

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  
July 21, 2011

P&H Mine Pro Services, Inc (P001)  
Gillette, WY

at

Navajo Mine  
BHP Navajo Coal Company  
Fruitland, San Juan County, New Mexico  
MSHA I.D. No. 29-00097

Accident Investigators

Ronald Gehrke  
Mining Engineer, District 9

Jeff D. (Bill) Scott  
Coal Mine Safety and Health Inspector

Originating Office  
Mine Safety and Health Administration  
District 9  
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## VIEW OF ACCIDENT SITE



## OVERVIEW

On Thursday, July 21, 2011, at approximately 9:05 p.m., Jeri L. Etsitty (Victim), a 37-year old administrative technician at the BHP Navajo Coal Company, with over four years of mining experience, was killed when she was struck from behind by a pickup truck, while she was walking on the mine access road. The pickup truck was driven by a contractor employee traveling to the mine site with a delivery. The accident occurred as Etsitty and another female technician were walking with the direction of traffic on the paved mine access road at dusk.

Etsitty and a co-worker had been walking towards oncoming traffic on the access road, but crossed to the other side of the road when they saw an oncoming vehicle approaching them. They were unaware there was a pickup truck coming up from behind them. Immediately after the oncoming truck passed, they attempted to cross the road back to the other side when Etsitty was struck by the pickup truck.

The practice of employees walking on the mine access road for exercise was a contributing factor to the accident. Inadequate training also contributed to the accident.

## GENERAL INFORMATION

The Navajo Mine is a large surface mine, located 16 miles southwest of Fruitland, New Mexico, and is operated by BHP Navajo Coal Company, a subsidiary of BHP Billiton located in Melbourne, Australia. The responsible person at the mine at the time of the accident was Vernon Bedoni, Front Line Supervisor. The miners are represented by the International Union of Operating Engineers (IUOE), Local 953.

Navajo Mine began operations under the current operator in 1984. The mine produced 7,809,929 tons of coal in 2010. Mining at the Navajo Mine is performed with draglines. Multiple seam mining is conducted in four active pits. The mine employs 420 miners.

P&H Mine Pro Services, Inc, MSHA contractor ID P001, had contracted with the mining company to do repair work on a dragline on the mine site. P&H had begun the project on the Navajo Mine facility approximately two weeks before the accident. The project was scheduled to continue for another two weeks. P&H workers were scheduled to work two 12-hour shifts.

At the time of the accident, an E01 inspection of the Navajo Mine property was in progress. The event was opened on May 19, 2011. The last completed E01 was closed on March 25, 2011. The non-fatal days lost (NFDL) incidence rate for the mine for 2010 was 1.15, compared to the national NFDL incidence rate for surface coal mines for 2010 of 1.12.

## DESCRIPTION OF ACCIDENT

On July 21, 2011, at approximately 2:30 p.m., Jeri L. Etsitty (victim) and Jolene Begay, Fleet Management System (FMS) Administrative Technicians reported for the start of their shift at the Administration building.

At approximately 8:00 p.m., William Thompson, Account Manager for P&H Mine Pro Services, picked up pizzas in Farmington, New Mexico, to deliver to the P&H night shift crew working at the dragline repair site at the Navajo Mine. He traveled to the mine site in a P&H company vehicle, a Ford Model F150 pickup truck.

The shift proceeded as usual until around 8:00 p.m., when stopped for their lunch break. Etsitty and Begay had a cookout near the Administration building, along with several of their co-workers. After the cookout, at about 8:45 p.m., they left the mine area and started walking across the parking lot and continued along the curve of the entrance road facing the oncoming traffic. BHP had a wellness program which encouraged personnel to participate in physical activity at some point in their work day. This roadway was often used for walking by participants of this program. Etsitty and Begay continued walking easterly, along the mine access road towards the cattle guard (an iron grating in the roadway that prevents the open-range grazing cattle from entering the mine property, see Appendix D) at the east end of the road.

