation according to the service manual.

Air System Design and Testing

Compressed air leaves the compressor, passes through a desiccant type air dryer, and then enters the primary air tank. Air from the primary tank is sent to the secondary brake tank. The secondary brake tank serves the secondary brake and parking brake systems. The governed operating range of the compressor specified in the service manual is 95 to 125 psi.

Both air tanks were drained during the investigation. Approximately ½ gallon of liquid was drained from the primary tank. The liquid appeared to contain the same type of methanol antifreeze that was added to the tank following the accident. No sludge or debris was found.

The secondary tank was drained and no liquid came out of the drain valve, indicating this tank was dry. Caterpillar's Operation and Maintenance Manual recommends draining the air tanks every 10 service hours or daily. It is not known when the air tanks were last drained prior to the accident.

Testing showed the cut-in and cut-out pressures of the air compressor governor were 100 psi and 127 psi, respectively. The low air action alarm and action light were tested and functioned, as described in the service manual, when the pressure fell to 60 psi.

Parking Brake Testing

Prior to starting the engine to allow removal of the truck from the accident location, the parking brake toggle switch was placed in the "on" position. After the engine started, the parking brake toggle switch was placed in the "off" position and the parking brake immediately released. Throughout numerous tests the parking brake immediately released every time the toggle switch was placed in the released position. The parking brake release malfunction reported by the driver did not recur.

The air pressure input and the hydraulic pressure output of the parking and secondary brake valve were tested. This valve controls the hydraulic pressure to apply and release the parking brake. Pressure gauges were installed to monitor the hydraulic release pressure to the parking brake from the parking and secondary brake valve, the internal hydraulic relief pressure setting for the parking brake release system, and the air pressure feeding the parking and secondary brake valve. In addition, the air pressure in the primary air tank was monitored with a pressure gage to determine the accuracy of the air pressure readout in the operator's cab, which received its pressure signal from this tank.

The testing showed that, in accordance with the service manual, full system air pressure was sent to the parking and secondary brake valve when the park brake toggle switch was placed in the "off" position. In addition, when the park brake control was in the "off" position, the hydraulic release pressure sent to the parking brakes was 680 psi. The relief pressure setting for the parking brake release system was also 680 psi. Both of these hydraulic pressures indicated the system was operating as described in the service manual.

When the parking brake toggle switch was moved to the "on" position, the input air pressure to the parking and secondary brake valve was cut off and the hydraulic parking brake release pressure fell to 0 psi which allowed the spring applied parking brake to apply. This indicated the system was operating as described in the service manual. The air pressure readout in the operator's cab indicated the same pressure (+/- 2 psi) as the air gage that was installed to monitor the primary air tank pressure.

The parking brake release feature that utilized an on-board electric motor and pump if the engine is inoperable, functioned as described in the service manual. In summary, the parking brake operated as described in the service manual and the brake release problem reported by the driver just before the accident occurred did not recur throughout the testing.

Parking Brake Release Hydraulic Filter

The parking brake release section of the hydraulic pump sends oil to the parking brake release hydraulic filter. The oil leaving the filter is sent to the parking and secondary brake valve so that filtered oil is sent to the parking brake spring retract chambers when the parking brake is released. This filter element was removed and cut open. No debris was found on the inside of the filter.

Retarder Design and Testing

The retarder system provided modulated engagement of the service brakes and was controlled by a friction lever on the right side of the steering column. The retarding force varied according to how far the control lever was moved. The truck was also equipped with an automatic retarder that could be switched on or off using a control in the operator's compartment. The automatic retarder will apply the brakes as necessary to maintain a preset engine RPM (1850 to 1950 rpm). The automatic retarder will not apply the brakes when the engine speed is below 1800 rpm. The automatic retarder can be overridden by depressing the accelerator pedal, applying the manual retarder lever, or pressing on the service brake pedal. When tested, the retarder prevented the truck from moving when the transmission was in first gear and the engine speed was increased to 1200 rpm. This met the performance specification in the service manual.

Hoist Neutralizer Feature

When the transmission is in the "reverse" position and the hoist control is moved to the "raise" or "lower" position, the transmission will automatically shift to neutral. This feature was tested and operated as designed.

Steering and Transmission

No steering or transmission defects were found.

