CAI-2010-46

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

COAL MINE SAFETY AND HEALTH

REPORT OF INVESTIGATION

Underground Mine

Powered Haulage Fatality
October 27, 2010

River View Mine
River View Coal LLC
Waverly, Union County, Kentucky
ID No. 15-19374

Accident Investigators

Timothy Gardner
Mine Safety and Health Coal Mine Inspector

Dale P. Ingold P.E.
MSHA Approval and Certification Center
Applied Engineering Division

Originating Office
Mine Safety and Health Administration
District 10
100 YMCA Drive
Madisonville, KY, 42431-9010
Jim Langley, District Manager

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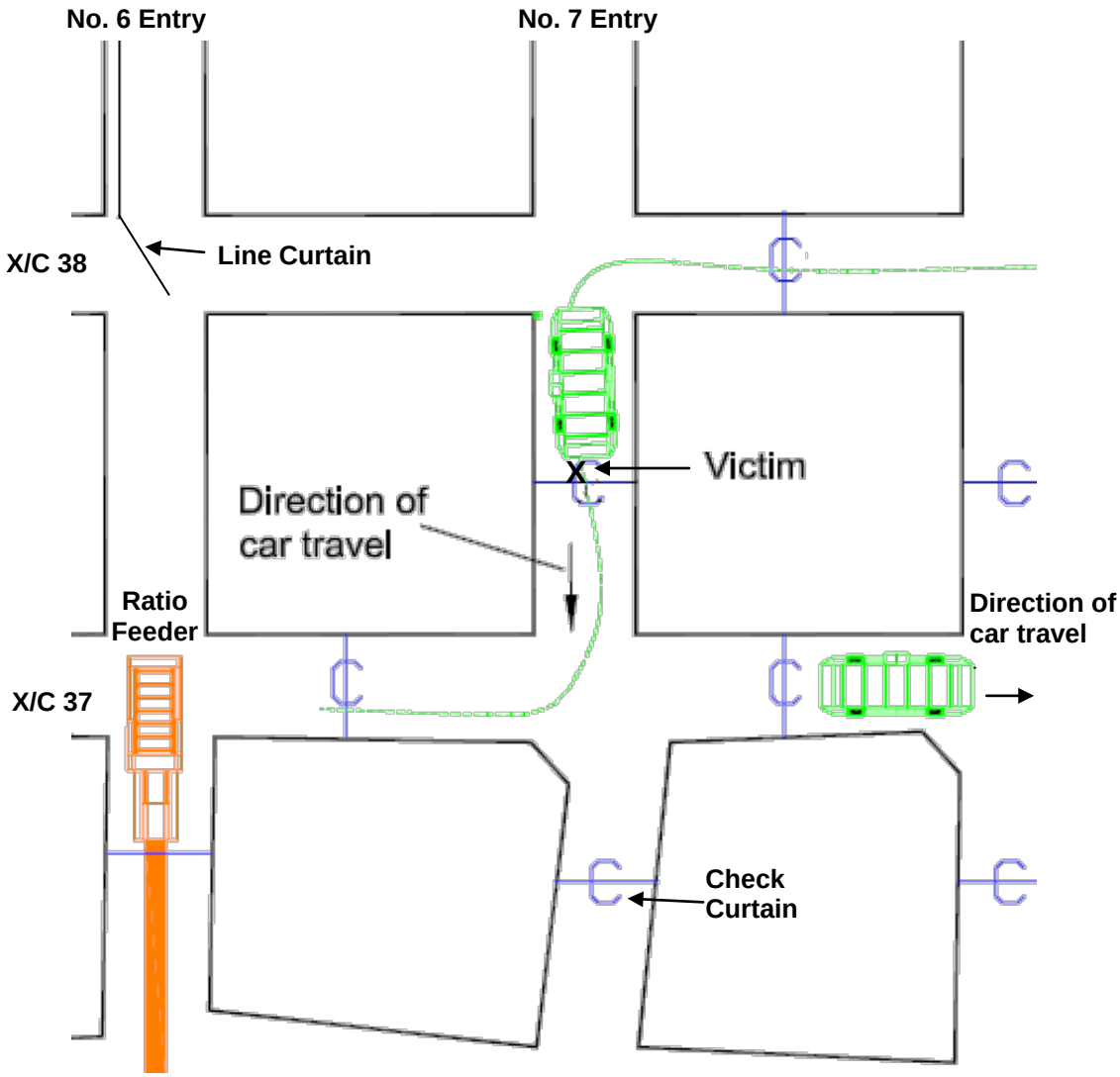
Accident Scene Sketch



