

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
December 12, 2009

Trivette Trucking (Q080)

at

Premier Elkhorn Coal Company
PE Southern Pike County
Myra, Pike County, Kentucky
I.D. No. 15-17360

Accident Investigator

Debra H. Howell
Coal Mine Safety and Health Specialist (Surface)

Originating Office
Mine Safety and Health Administration
District 6
100 Fae Ramsey Lane
Pikeville, KY 41501
Norman G. Page, District Manager

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Photograph of Accident Scene

OVERVIEW

At approximately 6:30 a.m., on Saturday, December 12, 2009, Stevie Johnson, a 52-year old Truck Driver and Chief Mechanic for Trivette Trucking, received fatal injuries when he exited the truck he was driving, and was struck by the left rear tandems of the truck. Johnson had approximately 30 years of experience as a truck driver/truck mechanic, all of which was with this contractor. He had approximately seven years experience at this mine. Johnson was hauling coal from the PE Southern Pike County Mine when the accident occurred.

GENERAL INFORMATION

Premier Elkhorn Coal Company, PE Southern Pike County mine, is a bituminous surface coal mine located in Myra, Pike County, Kentucky. The parent corporation is Tampa Energy Company (TECO). Contour mining of multiple seams is performed with front end loaders and off road haul trucks. This mine is currently performing reclamation activities. However, when a seam of coal is uncovered, the coal is loaded and shipped for processing. Trivette Trucking is one of the independent contractors that hauls coal from this mine.

The principal officer for Premier Elkhorn Coal Company is Don Hall, President of Operations. The mine operates one eleven-hour shift, five to six days per week and employs 10 persons. The mine produces approximately 1,000 tons of coal per day when coal is shipped. This occurs only a couple of times per month. This coal is usually hauled on Saturday. The coal is transported from the mine by truck to the Burke Branch Preparation Plant, where it is prepared for the market and shipped by rail.

Trivette Trucking is an independent trucking contractor having 15 to 20 coal trucks and employs 20 to 30 persons. The principal officer is Robin Trivette, Member (Owner).

The last regular safety and health inspection of the mine prior to the accident was completed on November 17, 2009. The Non Fatal Days Lost (NFDL) injury incidence rate at this mine for 2009 was 0.00 compared to the national average of 4.16. The NFDL injury incidence rate for this contractor for 2009 was 0.00 compared to the national average of 2.48.

DESCRIPTION OF ACCIDENT

On Saturday, December 12, 2009, the work areas and roadways were examined for hazards by Premier Elkhorn company personnel between 4:30 a.m. and 5:00 a.m. No hazards were detected or noted. At approximately 5:30 a.m., two front end loaders were trammed from an adjacent mine site, also operated by Premier Elkhorn, to the PE Southern Pike County mine. The coal trucks, which had been waiting at an area known as the "Cow Pasture," followed the loaders to an area known as the "Grassy Pit" to be loaded. Stevie Johnson, Victim, reported to work at this site at approximately 3:30 a.m. Upon arrival of the front end loaders, the work of loading the trucks proceeded as normal.

The fifth truck to be loaded was owned by Trivette Trucking and was driven by Johnson. Johnson had commented on the CB radio to other drivers between 5:30 a.m. and 6:15 a.m. that he was having a problem with the steering on the truck he was

driving. He stated that “he had put power steering fluid in the truck last night, but it might need some more,” and “the steering seems to be a little stiff.” Some of the other drivers, including Carl Collier (Sturgill Trucking), heard the comment. Johnson was loaded at 6:15 a.m.

Once loaded, Johnson exited the coal pit and drove to a location on the haul road where Collier was located. Johnson parked the truck in the haul road and Collier helped him raise the hood so he could visually check the steering system for leaks and low fluid. Collier got in the operator’s cab of Johnson’s truck and turned the steering wheel. No leaks were detected and the pump reservoir was full of fluid. Johnson then proceeded to drive the truck to the dump site.