Company Policies

Spring Creek Coal Company policy regarding the Caterpillar 789 braking system and overspeed prevention is contained in a written training manual. Regarding use of parking brakes, the manual states, "The park brake will spring apply all four wheel brakes and is to be used when waiting and loading at the loader or shovel. The park brake is to be used at the dumps when dumping a load, and for parking the truck!!!" Also, the task training, which Corriveau received for operating the truck, states that for parking, "Place transmission selector lever to neutral, after the machine has stopped. Engage the parking brake."

Testing Summary

Testing showed that the parking brake operated as designed and the air pressures and hydraulic pressures in the parking brake system were in accordance with the service manual. The brake release problem reported by the driver just before the accident occurred did not recur throughout the testing. However, when the truck was tested after the accident, it differed from the pre-accident condition in that the air system had been treated with methanol antifreeze and measures

had been taken to warm the engine to allow it to start in the severe cold weather. These are factors that tend to correct problems caused by frozen moisture which is a known cause of operational problems in air systems. When the accident occurred, the temperature was near 0°F. It was concluded that the parking brake did not release at the time of the accident because of moisture freezing in the air system. This prevented air pressure from reaching or moving the air actuated spool in the parking and secondary brake valve allowing hydraulic flow to release the parking brake.

Pre-operational Inspection

Corriveau conducted a pre-operational inspection of truck No. 503 prior to using it the shift of the accident. He noted that the air tank was “OK” and that the “Test Brake Systems – Service, parking, and emergency” were also “OK.” He noted that the fuel tank was leaking and there was an oil leak from the hoses at the front of the wishbone. These conditions did not affect the operation of the parking brake.

Training and Experience

Corriveau had 3 years, 13 weeks total mining experience, all at the Spring Creek Coal Company mine, with 24 weeks as a contract employee. On March 14, 2004, he completed task training on the Caterpillar 789B, 190-ton haul truck. He received Newly Employed Inexperienced Miner training in November 2003, and last received Annual Refresher training on January 24, 2006. A review of Corriveau’s training records indicated that he had received all required Part 48 training.

Accident Location and Conditions

The accident occurred in Pit 3 West at an area where waste coal was being dumped. Coal hauling operations were occurring in Pit 3 East at shovel No. 301 approximately 2800 feet from the accident site. See Appendix B for a map showing these locations in relation to other mine facilities.

Appendix C shows a map of the accident site. Truck No. 503 traveled 95.6 feet down a 5.2% grade from the point where Corriveau dumped the waste load. When it came to rest, the front of the truck was tilted 20.9 degrees down from the left to right side. The pit ramp was relatively smooth compacted scoria, free of debris and irregularities. The front of the truck came to rest on waste material that was piled on the side of the ramp against the adjacent spoil bank. The ramp was between 80 to 90 feet wide.

Victim Positioning

Because there were no witnesses to the accident, the actions that resulted in the victim being found under the left rear tires are unknown. Information indicated that Corriveau had set the parking brake when he dumped the load, but when he moved the parking brake toggle switch to the “off” position to pull forward, the brakes did not release. This prompted his call regarding the parking brake problem. After the call, he exited the operator’s cab, leaving the parking brake toggle switch in the “off” position and the gear selector in neutral. After Corriveau exited the cab, the parking brakes released, which allowed the truck to roll forward. Corriveau was either

on the deck outside the left side of the operator's cab and was thrown off the deck when the truck struck and climbed the berm; or, he had climbed down to the ground to chock the tires when the truck moved and he attempted to reboard but was struck by the rear tires.

ROOT CAUSE ANALYSIS

An analysis was conducted to identify the most basic causes of the accident that were correctable through reasonable management controls. The following root causes were identified:

1. **Root Cause:** Management did not have an effective program to ensure that truck operators set the parking brakes before exiting the cab of the truck.

Corrective Action: The mine operator reinforced and trained all qualified operators on the company's policy to apply the parking brake before exiting the cab of a haul truck.

2. **Root Cause:** Ineffective maintenance procedures allowed water to accumulate in the air tank/system causing the accident.

Corrective Action: The mine operator should revise and enforce equipment maintenance procedures to require air tanks to be drained according to manufacturer's recommended time frequencies.

CONCLUSION

On Tuesday, November 28, 2006, at approximately 1:05 a.m., Mario J. Corriveau, a 50-year old haul truck operator, was fatally injured at the Spring Creek Coal Company in a powered haulage accident. The accident occurred when the frozen parking brakes released unexpectedly allowing the truck to roll forward downgrade into the berm. Corriveau was either thrown from the truck and was struck and crushed by the left rear dual tires or he was on the ground and struck and crushed by the tires. The accident occurred due to an ineffective program to ensure that truck operators set the parking brake before exiting the cab of the truck. This allowed Corriveau to exit the truck cab and not return the parking brake toggle switch to the "on" position after the switch had been put in the "off" position to move forward to finish dumping the load. Management did not have effective maintenance procedures to ensure that water was drained from and not allowed to accumulate in the air tank/system and cause the freezing problem that was experienced at the time of the accident when the parking brakes would not release.