Just before Etsitty and Begay reached the cattle guard, Janitor, Laverne Peshlakai, was leaving the mine and stopped to talk to them. Peshlakai asked if they wanted a ride. Etsitty and Begay declined the offer and started to walk back towards the mine on the other side of the road. A Wagner Equipment Company service truck approached in front of Etsitty and Begay, and they walked to the other side of the road. Begay stated that the ladies would walk on the same side as oncoming traffic, but vacate the lane to the opposite side of the road when oncoming traffic approached.

After crossing to the other side, Begay stated she thought a vehicle was coming from behind them. Etsitty told Begay, she (Etsitty) thought it was the approaching Wagner service truck that Begay heard. At about 9:04 p.m., the Wagner service truck passed them on the opposite side of the road.

Immediately after the service truck passed, Etsitty and Begay heard a vehicle going over the cattle guard behind them. Begay remarked to Etsitty concerning her belief the truck was traveling at a high rate of speed, "Isn't there a speed limit sign? Doesn't that person see the sign, pedestrians walking? "

Etsitty said to Begay, "Let's go across to the other side." The two women turned to go to the opposite side of the road to vacate the traffic lane, when Etsitty was struck by the pickup truck driven by Thompson.

After the impact, Thompson stopped his pickup truck with his right tires off the road. The service truck driver, Kris Lindorff, noticed the pickup had stopped on the shoulder of the road. Lindorff stopped his service truck and proceeded to back to where the pickup truck was stopped. Lindorff exited his truck and ran to where Etsitty was laying. Lindorff found no pulse on Etsitty's wrist, neck, or sternum. Lindorff then started cardio pulmonary resuscitation (CPR).

Lindorff called the Area 3 Security Office and reported the accident. He also requested the mine rescue team and instructed security to contact the Navajo Police and San Juan Valley Fire Department.

Abel Peter, a contactor employee with Acme, left the mine shortly after Lindorff, and arrived at the accident scene after the collision and helped in comforting Begay.

The Navajo Mine Rescue Team and Vernon Bedoni, Front Line Supervisor, arrived at the accident scene. The San Juan Regional Ambulance and Navajo Police arrived on scene and Etsitty was pronounced dead at the site at approximately 12:00 a.m. on July 22, 2011.

## INVESTIGATION

The Mine Safety and Health Administration (MSHA) was notified of the accident at 9:15 p.m. on July 21, 2011, when the mine operator called Jeff D. (Bill) Scott, Coal Mine Safety and Health Inspector, Farmington, New Mexico Field Office, at his residence. Scott spoke with Leonard Palmer, Safety Superintendent, Navajo Mine. Palmer reported that there had been an accident. He and Scott discussed whether the accident scene was under MSHA's jurisdiction. Scott advised Palmer to call the MSHA hotline. Scott called Don Gibson, Assistant District Manager for Inspection Programs, District 9, and notified him of the accident. Scott had several short telephone calls with Palmer and Gibson, discussing the location of the accident and if the site was on mine property. It was determined that the accident site on the Area 3 Facilities access road (BIA N4104) was on mine property. Scott issued a verbal 103(j) Order to Palmer at 9:27 p.m.

Subsequently, the MSHA Call Center was notified of the accident at 9:40 p.m. on July 21, 2011, by the mine operator. At that time, the mine reported a female employee was walking up the side of a road, when a vehicle (contractor employee) struck her from behind with a company vehicle. Paramedics and a ground ambulance were on the scene.

Scott traveled to the mine to assess the accident scene. He arrived at the accident site about 11:45 p.m. and obtained preliminary information concerning the accident. Also on the site at that time was Dale E. West, Criminal Investigator for the Navajo Tribal Police, and his staff.

An MSHA investigation team was assembled and arrived at the mine site on July 22, 2011. After a physical examination of the scene, the team arranged to conduct interviews with the witnesses to the accident and individuals with knowledge about the accident. The accident scene was documented with photographs, maps, and measurements. Interviews were conducted with persons knowledgeable of the accident. A list of persons who participated in the investigation is contained in Appendix A.