The sixth truck, owned by Greg Bentley Trucking and driven by Tim Bentley, was loaded and left the pit area. While descending a section of the haulage roadway, Bentley observed the truck driven by Johnson overturned in the roadway. Bentley stopped and parked his truck above the accident site, walked down to the scene. The road grader, operated by Jeff Wright, of Premier Elkhorn, was in operation on the other side of the overturned truck. Bentley and Wright began looking for Johnson. Bentley found Johnson in the ditch on the outer side of the roadway. Wright contacted Gregory Hayes, Premier Elkhorn Reclamation Foreman and MET, and informed him of the accident. Hayes responded to the accident scene, but was unable to administer any type of first aid due to the injuries Johnson had received. An ambulance and the coroner’s office were notified. The victim was pronounced dead at the scene by Pike County Coroner Russell Roberts at 8:37 a.m. There were no eyewitnesses to the accident.

INVESTIGATION OF THE ACCIDENT

Anthony Burke, Supervisory Conference and Litigation Officer for MSHA District Office at Pikeville, Kentucky, was notified of the accident at 6:59 a.m. by the MSHA Call Center. Burke was also contacted by David Wilder, Safety and Environmental Director for Premier Elkhorn Coal Company, via telephone at 7:25 a.m. Burke issued a verbal 103(j) Order to close all haul roads on mine property, secure the accident scene while the investigation was conducted and to ensure the safety of any person traveling on the mine roadways.

MSHA personnel from the Whitesburg and Pikeville offices were immediately dispatched to the mine site. The 103(j) Order was modified to a 103(k) Order upon arrival at the mine. Photographs and relevant measurements were taken. The investigation was conducted in cooperation with the Kentucky Office of Mine Safety and Licensing.

A mechanical engineer from the MSHA Approval and Certification Center (A&CC) office arrived on December 14, 2009, to conduct a detailed mechanical evaluation of the International Paystar 5600 truck involved in the accident. A review of the training records was conducted. Interviews were conducted with five employees of Trivette Trucking, six truck drivers from other companies and three employees of Premier Elkhorn Coal Company deemed to have knowledge of the facts regarding the accident. The interviews were conducted at the Kentucky Office of Mine Safety and Licensing office at Pikeville, Kentucky on December 14, 2009.

DISCUSSION

Mechanical Evaluation of Truck

The truck involved in the accident was a 2006 International Paystar, Model 5600i Haul Truck, Vehicle Identification Number (VIN) 1HTXHAPTX6J233337. The front end of the truck was damaged in the accident and the engine was not operational. The electrical system was also not operational due to damage to the batteries and cables. The transmission bell housing was cracked, numerous air lines were damaged, and the front left wheel broke off from the axle. The cab, which was recessed in slightly compared to the dump body, was not damaged. The doors functioned and all the cab glass was intact. The two ends of the seat belt latched together when tested.

The truck had an extended weight allowance limit of 90,000 lbs. The maximum Gross Vehicle Weight Rating (GVWR) was 82,600 lbs. The empty weight of the truck was approximately 40,000 lbs. Based on the weigh tickets for the truck, when it last hauled from the same location on December 5, 2009, the GVW for the truck at the time of the accident was estimated to be 120,200 lbs. In addition, the loader operator stated that on the day of the accident he was loading the trucks with a slight heap. The estimated GVW of 120,200 lbs. was 37,600 pounds over the maximum GVWR recommended by the manufacturer.

Premier Elkhorn employees were responsible for loading the trucks and operating the weigh station for the trucks at the prep plant. The loader operators which loaded the trucks the day of the accident stated in the interviews that they heaped the load in the truck beds this date. Weigh tickets obtained from the Premier Elkhorn Burke Branch Prep Plant from different dates, different mines, and different trucks demonstrate a practice of overloading the trucks.