Approved by:

Allyn C. Davis
District Manager

Date

ENFORCEMENT ACTIONS

A 103(k) Order No. 7610133 was issued to Spring Creek Coal Company to ensure the safety of the persons involved in the recovery work at the fatal truck accident site in the Pit 3 West area.

A 104(a) Citation No. 7621363 was issued to Spring Creek Coal Company for a violation of 30 CFR 77.404(a). The Caterpillar 789B haul truck, Company Number 503, was not maintained in safe operating condition in that water from condensation was allowed to accumulate in the brake air system contributing to a fatal accident on November 28, 2006. The truck was being operated in Pit 3 West, where the truck operator dumped a load of waste coal. After releasing the park brake toggle switch, the park brakes would not disengage/release due to water freezing in the air system. With the truck parked, the operator exited the cab. The park brakes then released allowing the truck to go in motion. The operator was found crushed under the left rear dual tires.

A 104(a) Citation No. 7621364 was issued to Spring Creek Coal Company for a violation of 30 CFR 77.1607(n). The Caterpillar 789B haul truck, Company No. 503, was left unattended by the operator on November 28, 2006, when a fatal accident occurred in the Pit 3 West ramp area at approximately 1:05 a.m. The wheels were not turned into a berm or blocked and the truck was parked on a 5.2% grade. The operator exited the cab without setting the parking brake and the truck went in motion and struck a berm approximately 100 feet away. The operator was found crushed under the left rear tires.

APPENDIX A

List of Persons Participating in the Investigation

RIO TINTO ENERGY AMERICA

Colin Marshall	President and CEO
Preston Chiaro	Chief Executive - Energy
Patrick James	Director of Safety
Kelly Sanders	Vice President - Operations
Mark Taylor	Attorney at Law

SPRING CREEK COAL COMPANY

Marc Ostrem	Mine Manager
Kean Johnson	Site Manager, Safety and Health
Eric Strom	Technical Services Manager
Lane A. Vanderhoef	Production Supervisor
Brad Orr	Maintenance Manager
Allan Trumbull	Safety Assistant
Pat Patterson	Stacker Reclaim Operator/MERT Member
Jason Aylesworth	Mechanic/MERT Member
Jonathan Miles	MERT Member
Dennis Zemski	Mechanic
Cliff Swinyer	Shovel Operator/MERT Member
Lee W. Hamilton	Shovel Operator/MERT Member
E. B. DeWitt	Dragline Groundsman/MERT Member
James Leno	Mechanic
Brent Looper	Plant Utilityman/MERT Member
Paula Hovey	Road Grader Operator
Michael Atkinson	Haul Truck Operator/MERT Member