## DISCUSSION

### Location of Accident

The accident occurred on BIA (Bureau of Indian Affairs) N4104 road, which serves as the A3 facilities area and mine site access road (see Appendix C). This road crosses the Navajo Mine permit/lease boundary and intermingles with mining activities before it exits the mine property on the west boundary. Local, non-employee traffic uses the road, as well as occasional local pedestrian traffic. The road was rebuilt and paved by the operator in approximately 1985.

The speed limit on this section of the roadway was posted as 40 mph. Signage included a 35 mph speed limit sign for the curve before the cattle guard and the mine had erected a "CAUTION PEDESTRIANS WALKING ON ROADWAY, 10:00 a.m.– 2:00 p.m." sign. This warning sign had been in place since the late 1980's. The sign had misleading information. Pedestrian traffic used the roadway at other times than stated.

On the opposite side of the road, there was a curve sign and a 40 mph speed limit sign (See Appendix D for pictures and the locations of these signs). Begay stated that crossing the road to walk on the same side as oncoming traffic was a common practice for the women.

### Mine Access Road Accident Scene

The length of the mine access road from the cattle guard to the Area 3 Facilities area was about one mile. The accident occurred about 1,300 feet from the cattle guard. The width of the pavement at the accident site was 24 feet and the slope of the roadway was approximately 3.6 percent downgrade, from the cattle guard to the accident site. The road surface in this section had numerous bumps and humping of the pavement, due to settlement of the road over the years. These conditions caused a noticeable washboard effect in this section of the road and the conditions were present, intermittently, over the entire BIA N4104 road.

Measurements from the accident scene showed the pickup truck travelled about 69 feet from when the right front tire left the edge of the pavement to where the truck came to a complete stop. The final location of the victim was approximately 50 feet in front of the stopped vehicle and positioned face down on the edge of the roadway (see Appendix E). The pickup truck came to a complete stop with the right front wheel off the pavement and the left front wheel on the edge of the pavement (see Appendix D).

Navajo Tribal Police Investigator Dale E. West presented his findings to the Supervisory Assistant United States Attorney (AUSA) for the State of New Mexico. The AUSA decided not to pursue the matter, stating there was no evidence of extreme carelessness.

#### Prior Incident on the Mine Access Road

A prior incident involving employees walking on the mine access road and vehicle traffic occurred on March 2, 2010. Employees were walking during their lunch break from the A3 buildings to the cattle guard on the mine access road, when four contractor semi-trucks hauling gravel passed them. It was reported to mine management that the trucks were perceived as speeding while pedestrians were on the access road.

Mine management investigated the incident and determined that training concerning pedestrians on the access road had not been, and was not being, provided to pedestrians and drivers of vehicles on the mine access road. Mine management also determined that a written policy, procedure, or program did not exist concerning pedestrians on the access road. After this investigation of the March 2, 2010 incident and determination, mine management failed to develop and institute proper training and a written policy, procedure, or program to address the hazards associated with pedestrians and vehicle interaction on the mine access road.

#### FMS Administrative Technician

Etsitty and Begay were classified as FMS Administrative Technicians and were responsible for data collection, entry, and reporting of the FMS for the heavy equipment on the mine site. It was common for two technicians to work on Thursday. That day was the last shift of the week for one technician and the start of the work week for the other technician.

On the night of the accident, Etsitty had a mine radio to monitor calls from the foreman and others concerning the status of equipment repairs and downtime. Part of Etsitty and Begay's assigned duties was to monitor and record equipment downtimes for entry into the FMS system.

#### P&H Company Vehicle

Thompson was driving a P&H Mine Pro, 2010 Ford Model F150 pickup truck

(VIN 1FTEX1E81AKE63311), with approximately 11,000 miles. The truck was inspected after the accident and no defects were found. The steering and brakes were tested subsequently and found to be within manufacturer's specifications. The vehicle was equipped with the Ford Crew Chief global positioning system (GPS) and the data was examined. No useful information concerning the accident was obtained. Also the data from the power-train control module (PCM) was downloaded just after the accident and again at a later date. No useful data pertaining to the accident was obtained.

Useable skid marks were not identified at the scene because of the truck's anti-locking braking system. No other means of determining speed were available.

