

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

COAL MINE SAFETY AND HEALTH

REPORT OF INVESTIGATION

Surface Mine Facility

Slip and Fall Accident

March 9, 2008

Resulting Death April 4, 2008

Chargeable as of November 24, 2008

Warrior Preparation Plant
Warrior Coal, LLC
Madisonville, Hopkins County, KY
ID No. 15-14335

Accident Investigators

William Barnwell
Mining Engineer
Mine Safety and Health Specialist

Originating Office
Mine Safety and Health Administration
District 10
100 YMCA Drive
Madisonville, KY, 42431-9010
Carl E. Boone II, District Manager

TABLE OF CONTENTS

OVERVIEW.....	1
GENERAL INFORMATION	2
DESCRIPTION OF ACCIDENT.....	2
INVESTIGATION OF ACCIDENT	3
DISCUSSION	4
ROOT CAUSE	4
CONCLUSION.....	5
ENFORCEMENT ACTION	6
APPENDIX A - Persons Participating in the Investigation	7
APPENDIX B - Photographs (Accident Site).....	8

OVERVIEW

On Sunday, March 9, 2008, five miners were scheduled to perform train load-out duty at the Warrior Coal, LLC, Warrior Preparation Plant, MSHA ID, 15-14335. At approximately 6:30 a.m., Michael H. Rickard, laborer, was injured as he walked outside the warehouse. Rickard slipped and fell on an icy walkway, injuring his right leg. He was found lying on the ground near his personal vehicle by co-workers. First aid was administered and Rickard was transported by ambulance to the Madisonville Regional Medical Center. He received immediate treatment for a broken right leg. Surgery was also performed to insert a steel rod and screws. After surgery, Rickard developed pneumonia and was in and out of critical care while hospitalized. Upon release from the hospital on March 25, 2008, Rickard developed further complications with his breathing. He refused to re-enter the hospital until April 3, 2008, when his condition became acutely worse. Rickard died in the hospital on April 4, 2008.

On April 7, 2008, the Warrior Preparation Plant Safety Director, Jamie Woodruff notified Ray Cartwright, Coal Mine Inspector (CMI), of Mr. Rickard's death. On April 9, 2008, Mine Safety and Health Administration (MSHA) started an investigation with regard to chargeability of the accident as a mine-related fatality. Information was forwarded on May 12, 2008, to MSHA Headquarters for the Agency's Fatality Review Committee. Based on the results of MSHA's investigation, and a review of the available medical documentation, the Committee issued its conclusion on November 24, 2008. The Committee determined Rickard's death should be charged. The death certificate indicates Rickard died of asphyxia due to septic shock, due to pulmonary fibrosis. The MSHA Fatality Review Committee's conclusion stated Rickard's death was due to the complications of the surgical procedure that was performed to remedy a work-related injury.

GENERAL INFORMATION

Warrior Preparation Plant is operated by Warrior Coal, LLC. It is located 1.7 miles south of Manitou, Hopkins County, Kentucky, off State Highway 630. At the time of the accident, the facility employed 38 surface miners working two production shifts and one maintenance shift per day. The plant produces 7,500 tons of coal daily.

At the time of the accident, the facility had four weekend train load-out crews. The crews rotated weekend work.

The principal officers for the mine at the time of the accident were:

Eric K. AndersonGeneral Manager
Kevin Vaughn.....Director of Safety and Training
Frank Roberts.....Preparation Plant Superintendent

The principal officers for the Corporate Office at the time of the accident were:

Joseph W Craft III..... President, & CEO
Thomas L Pearson.....Senior V.P. of Law & Administration Secretary
Charles R Wesley, III Senior Vice President of Operations
Gary J RathburnSenior Vice President of Marketing
Dale G Wilkerson..... Vice President of Controller & Assistant Secretary

A regular safety and health inspection was in progress at the time of the accident by the Mine Safety and Health Administration (MSHA). The total injury incidence rate for the mine in 2007 was 1.74 compared to a national injury incidence rate of 4.71.

DESCRIPTION OF ACCIDENT

On Sunday morning, March 9, 2008, five miners were scheduled to perform train load-out duty. Normal operations of the preparation plant did not occur that day. At approximately 6:30 a.m., Michael H. Rickard was injured as he walked outside the warehouse where he slipped and fell, injuring his right leg. The weather was cold with icing conditions. There were no witnesses to the accident. Rickard was found by co-workers, lying on the ground near his personal vehicle. First aid was given to Rickard and an ambulance was contacted at 6:44 a.m. Rickard was transported to the Regional Medical Center where he was treated for a broken right leg (tibia and fibula).

INVESTIGATION OF THE ACCIDENT

On March 20, 2008, Ray Cartwright, Coal Mine Inspector, was at the mine on a regular inspection. During the course of the inspection, the accident involving Rickard was discussed. Rickard had not returned to work since the accident. On April 7, 2008, Safety Director Jamie Woodruff mentioned to Cartwright that Mr. Rickard had died. Woodruff asked Cartwright about the status regarding completion of the MSHA Form 7000-1, Accident, Injury and Illness Report. On April 8, 2008, Cartwright informed management at the MSHA District 10 Office of the death of Rickard. MSHA Headquarters was notified for guidance. The District was instructed to conduct a chargeability investigation and forward all information to MSHA Headquarters. An investigation was started on April 9, 2008 and a chargeability report was completed and sent to MSHA Headquarters on May 12, 2008. Medical records and a copy of the death certificate were submitted as part of the report. On November 24, 2008, the MSHA Fatality Review Committee issued a finding that the fatality was chargeable as a mining-related fatality.