OVERVIEW

On Wednesday, October 27, 2010, at approximately 7:50 a.m., 39-year old James J. Falk (victim), Continuous Mining Machine Helper, was killed when he was struck by a shuttle car being operated on the No. 6 Working Section, MMU# 014-0. Falk was last seen in the No. 7 Entry between crosscuts No. 37 and No. 38, on the inby side of the ventilation curtain, making repairs to the curtain. Justin Butts, Shuttle Car Operator, was hauling coal from the continuous mining machine to the ratio feeder, when he trammed out of the last open crosscut into the No. 7 entry and struck Falk, while the victim was repairing the curtain. Butts, unaware of the accident, was returning from the ratio feeder, when he discovered Falk in the No.7 entry, approximately twenty seven feet outby the check curtain. Falk was recovered by mine personnel and transported to the surface.

GENERAL INFORMATION

River View Mine is operated by River View Coal, LLC and the parent company is Alliance Resource Partners LP. The mine is located approximately four miles south-east of Uniontown, Kentucky. At the time of the accident, the mining operation employed 514 employees, with 498 underground miners and 17 on the surface. The mine is opened by one slope and one shaft. The mine operates two shifts per day, five days per week, from the KY No. 9 and KY No. 11 coal seams. The mine produces coal during two 10 hour shifts and has an 8 hour maintenance shift that overlaps the two production shifts each day. The daily production averages 46,500 tons from 16 mechanized mining units (MMU).

The principal officials for River View Coal, LLC were:

Heath Lovell.....General Manager
Rick Brown..... Underground Mine Superintendent
Kevin Vaughn..... Safety Manager

The principal officers for Alliance Resource Partners, LP were:

Joseph W. Craft III .....President and Chief Executive Officer
Brian L. Cantrell .....Senior Vice President and Chief Financial Officer
R. Eberley Davis .....Senior Vice President, General Counsel and Secretary
RoBurke G. Sachse .....Executive Vice President
Charles R. Wesley ..... Director and Executive Vice President
Thomas M. Wynne.....Senior Vice President and Chief Operating Officer

A regular safety and health inspection by MSHA was in progress at the time of the accident. The previous inspection was completed on September 28, 2010. The Non Fatal Days Lost (NFDL) incidence rate for the mine in 2009 was 2.33, compared to a national NFDL incidence rate of 4.04 for underground mines.

DESCRIPTION OF ACCIDENT

On Wednesday, October 27, 2010, Falk reported to work at the River View Mine on the dayshift for a normal workday. Alan Berry, Mine Foreman, assigned Falk to the No. 6 Working Section in the 11 coal seam because one member of the crew was absent. James Hays, Section Foreman for the No. 6 Working Section, met Falk in the staging area on the surface and introduced him to one of the roof bolting machine operators. Hays instructed Falk to follow the roof bolter to the mantrip. Falk talked with Andrew Burke, Roof Bolter, while waiting in the staging area. Falk told Burke he didn't have a job assignment for that day, but was going to No. 6 Working Section.
At approximately 6:15 a.m., the No. 6 Working Section crew entered the mine and traveled to the section via diesel personnel carrier, arriving at approximately 6:40 a.m.

On the section, Hays left the power center to conduct his on shift examination, starting on the left side of the section. Falk and others gathered at the section power center while some miners reported to their equipment. Falk talked to Clayton Wall, Left Side Scoop Operator at the power center. Falk was asking questions concerning "what curtains needed to be hung up." At approximately 7:05 a.m. both Wall and Falk left the power center to begin their assigned task. By this time production had started.