Thompson had worked for P&H Mine Pro for 21 years, with the last nine years in Farmington, New Mexico, and was familiar with the mine access road (BIA N4104 Road). On the day of the accident, Thompson had delivered pizzas to the day shift P&H crew working on the dragline repair. He had arrived at 1:05 p.m. and left the mine site at about 3:50 p.m., traveling on the same road where the accident occurred.

#### Weather and Clothing

July 21, 2011, was a typical southwestern summer day and evening. The temperature ranged from 96 °F in the day, to a low of 65 °F that night. There was no precipitation and the sun set at 8:59 p.m. At the time of the accident, nightfall was approaching and the sun had set just minutes earlier. Visibility was adequate for walking unassisted by artificial light. Ms. Begay stated that neither of the ladies would walk at night, but often walked in the evening.

The two technicians were wearing orange safety vests with reflective striping and dark denim jeans. The vests were in like-new condition. The Navajo Nation police re-enacted the accident a week after the fatality. The re-enactment was filmed. Two vehicles traveled the road at the posted speed limit, going in opposite directions. Two individuals wearing reflective material stood along side the road at the location of the accident. The west bound vehicle could not differentiate between the vested persons and the delineation poles with reflectors that alert drivers of the side of the road.

#### Safety Program

The safety program at the Navajo mine did not address the wellness program and walking on the road. The access roadway did not have a designated walkway for use by pedestrian traffic. The wellness program was started back in the middle 1980's as a program to encourage walking to help fight diabetes. The wellness program had not been promoted by mine management lately.

### Medical Evaluation

Ms. Etsitty's body was removed from the accident scene and taken to the Cope Memorial Funeral Home, in Farmington, New Mexico. Family members requested an autopsy not be performed. A blood sample was obtained and analyzed. The analysis did not reveal any substances that contributed to the accident.

Thompson was taken to the San Juan Regional Medical center and released. A breathalyzer and drug screening test was given to Thompson. The results were negative.

### Training and Experience

Training records of the individuals involved in the accident were reviewed and deficiencies were identified that contributed to the accident. Etsitty had received her new miner training on May 17, 2007. Etsitty worked in the Corporate Branch Office in downtown Farmington, New Mexico. In 2009, Etsitty was reassigned to the Navajo Mine office. Etsitty was not given Newly Employed Experienced Miner Training at that time.

The Navajo Mine approved training plan was reviewed and the subject of hazards associated with being a pedestrian on the mine access road was not included. Etsitty's latest annual refresher training was May 24, 2011. The annual refresher course did not include the hazards associated with being a pedestrian on the mine access road.

Thompson had his annual refresher training on May 6, 2011, his site hazard training for the Navajo Mine on December 20, 2010, and new task contractor training on July 11, 2011. The approved § 48.31, Hazard Training, did not include the hazards associated with possible pedestrian traffic on the mine access road.

## ROOT CAUSE ANALYSIS

A root cause analysis was conducted. Root causes were identified that could have prevented the accident or mitigated its severity. Listed below are root causes identified during the analysis and their corresponding corrective actions to prevent a recurrence of the accident.

Root Cause: The Mine's Safety Program did not address the practice of walking on the mine access road. Following a prior incident, mine management determined a written program, procedure, or policy was not developed addressing pedestrian-vehicle interaction on the mine access road. After this incident and determination, mine management failed to develop such a written program, procedure, or policy.

Corrective Action: Mine management issued a safety communication as part of the Safety Program on July 25, 2011, that prohibited walking on the access roads on the mine site. It stated: "Effective immediately, any employee or contractor working for New Mexico Coal is prohibited from walking along any public road or mine access roadway during their working day or during their shift, even while on a lunch or other break."

Root Cause: The approved § 48.26, Experienced Miner Training, and § 48.31, Hazard Training, did not include the subject of possible pedestrian traffic on the mine access road. Mine personnel were known to walk on the access road occasionally, and vehicle traffic entered the mine property at this location. Following a prior incident, mine management determined the proper training was not being given to pedestrians and drivers of vehicles on the mine access road. Mine management failed to revise their training practices.