Steering System Evaluation

The truck was equipped with a Sheppard M-100/M-80 dual power steering gear system. After the truck was up-righted, the power steering reservoir level was checked and was found to be $\frac{1}{4}$ inch above the bottom end of the dipstick in the "add" zone on the "cold check" side of the dipstick. Power steering fluid was leaking from the steering gearbox. There was also a smaller amount of leakage from the power

steering hoses. The gearbox was later disassembled and the pressure seals on both sides of the shaft supporting the sector gear were found to be installed backward which allowed this leakage at the sector shaft. The Sheppard Service Manual for this unit indicated that the pressure seals on the truck were incorrectly installed with the black lip toward the outside and the white side toward the inside. The incorrectly installed seals allowed leakage. Low power steering fluid level causes air to be introduced into the system. The service manual states that "hard" steering could result if air is in the system. Due to the damage caused by the accident, the presence of air at the time of the accident could not be determined by testing. Other damage to the steering system could not be ruled out as occurring due to the accident. MSHA's A&CC investigator contacted the R.H. Sheppard Co., Inc., manufacturer of the steering box, to answer questions regarding the steering gear. Jeff Neiderer, Technical Center Manager, R.H. Sheppard Co., Inc., traveled to the accident site and inspected the steering gear component parts.

The power steering pump was removed from the truck and sent to the manufacturer of the pump, TRW Automotive, for evaluation. This testing indicated that the pump flow and pressure performance was acceptable according to the manufacturer's specifications.

Transmission

After the accident, the transmission was found to be in neutral with the selector switches on the gear shift lever in the low range, low split position. A dent was found in the floorboard under the rubber boot for the gear shift lever. The location of the dent was consistent with pushing the gear shift lever into a neutral position. It appears that this occurred due to the impact and force of the accident. No visible defects were found in the driveline shafts and universal joints (U-joints) from the engine to the drive axles.

Brakes

The brake on the right rear tandem axle did not function. The S-cam was found to be jammed in a "high-cam" position.

The brake drums on the front-right tandem axle and both the right and left rear tandem axles were worn beyond the maximum allowable diameter stamped on the drums. Blueing was present on the right front and left rear tandem axle brake drums. Blueing indicates excessive heat and compromises the braking capacity.

No deficiencies were found in the engine brake or parking brake system. No audible air leaks could be detected when the brakes were applied. The pushrod travel on all chambers checked were within maximum allowable limits.

The left front steering axle was not checked in it's entirety due to damage resulting from the accident.

Weather Conditions

The accident occurred at approximately 6:30 a.m. on the first trip of the shift. The temperature ranged from approximately 14 degrees Fahrenheit where the truck had been parked overnight to the twenties in the area where the truck was loaded. The air and fuel systems were evaluated to attempt to identify deficiencies and determine if the sub-freezing temperature prior to the accident was a factor.

The air dryer was pressure tested and the purge valve and the output line to the air tanks did not leak. Some water was found in the air tanks. Frozen moisture can cause operational problems in air systems. During the testing after the accident, no operational problems were found due to frozen moisture; however the temperature rose above 32 degrees Fahrenheit before the testing could be done. The amount of water in the air tanks at the time of the accident could not be determined, since the tanks had been damaged in the accident and water could have escaped.

The fuel tank on the truck was nearly full. The primary and secondary fuel filters were both full and no water droplets were found when the fuel was poured into a clear container. The fuel was tested by a third party laboratory and had a cold filter plugging point of negative 2 degrees Fahrenheit. This test gives an estimate for the lowest temperature that a diesel fuel will give trouble-free flow in the fuel system.

Roadway Conditions

The roadway consisted of a compacted shot rock base with a limestone gravel surface. The average width of the road was eighteen feet.