Falk walked to the No. 10 Face where the continuous mining machine was operating and talked with Chris Kingston, continuous mining machine operator. Falk told Kingston "he had just come up from the 9 seam he had been scooping; the hostler job (miner helper) was new to him." Kingston told Falk "check your curtains, you're responsible for the ventilation and help the miners [continuous mining machines] move from place to place, that's what your job consists of."

Falk walked to the No. 8 Entry where the right side bolting crew and bolting machine were located just outby the last open crosscut. Falk stopped and talked with John Collins and Burke, Right Side Roof Bolters. While at this location a shuttle car passed through the last open crosscut traveling to the feeder; tearing down the line curtain in No. 9 Face. Falk and Burke repaired the curtain. Falk then left the bolting crew and went to the No. 7 Entry. As Falk entered the No. 7 Entry, he met Hays. The two men met just inby the last open crosscut in No. 7 Entry. Falk asked how long he would be with this crew and what he would be doing. Hays replied that because a miner was away from work, Falk would probably be there two or three days. Hays also informed Falk that he would be maintaining the ventilation curtains, so that he would become familiar with the section. He also told him, for that day, not to fill in for the mining machine or shuttle car operators at lunch. Hays stated that Falk told him, "He wasn't really familiar with a split air unit." Hays replied, "It's just a few more curtains, if you got any questions, just ask any one of us and we'll help you."

Falk returned to the roof bolting machine in No. 8 Entry with a piece of curtain. He placed the curtain on the bolting machine and talked with the bolting crew. Falk told the operators he wasn't familiar with split air and asked questions about ventilation. Collins and Burke explained to Falk which entries the intake came up and how to "wing out" the faces [install face ventilation controls]. Falk stated "I'm going to check curtains." Collins told Falk jokingly to "watch out for the [shuttle] cars," as he was leaving. Falk left the bolting crew, approximately five minutes prior to the accident, traveling outby in No. 8 Entry to the second open crosscut, turning right and heading toward No. 7 Entry.

Calvin Wilson, Right Side Shuttle car Operator, was leaving the feeder and observed Falk in the No. 7 Entry on the left side near the rib (location described from Wilson's view point, looking inby), making a repair to the check curtain. Falk had raised the curtain and made visual contact with Wilson as he passed by, traveling to the No. 10 Face. At this time Falk was on the inby side of the curtain with his back toward the last

open crosscut. This was Falk's last known location (See APPENDIX B, Exhibits 1 and 2).

Justin Butts, right side shuttle car operator, was traveling with a load of coal from the No. 10 Face to the feeder located one crosscut outby the last open crosscut in No. 6 Entry. Butts' route from No. 10 Face was through the last open crosscut to No. 7 Entry, turn left (outby) into the No. 7 entry, travel to the next crosscut, turn right into the crosscut and travel to the feeder in the No. 6 Entry (See APPENDIX B, Exhibit 2). As Butts turned left in No. 7 Entry, he passed through a check curtain at approximately the midway point in the pillar line where Falk was last seen repairing the curtain. At approximately 7:50 a.m., during his return trip from the feeder to the continuous mining machine, Butts discovered Falk lying in the haulageway of the No. 7 Entry, approximately 27 feet outby the curtain (See APPENDIX B, Exhibit 3). Butts exited his car and ran to Falk. At this time, Wilson was driving his shuttle car to the feeder. Butts flagged Wilson to stop. Wilson exited his car and Butts instructed him to notify Hays of the accident.

Hays was in the No. 10 Face with Kingston when Wilson notified them of the accident. Hays and Kingston ran to the accident scene to assess Falk's condition. In the meantime, Butts had gone toward the power center, where he told Wall about the accident. Wall notified via mine phone the No. 11 seam guard and Rick Brown, Mine Superintendent. Hays, realizing that treatment could not be performed because of Falk's condition, sent the section crew to the power center, while he remained with Falk until the safety department personnel arrived. Falk was transported to the surface. Stephen Shouse, Union County Coroner, transported Falk to the State's Medical Examiner's Office, located in Madisonville, Kentucky.