Corrective Action: All approved training at the mine has been modified to include the hazards associated with possible pedestrian traffic on the mine access road.

Root Cause: The mine access road did not have adequate signage to inform motorists using the mine access road of the possibility of pedestrian traffic in the area at any time.

Corrective Action: New signs have been erected to inform anyone traveling on the access road of the possibility of pedestrians in the area.

Root Cause: Employees had to walk on the mine access road for exercise, which contributed to the accident. There were no separate walkways on the access road for pedestrians to walk safely along the roadway. The employees walked on the paved road surface where the vehicles accessing or leaving the mine site traveled.

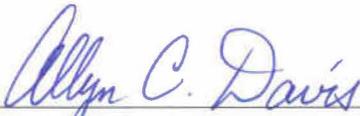
Corrective Action: Mine management issued a safety communication as part of the Safety Program on July 25, 2011, that prohibited walking on the access roads on the mine site. It stated: "Effective immediately, any employee or contractor working for New Mexico Coal is prohibited from walking along any public road or mine access roadway during their working day or during their shift, even while on a lunch or other break."

## CONCLUSION

The accident occurred when an Administrative Technician was walking with the direction of traffic on the paved mine access road at dusk. She was struck from behind by a pickup truck. The victim and another Technician had been walking west in the eastbound lane of the road. When a service vehicle approached from the west, the victim and her companion crossed to the westbound lane. Immediately after the mine service vehicle passed, the two women attempted to cross back to the eastbound lane, when one was struck and killed by an approaching westbound pickup that was unnoticed by the women.

The Mine's Safety Program did not address the possibility of pedestrians using the mine access road. Further, the approved experienced miner training, § 48.26, and the hazard training program, § 48.31, did not address the hazard of pedestrians on the access road. A prior incident on the access road alerted mine management that a written standard or procedure did not exist in the Mine's Safety Program or training programs concerning pedestrians being present on the mine access road. Mine management failed to revise the Mine's Safety Program and training programs. These deficiencies contributed to the accident.

Approved by:



Allyn C. Davis  
District Manager



Date

## ENFORCEMENT ACTIONS

1. A 103(k) Order, Number 8466742, was issued to BHP Navajo Coal Company to ensure the safety of persons at the accident site until an investigation could be conducted and operations could be safely resumed.
2. A 104(a) Citation, Number 6688949, was issued to BHP Navajo Coal Company for a violation of 30 CFR § 77.1708. The Mine's Safety Program did not address the hazards and the procedure of walking on the mine access road. Employees walked on the mine access road for exercise. There were no separate walkways on the access road for pedestrians to walk safely along the roadway. The employees walked on the paved road surface where the vehicles accessing or leaving the mine site traveled. On July 21, 2011, at approximately 9:05 p.m., a fatal accident occurred when a 2010 Ford Model F150 pickup truck (VIN 1FTEX1E81AKE63311) struck an Administrative Technician from behind, while she was walking on the mine access road (BIA N4104 Road). The accident site on the mine access road was approximately 1300 feet east of a cattle guard and about 4000 feet west of the A3 facilities area. Mine management knew that miners used this mine access road for walking and that a prior incident had occurred between miners walking on the road and truck traffic traveling on the access road. Mine management investigated the incident and determined the Mine's Safety Program did not have a written procedure addressing pedestrians on the access road. Mine management did not revise the Mine's Safety Program before the fatal accident.
3. A 104(d)(1) Order, Number 6688950, was issued to BHP Navajo Coal Company for a violation of 30 CFR § 48.31(a). The approved Part 48.31 Hazard Training given to vehicle operators did not include the hazards associated with possible pedestrian traffic on the mine access road. Mine personnel were known to walk on the access road occasionally when vehicle traffic traveled on the access road. On July 21, 2011, at approximately 9:05 p.m., a fatal accident occurred when a 2010 Ford Model F150 pickup truck (VIN 1FTEX1E81AKE63311) struck an Administrative Technician from behind, while she was walking on the mine access road (BIA N4104 Road). The accident site on the mine access road was approximately 1300 feet east of a cattle guard and about 4000 feet west of the A3 facilities area. Mine management knew that miners used the access road for walking and that a prior incident had occurred between miners walking on the road and truck traffic traveling on the access road. Mine management investigated the incident and determined hazard training did not address pedestrians on the access road. Mine management failed to revise its training practices before the fatal accident. This violation is an unwarrantable failure to comply with a mandatory standard.
4. A 104(d)(1) Order, Number 6688951, was issued to BHP Navajo Coal Company for a violation of 30 CFR § 77.1600(b). Signage was not adequate to clearly warn