After being loaded, the truck descended a grade approximately 1,300 feet long, with an average overall grade of approximately 14 percent to the point where the accident occurred. The haul road leveled off about 200 feet beyond where the truck came to rest. The berm height along the outer bank of this road was 36 inches from road bed level. A ditch at the base of the berm was an additional 18 inches in depth at the accident location.

Tire tracks from the truck travel lead toward the ditch and berm 283 feet from the point where the truck came to rest. These tracks continued in the roadway for an additional 215 feet before the inside left rear tire entered the ditch. Evidence indicates that Johnson left the truck cab at least 13 feet before the tire entered the ditch. The first location of disturbance in the berm was 53 feet from the final resting point of the truck. This is 230 feet from the point where the truck initially veers from the normal roadway. The first evidence of Johnson leaving the cab of the truck was 81 feet from the final resting point of the truck.

The technical evaluation of the truck revealed deficiencies in the steering and braking systems. It could not be determined if the steering deficiency or the water in the air tanks contributed to the accident. It is more plausible that the brake deficiencies, combined with overloading the truck, were the underlying causes of the driver losing control of the truck.

Management Oversight of Loading of Trucks

Overloading of trucks was an accepted practice by Premier Elkhorn and Trivette Trucking based on a review of the weigh tickets. The victim's truck was overloaded by an estimated 37,000 pounds. A review of the weigh tickets for this and other trucks on earlier dates demonstrates that there was a pattern and practice of such overloading. Premier Elkhorn and Trivette Trucking were both aware of the overloading of the trucks from the weigh tickets, which were used for payment. The truck drivers received a copy of the weigh ticket from Premier Elkhorn for each load.

Pre-operative Examination

Recorded pre-operational examinations for this truck had not been documented since October 2009. Other drivers for the contractor stated during interviews that pre-operative examinations were conducted daily and deficiencies were corrected prior to using the trucks. 30 CFR § 77.1606(a) requires that "equipment defects affecting safety shall be recorded and reported to the mine operator." No record of a pre-operational examination indicating a deficiency to this truck was found during the investigation. It is possible no documentation or reporting was made because the victim was also the chief mechanic and would be the person responsible for correcting any safety defect.

Maintenance Program

Scheduled periodic maintenance involves in-depth examinations and would have identified the brake defects found on the victim's truck. Trivette Trucking had no records indicating that this maintenance had been performed. For trucks being operated at mines, International Truck and Engine Corporation (International), the truck manufacturer, recommends a complete inspection of the braking system (scheduled periodic maintenance) at intervals not exceeding 10,000 miles. At the time of the accident, the truck had been driven 162,141 miles, all of which was during ownership by Trivette Trucking, who purchased the truck when it was new. Therefore, Trivette Trucking should have performed these in-depth examinations at least 16 times. The maintenance program only monitored the frequency of oil changes and lubrication.

The Operator's Manual for the truck states that, for Air Brake Inspection and Adjustment, a regular schedule (scheduled periodic maintenance) for periodic cleaning, lubrication, adjustment and inspection should be established based on the

type of vehicle operation. In the Operator's Manual International states that the vehicle owner can contact them if they are uncertain of the proper schedule.

The victim was also the chief mechanic for Trivette Trucking. He was responsible for directing matters involving the maintenance and operation of all the trucks on a daily basis, according to testimony obtained during the investigation. In addition to having management responsibility, he had also been driving this truck for several weeks prior to the accident.

A hazardous condition complaint concerning Trivette Trucking was received by MSHA on the day of the accident. The general condition of trucks checked during the investigation of the hazardous condition complaint indicated the contractor's lack of maintenance was not exclusive to the truck involved in the accident. Twenty nine citations for safety defects were issued on other trucks being operated by this contractor during the investigation of the complaint.

Training

The review of the training records for the victim indicated the training was up-to-date and sufficient.