MONTANA DEPARTMENT OF LABOR AND INDUSTRY SAFETY AND HEALTH BUREAU

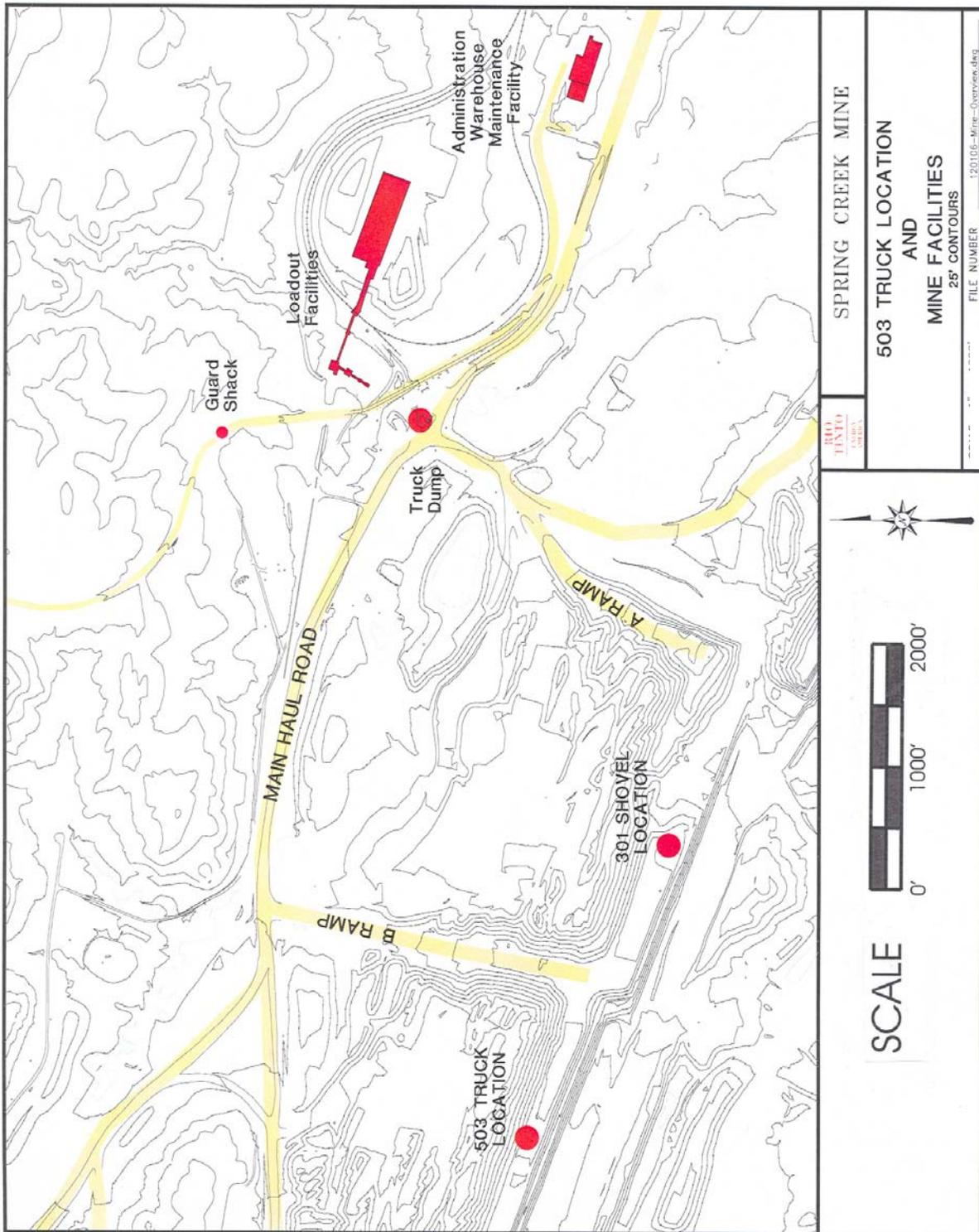
William Schwarzkoph	Coal Mine Inspector/ Mine Safety and Health Instructor
Jerry Metcalf	Coal Mine Inspector

MINE SAFETY AND HEALTH ADMINISTRATION

Peter Del Duca	Mining Engineer
Phillip Gibson	Coal Mine Safety and Health Inspector/ Lead Accident Investigator
Ronald Medina	Mechanical Engineer
Robert Montoya	Training Specialist
William Younkin	Coal Mine Safety and Health Inspector