motorists that pedestrians could be walking on the mine access road at anytime. The sign stated " CAUTION PEDESTRIANS WALKING ON ROADWAY, 10:00 a.m. - 2:00 p.m." The sign had been in place for several years. On July 21, 2011, at approximately 9:05 p.m., a fatal accident occurred when a 2010 Ford Model F150 pickup truck (VIN 1FTEX1E81AKE63311) struck an Administrative Technician from behind, while she was walking on the mine access road (BIA N4104 Road). The accident site on the mine access road was approximately 1300 feet east of a cattle guard and about 4000 feet west of the A3 facilities area. Mine management knew that miners had walked on this mine access road at times other than the time stated on the "CAUTION" sign. This violation is an unwarrantable failure to comply with a mandatory standard.

5. A 104(d)(1) Order, Number 6688952, was issued to BHP Navajo Coal Company for a violation of 30 CFR § 48.26(a). The approved Part 48.26 Experience Miner Training did not include the hazards associated with being a pedestrian on the mine access road. Mine personnel were known to walk on the access road occasionally when vehicle traffic traveled on the mine access road. On July 21, 2011, at approximately 9:05 p.m., a fatal accident occurred when a 2010 Ford Model F150 pickup truck (VIN 1FTEX1E81AKE63311) struck an Administrative Technician from behind, while she was walking on the mine access road (BIA N4104 Road). The accident site on the mine access road was approximately 1,300 feet east of a cattle guard and about 4,000 feet west of the A3 facilities area. The victim had not received newly employed Experience Miner Training after being transferred from the Farmington Corporate Office to the mine site. Mine management knew that miners used this mine access road for walking and that a prior incident had occurred between miners walking on the road and truck traffic traveling on the access road. Mine management investigated the incident and determined training did not address pedestrians on the access road. Mine management failed to revise its training practices before the fatal accident. This violation is an unwarrantable failure to comply with a mandatory standard.

## **Appendix A**

### **List of Persons Participating in the Investigation**

#### **BHP NAVAJO COAL COMPANY**

Patrick Riser	General Manager
Val Lynch	Manager of Safety
Tyler Martin	Maintenance Safety Coordinator
Leonard Palmer, Sr.	Safety Superintendent

#### **P&H MINE PRO SERVICES, INC**

Lance Wheeler	Regional Safety Manager
Earl E. Byrd	Senior Safety Specialist
Seth Bingham	Attorney
Richard Wade	Attorney

#### **INTERNATIONAL UNION OF OPERATING ENGINEERS**

J.D. Arnold	Electrician / Primary Union Representative
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#### **MINE SAFETY AND HEALTH ADMINISTRATION**

Ronald Gehrke	Coal Mine Safety and Health Engineer
Jeff D. (Bill) Scott	Coal Mine Safety and Health Inspector
Dan Vetter	District 9, Staff Assistant

## Appendix B

### Persons Interviewed during the Investigation

#### BHP NAVAJO COAL COMPANY

Jolene Begay	Administrative Technician
Fred Peter	Equipment Operator B
Bobby Griffith	Equipment Operator A
Vernon Bedoni	Supervisor
Deirdra Platero	Security Personnel/ Guardsmark
D.C. Gomez	Loader Operator
Abel Peter	Contractor/ Acme Soil Remediation
Laverne Peshlakai	Contractor/Clean Sweep Janitorial
Ben Hoskie	Engineering Manager
Dustin Fisher	Drill & Blast Supervisor