Seat Belt

A seat belt was provided and was operative when tested. Although not required by regulation, seat belt usage is highly recommended by MSHA. Code of Federal Regulation 30 CFR § 77.1710(i) requires, "Seatbelts in vehicle where there is a danger of overturning and where roll protection is provided." The truck involved in the accident was not provided with rollover protection. If the driver had stayed in the truck and used the seat belt, the fatal accident may have been prevented, based on the lack of damage to the cab of the truck.

ROOT CAUSE ANALYSIS

An analysis was conducted to identify the most basic causes of the accident that were correctable through reasonable management controls. Listed below are the root causes identified during the analysis and the corresponding corrective actions implemented to prevent a recurrence of the accident:

Root Cause: Trivette Trucking did not have established procedures to ensure the trucks received adequate maintenance to prevent and identify safety defects. The maintenance program only monitored the frequency of oil changes and lubrication. Premier Elkhorn did not fulfill its responsibility as the mine operator to assure the contractor's trucks were properly maintained.

Corrective Action: A revised policy to ensure that trucks receive adequate maintenance to prevent and identify safety defects has been established by Trivette Trucking. Maintenance is now documented and can now be easily monitored. Premier Elkhorn has developed a policy at this mine to conduct or observe random inspections of the trucks operated by contractors.


Root cause: A policy to establish a safe weight limit for the loading of the trucks had not been developed by Trivette Trucking or Premier Elkhorn. The trucks were routinely loaded to a weight exceeding the manufacturer's gross vehicle weight rating.

Corrective Action: Training has been given to the drivers in regards to the hazards created by exceeding the manufacturers gross vehicle weight limits. Drivers have been instructed to not haul when overloaded.

CONCLUSION

The accident occurred because the driver lost control of the overloaded truck, exited the cab and was struck by the left rear tandems, resulting in fatal injuries. The truck he was driving was not equipped with adequate brakes. Both the mine operator, Premier Elkhorn Coal Company and the contractor, Trivette Trucking, were aware that trucks were routinely overloaded and did not act to stop this practice. Also, Trivette Trucking and Premier Elkhorn failed to provide effective oversight to assure that safety defects were identified during scheduled periodic in-depth maintenance was performed, and defects were corrected before the equipment was used.

Approved by:



Norman G. Page
District Manager

7-15-2010

Date

ENFORCEMENT ACTIONS

1. 103(j) Order No. 8230303 was verbally issued to Premier Elkhorn Coal Company

Condition or Practice: "A fatal haulage accident occurred at this mine at approximately 6:30 a.m. This accident occurred on the main haulage roadway between the cut-through at the top of the hill and the flat area at the bottom of this section of road. This order was issued verbally to the mine operator at 7:26 a.m.

"This order is being issued, under Section 103(j) of the Federal Mine Safety and Health Act of 1977, to prevent destruction of any evidence which would assist in investigating the cause or causes of the accident and to provide for the safety of all personnel working or traveling in the affected area until such investigation has been completed."

This 103(j) order was modified to a 103(k) order.

2. 103(k) Order No. 8230304 was issued to Trivette Trucking (Q080)

Condition or Practice: "A fatal haulage accident occurred at the Premier Elkhorn Coal Company, PE Southern Pike County Mine, on December 12, 2009. The accident involved the Red International Coal Truck, Vehicle ID # 1HTXHAPTX6J233337, belonging to this contractor. The victim was employed by this contractor."

"This order is being issued, under Section 103(k) of the Federal Mine Safety and Health Act of 1977, to prevent destruction of any evidence which would assist in investigating the cause or causes of the accident and to provide for the safety of all personnel until the mechanical evaluation of the accident is completed."

3. 104(d)(2) Order No. 8230314 was issued to Trivette Trucking (Q080), for a violation of 30 CFR § 77.1607(b)

Condition or Practice: "A fatal accident occurred on December 12, 2009, when the driver of the 2006 Red International Paystar coal haulage truck, VIN #1HTXHAPTX6J233337, failed to maintain control of the loaded truck while descending the mine haul road.