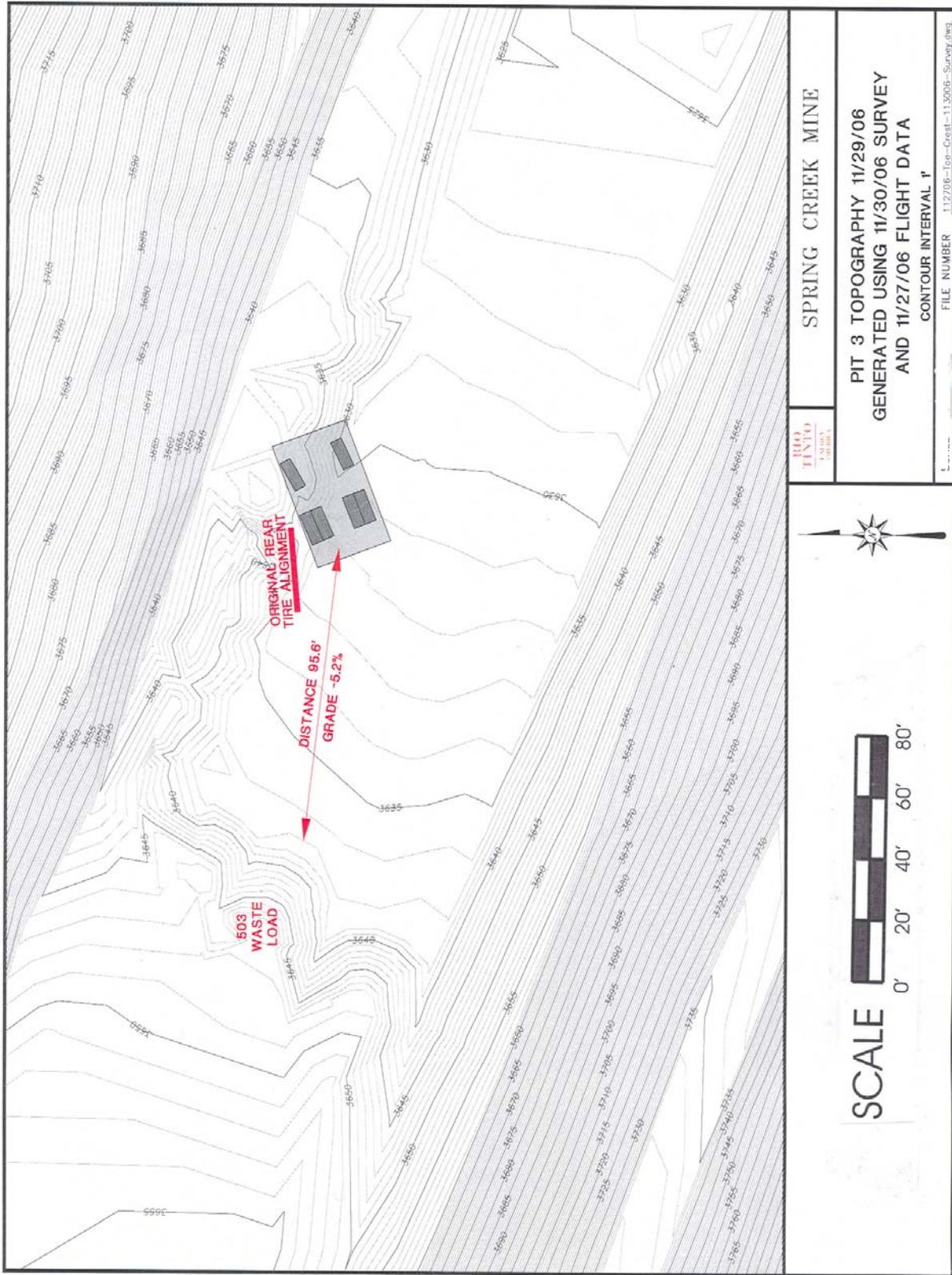
APPENDIX B

MAP SHOWING LOCATION OF NO. 503 TRUCK AND NO. 301 SHOVEL IN PIT 3



APPENDIX C

MAP OF ACCIDENT SITE IN PIT 3 WEST



APPENDIX D

VICTIM INFORMATION – MSHA FORM 7000-50b

Accident Investigation Data - Victim Information

U.S. Department of Labor
Mine Safety and Health Administration



Event Number: 4 2 6 6 7 8 7

Victim Information: 1																			
1. Name of Injured/Ill Employee: Mano J. Corveau			2. Sex: M		3. Victim's Age: 50		4. Last Four Digits of SSN:			5. Degree of Injury: 01 Fatal									
6. Date(MM/DD/YY) and Time(24 Hr.) Of Death: a. Date: 11/28/2006 b. Time: 1:05						7. Date and Time Started: a. Date: 11/27/2006 b. Time: 19:00													
8. Regular Job Title: 176 Truck driver				9. Work Activity when Injured: 055 Operate haulage truck				10. Was this work activity part of regular job? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>											
11. Experience		Years	Weeks	Days	b Regular		Years	Weeks	Days	c This		Years	Weeks	Days	d. Total		Years	Weeks	Days
a. This										c. This					d. Total				
Work Activity:		2	35	0	Job Title:		2	35	0	Mine:		3	13	0	Mining:		3	13	0
12. What Directly Inflicted Injury or Illness? 087 Wheels from haul truck						13. Nature of Injury or Illness: 170 Crushing													
14. Training Deficiencies: Hazard: New/Newly-Employed Experienced Miner Annual: Task:																			
15. Company of Employment: (If different from production operator) Operator Independent Contractor ID: (if applicable)																			
16. On-site Emergency Medical Treatment: Not Applicable: First-Aid: CPR: EMT: <input checked="" type="checkbox"/> Medical Professional: None:																			
17. Part 50 Document Control Number: (form 7000-1) 220063390008						18. Union Affiliation of Victim: 9999 None (No Union Affiliation)													