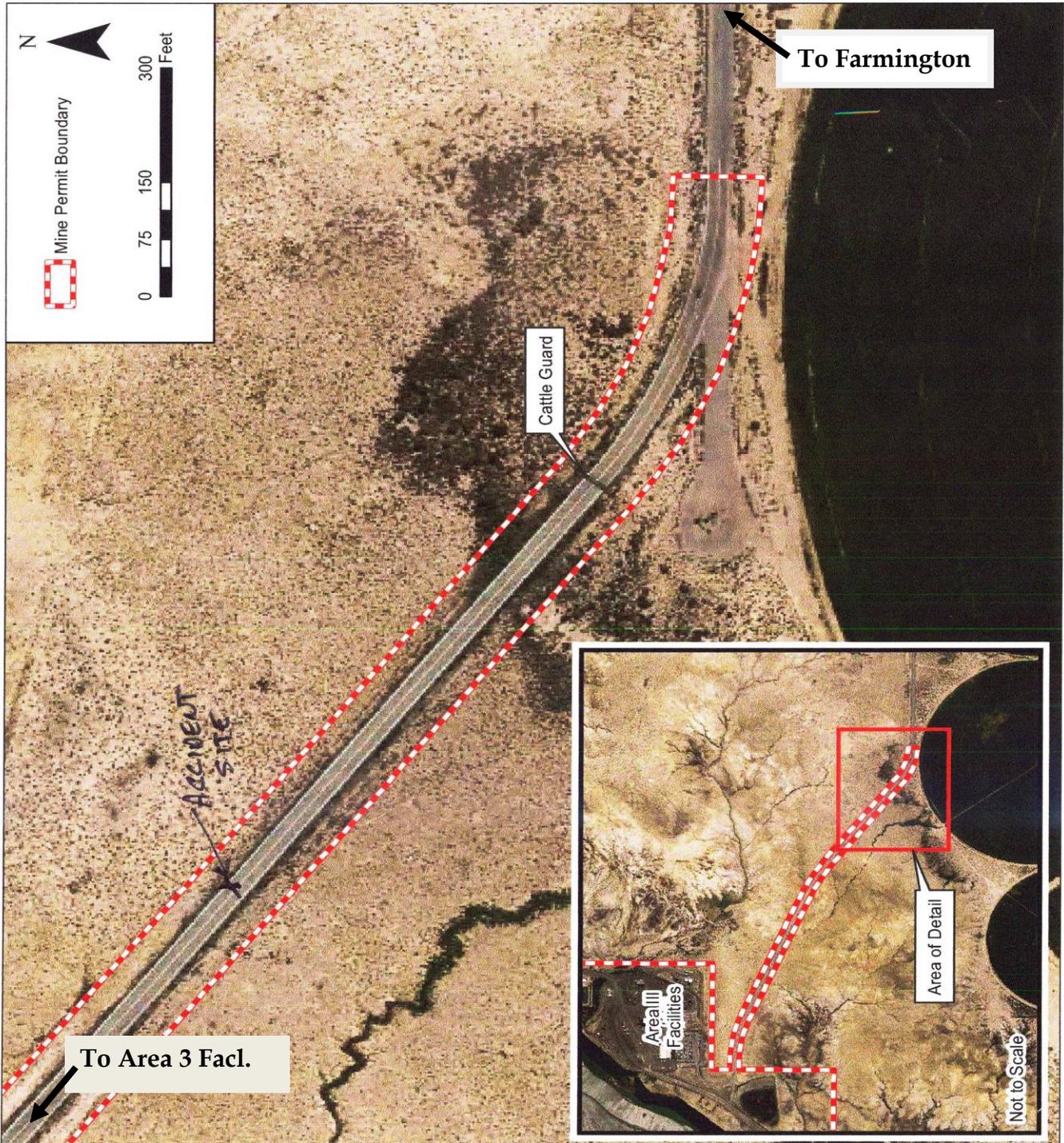
#### P&H MINE PRO SERVICES, INC.