Overloading of the truck was a factor in the driver losing control. The estimated weight of the loaded truck was 37,600 pounds over the maximum GVWR recommended by the manufacturer. Management for Trivette Trucking was aware that the trucks were routinely overloaded and did nothing to stop this practice.

This condition is an unwarrantable failure to comply with a mandatory safety standard.

4. 104(d)(2) Order No. 8230315 was issued to Trivette Trucking (Q080) for a violation of 30 CFR § 77.1605(b)

Condition or Practice: "The Red International Paystar, Model 5600i, haul truck, VIN #1HTXHAPTX6J233337, was not equipped with adequate brakes. A mechanical evaluation of the truck conducted during the fatal accident investigation involving this truck indicated that the following conditions were present:

Both the left and right side brake drums on the steering axle had deposits of dried grease on the drum lining friction surface. These conditions compromise the braking capacity.

The right side brake on the rear tandem axle did not function when tested.

Wear on the brake drums in excess of maximum allowable diameter was found on the right front tandem and both the left and right side of the rear tandems.

Bluing was found on the right side drum on the front tandem and the left side drum on the rear axle. Bluing indicates excessive heat. These conditions compromise the braking capacity.

MSHA's accident investigation disclosed that Trivette Trucking did not have procedures to ensure that the trucks received adequate maintenance to identify and correct safety defects. This condition is an unwarrantable failure to comply with a mandatory safety standard.

5. 104(d)(1) Citation No. 8230316 was issued to Premier Elkhorn Coal Company for a violation of 30 CFR § 77.1607(b)

Condition or Practice: "A fatal accident occurred on December 12, 2009, when the driver of the 2006 Red International Paystar, Model 5600i, haul truck, VIN #1HTXHAPTX6J233337, failed to maintain control of this loaded truck as it descended the mine haul road.

Overloading of the truck contributed to the driver losing control. The estimated weight of the loaded truck was 37,600 pounds over the maximum GVWR recommended by the manufacturer. Premier Elkhorn was aware that the trucks were routinely overloaded and did nothing to stop this practice.

This condition is an unwarrantable failure to comply with a mandatory safety standard.”

6. A 104(a) Citation No. 8230317 was issued to Premier Elkhorn Coal Company for a violation of 30 CFR § 77.1605(b)

Condition or Practice: “The 2006 Red International Paystar, Model 5600i, haul truck, VIN #1HTXHAPTX6J233337, was not equipped with adequate brakes. This truck was involved in a fatal accident on December 12, 2009.

Premier Elkhorn failed to provide oversight to the contractor, Trivette Trucking, to assure that the above listed truck being operated at the mine was equipped with adequate brakes.

A mechanical evaluation of the truck conducted during the fatal accident investigation indicated that the following conditions were present:

Both the left and right side brake drums on the steering axle had deposits of dried grease on the drum lining friction surface. These conditions compromise the braking capacity.

The right side brake on the rear tandem axle did not function when tested.

Wear on the brake drums in excess of maximum allowable diameter was found on the right front tandem and both the left and right side of the rear tandems.

Bluing was found on the right side drum on the front tandem and the left side drum on the rear axle. Bluing indicates excessive heat. These conditions compromise the braking capacity.

APPENDIX A

List of Persons Participating in the Investigation

Kentucky Office of Mine Safety and Licensing

Gregory Goins	Deputy Chief Accident Investigator
Richard Gibbs	Surface Safety Analyst

Mine Safety and Health Administration

Danny Deel	Acting Assistant District Manager for Enforcement
David Ison	Supervisory CMS&H Inspector
James Newman	Acting Supervisory CMS&H Inspector
Robert H. Bellamy	Staff Assistant
Debra Howell	Surface Specialist/Accident Investigator
Gregory Hall	Civil Engineer/Accident Investigator
Travis Hall	CMS&H Surface Inspector/Accident Investigator
Kenneth Fleming	CMS&H Inspector/Accident Investigator
Ronald Medina	Mechanical Engineer
Tom Grooms	Attorney