On December 2, 2008, a fatal injury investigation was started jointly with the Kentucky Office of Mine Safety and Licensing (OMSL). Information obtained in the earlier investigation on April 9, 2008 was utilized for the fatal accident report. On that date, MSHA's accident investigation team traveled to the mine and conducted a physical examination of the accident site.

During the fatality investigation, the team interviewed two hourly laborers and one supervisor, who were on site when the accident occurred. Sharon Rickard, the spouse of Mr. Rickard, was also interviewed on April 9, 2008. When asked about the accident, Mrs. Rickard stated her husband said he fell off the dock in front of the overhead door. However, Safety Manager, Jamie Woodruff, said Rickard told him in the emergency room that he did not fall off the dock. Rickard's co-workers, Greg Lykins, Charles Mitchell, and Preparation Plant Superintendent, Franklin Roberts, stated Rickard was unable to move when discovered lying on the walkway adjacent to his personal truck. Roberts stated Rickard was not muddy or wet, which would be expected if he had crawled out of the dock's pit area to where he was discovered. According to Sharon Rickard, Lykins and Mitchell, Rickard slipped on "black ice" that had formed in the walkway leading to the parking area, adjacent to the warehouse.

The investigation revealed that there was no stated or written policy or procedure in place at the facility to address snow or ice removal. The operator provides "snow melt" and calcium chloride, which are left to the employees' discretion for application.

DISCUSSION

PHYSICAL FACTORS:

The weather was cold with icing conditions. It had snowed a couple days prior to the accident. According to Roberts, the snow had melted on portions of the walkway and had frozen during the night, causing “black ice.” The walkway was slightly inclined adjacent to a loading dock. No snow or ice had been removed prior to the miners traveling this area.

WORK PROCEDURES/TRAINING:

Rickard had a total of 18 years mining experience. He had six years experience at the task being performed as a laborer at the time of accident. Rickard’s assigned duty was to facilitate the loading of a unit train. His normal routine was to travel alone to the load-out facility where he would start the conveyor belt. He was then to remain in the “belt shanty” control room, where he could monitor the belts. Rickard normally worked as a second shift warehouse person and dispersed parts. On occasion, Rickard also operated equipment on a fill-in basis.

HUMAN FACTORS:

Mr. Rickard was 60 years of age and had a pre-existing medical condition (Pulmonary Fibrosis).

ROOT CAUSE ANALYSIS

An analysis was conducted to identify the most basic cause of the accident that was correctable through reasonable management controls. During the analysis, a root cause was identified that, if eliminated, could have either prevented the accident or mitigated its consequences.

The root cause listed below identified during the analysis and the corresponding corrective action implemented to prevent a recurrence of the accident:

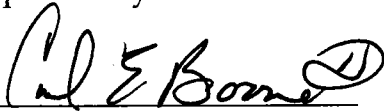
1. *Root cause:* An effective policy was not in place and implemented to ensure that the designated walkway was kept free of ice and snow.

Corrective Action: Warrior Coal, LLC, Warrior Preparation Plant, shall update their safety program with procedures for maintaining regularly traveled walkways in safe condition during inclement weather conditions such as freezing rain, snow, and ice, prior to miners accessing these areas. A copy of the instructions will be given to all company and contractor employees and posted at the mine site.

CONCLUSION

The walkway was not maintained free of snow and ice which resulted in the fall of Mr. Rickard. The lack of effective policies and procedures contributed to these conditions and the resultant fall. Mr. Rickard's death was charged to the mining industry because his death was due to the complications of the surgical procedure that was performed to remedy a work-related injury.

Approved By:



Carl E. Boone II
District Manager

3-23-9

Date

ENFORCEMENT ACTION

A 104 (a) citation, No. 8492059, citing Title 30, Code of Federal Regulations (CFR), Section 77.205 (d), S & S, with Moderate Negligence was issued to Warrior Preparation Plant. The citation stated, "The walkway, outside the warehouse adjacent to the loading dock, was not maintained free of snow and ice. "Black ice" had formed and an employee slipped and fell, breaking his right fibula and tibia on March 9, 2008. The employee later died on April 4, 2008 due to complications of the surgical procedure that was performed to remedy the injury."

**Appendix A
Persons Participating in the Investigation**

Warrior Coal, LLC

<u>Name</u>	<u>Title</u>
Eric K. Anderson	General Manager
Kevin Vaughn.....	Director of Safety and Training
Franklin Roberts	Preparation Plant Superintendent
Greg Lykins	Laborer/Equipment Operator
Chuck Mitchell	Laborer/Equipment Operator
Sharon Rickard	Spouse of Victim

Kentucky Office of Mine Safety & Licensing

<u>Name</u>	<u>Title</u>
Joe Gill	Inspector Principle

Mine Safety and Health Administration

<u>Name</u>	<u>Title</u>
William Barnwell	Coal Mine Safety and Health Inspector (Roof Control Specialist)
Ray Cartwright.....	Coal Mine Safety and Health Inspector (Surface)
Troy Davis.....	Coal Mine Safety and Health (Staff Assistant)

**Appendix B
Accident Site**