William Thompson	Account Manager
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#### WAGNER EQUIPMENT COMPANY

Kris Lindorff	Field Service Mechanic
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Appendix C  
Accident Location Mine Access Road (BIA N4104 Road)

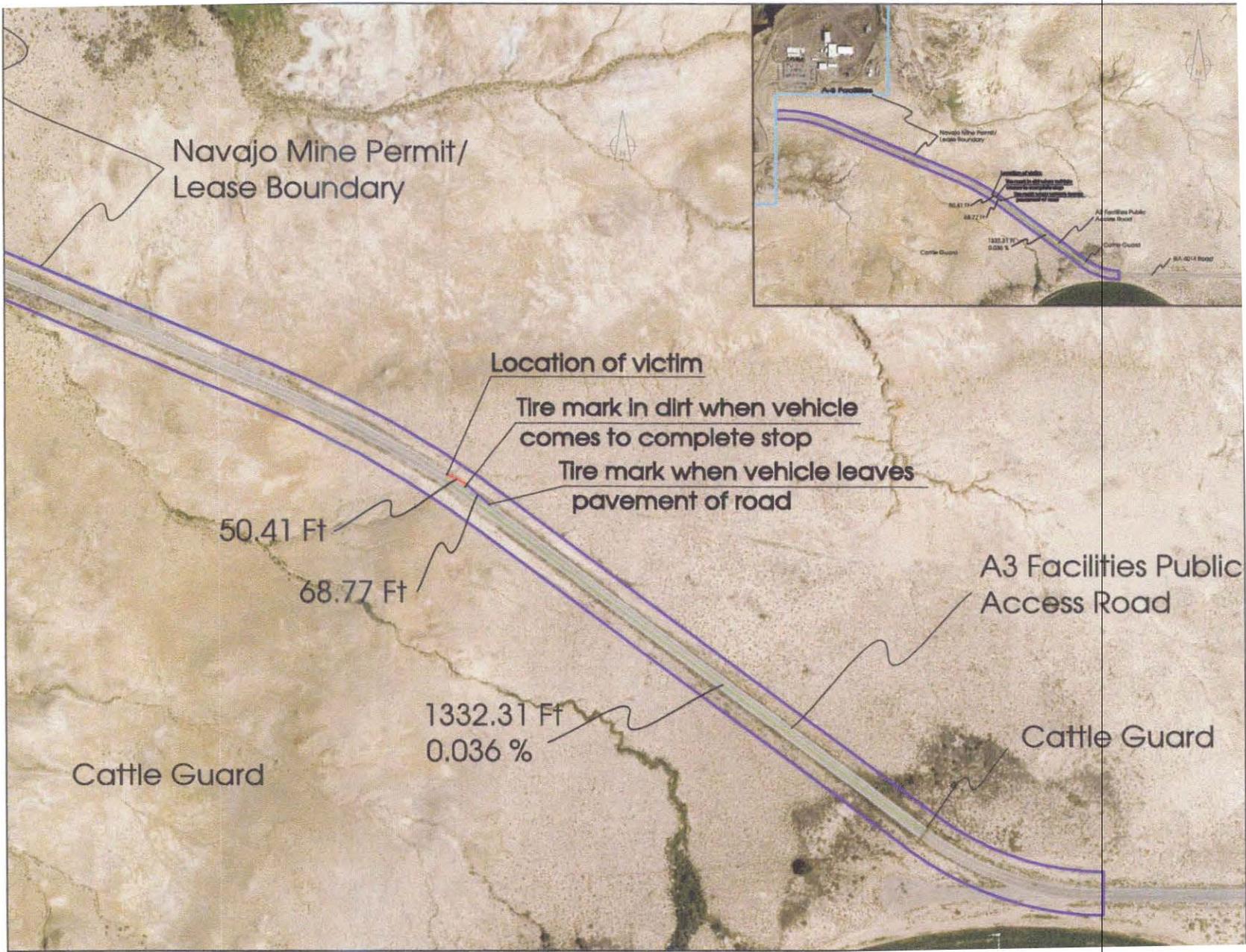


## Appendix D Signage on Mine Access Road (BIA Road N4104)



### Final Location of Truck





Appendix E  
Locations of Pickup Truck and Victim