Other

Jeff Neiderer	Technical Center Mgr., R.H. Sheppard Co., Inc.
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APPENDIX B

List of Persons Interviewed

Premier Elkhorn Coal Company

Bobby Warf	Loader Operator
Dan Thacker	Loader Operator
Jeffrey Wright	Grader Operator

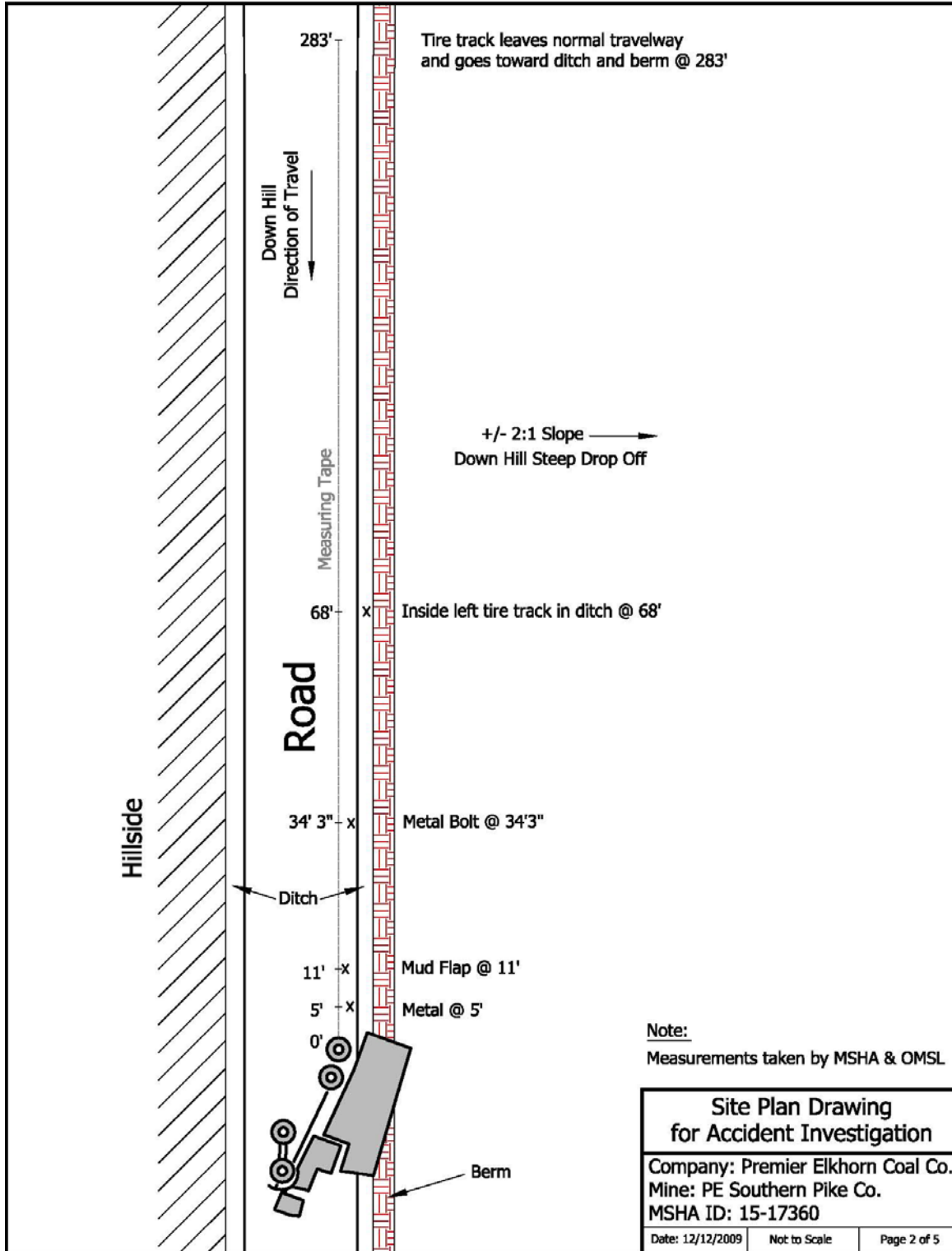
Trivette Trucking, LLC

Ronnie Phipps	Driver, Trivette Trucking, LLC
Rocky Jones	Driver, Trivette Trucking, LLC
Terry Little	Driver, Trivette Trucking, LLC
David Ken Compton	Driver, Trivette Trucking, LLC
Robin Lynn Trivette	Owner, Trivette Trucking, LLC

Other Persons Interviewed

Timothy Greg Bentley	Driver, Greg Bentley Trucking
Greg Bentley	Owner, Greg Bentley Trucking
Ralph Hall	Driver, Trace Enterprises, Inc,
Lindy Tackett	Driver, Trace Enterprises, Inc.
Carl Collier	Driver, Sturgill Trucking
Jimmy Slone	Driver, Sturgill Trucking

Appendix C Sketch of Accident Scene



Appendix D Victim Information

Accident Investigation Data - Victim Information										U.S. Department of Labor		Mine Safety and Health Administration			
Event Number: <input type="text" value="4"/> <input type="text" value="1"/> <input type="text" value="9"/> <input type="text" value="6"/> <input type="text" value="5"/> <input type="text" value="2"/> <input type="text" value="0"/>															
Victim Information: <input type="text" value="1"/>															
1. Name of Injured/Ill Employee: <i>Stevie Johnson</i>			2. Sex: <i>M</i>	3. Victim's Age: <i>52</i>		4. Last Four Digits of SSN: <i>8081</i>		5. Degree of Injury: <i>01 Fatal</i>							
6. Date(MM/DD/YY) and Time(24 Hr.) Of Death: <i>a. Date: 12/12/2009 b. Time: 8:37</i>						7. Date and Time Started: <i>a. Date: 12/12/2009 b. Time: 4:00</i>									
8. Regular Job Title: <i>176 Truck Driver</i>				9. Work Activity when Injured: <i>058 Operating Coal Haulage Truck</i>				10. Was this work activity part of regular job?							
								Yes <input type="checkbox"/> X No <input type="checkbox"/>							
11. Experience	Years	Weeks	Days	b. Regular	Years	Weeks	Days	c. This	Years	Weeks	Days	d. Total	Years	Weeks	Days
a. This				Job Title:				Mine:				Mining:			
Work Activity:	<i>30</i>	<i>0</i>	<i>0</i>		<i>30</i>	<i>0</i>	<i>0</i>		<i>0</i>	<i>36</i>	<i>0</i>		<i>30</i>	<i>0</i>	<i>0</i>
12. What Directly Inflicted Injury or Illness? <i>110 Struck by truck when he exited the cab</i>						13. Nature of Injury or Illness: <i>170 Crushed Between Truck and Roadway</i>									
14. Training Deficiencies:															
Hazard:		New/Newly-Employed	Experienced Miner:	<input checked="" type="checkbox"/>	Annual:		Task:								
15. Company of Employment:(If different from production operator) <i>Trivette Trucking</i>										Independent Contractor ID: (if applicable)		<i>Q080</i>			
16. On-site Emergency Medical Treatment:															
Not Applicable:	<input checked="" type="checkbox"/>	First-Aid:		CPR:		EMT:		Medical Professional:		None:					
17. Part 50 Document Control Number: (form 7000-1)						18. Union Affiliation of Victim: <i>9999</i>		<i>None (No Union Affiliation)</i>							
MSHA Form 7000-50b, Dec 1994										Printed		03/29/2010 10:17:07 AM			