INVESTIGATION OF THE ACCIDENT

On the day of the accident, Troy Davis, MSHA District 10 Staff Assistant, was notified at 8:00 a.m. by the Mine Safety and Health Administration (MSHA) Hotline operator of the accident. Tim Gardner, MSHA Coal Mine Inspector (CMI), was assigned as the lead accident investigator and dispatched to the mine. Michael Moore, MSHA Electrical Supervisor and Louis Adams, MSHA Electrical Specialist, were dispatched to the mine to assist Gardner during the investigation. Adam Carlisle, MSHA CMI, was on mine property at the time the accident occurred. Carlisle issued a 103(k) Order to ensure the miner's safety and preserve the accident scene until an investigation could be conducted.

On October 27, 2010, Gardner, Moore, Adams and Archie Coburn, MSHA CMI, along with Greg Goins, Kenny Mitchell, Bill Millay, and Larry Fuller, Kentucky Office of Mine Safety and Licensing (OMSL) Accident Investigators, traveled to the accident scene to take measurements and photographs. Interviews were held at the MSHA Morganfield

Field Office on Thursday, October 28, 2010. Seven miners and two mine management officials were interviewed.

On January 19 and 28, 2011, Gardner, Goins and Dale P. Ingold P.E., MSHA Approval and Certification Center Applied Engineering Division, conducted visibility studies on the shuttle car.

DISCUSSION

No. 6 SECTION:

The entries are numbered from left-to-right. Mining is conducted with two radio remote control continuous mining machines, operating independently on two separate air splits. The mining machine on the left side of the section is used to mine the No. 1 to No. 5 Entries. The right side machine is used to mine the No. 6 to No. 10 Entries. Two shuttle cars, a dual boom roof bolting machine, and a scoop are assigned to each mining machine or MMU. The accident involved one of the right side shuttle cars and occurred in the No. 7 Entry between crosscuts No. 37 and No. 38.

The No. 6 Section was mining the 1st Northwest Panel off 1st Southwest Mains. The section had 10 entries with the entries on 80 foot centers and crosscuts on 80 foot centers. The conveyor belt was located in the No. 6 entry. The belt had been extended to crosscut No. 37 the previous shift.

SHUTTLE CAR:

The Auxier Welding Coal Transporter (shuttle car), Model No. CT27-B-6-64, Serial No. 1109, is a piece of electrical powered, coal haulage equipment. The operator deck was on the right side (facing the dumping end while standing at the loading end) in the center of the shuttle car. The deck was equipped with two seats and two sets of controls for tramming, braking, and steering to allow the operator to face the direction of travel at all times. The brake pedal was located on the left side of either seat and the tram pedal was located on the right side of either seat as a standard automotive design. There were two steering levers that allowed the operator to control the steering from either seat. The control switches for the pump motor, start/stop, lights, and the electrically powered conveyor, were located on the side between the seats and were accessible to the operator from either seat. The deck was equipped with panic bars readily accessible at either seat. The shuttle car was supplied with 550 volts direct current (VDC) power through a 2/0, two-conductor trailing cable via the cable reel. The cable reel was located on the right side on the dump end of the shuttle car.

MACHINE DIMENSIONS:

The shuttle car is 28 feet and 1.5 inches in length, and the width is 10 feet and 2.5 inches (excluding the canopy). The width on the dump end is 9 feet and 8.25 inches. This measurement includes the conveyor speed reducer, conveyor motor, and the cable guide. The width of the conveyor is 64 inches. The width of the operator's deck extends 17 inches outside the main body of the car. The location of the operator's deck

is 125 inches from the load end, 148 inches from the dump end, and the operator's deck is 64 inches long. The operator deck is located on the right side of the shuttle car. The height of the canopy measured 51 inches from the floor, 37 ¼ inches from the floor in the deck, and covers the operator deck. The canopy top is 1 inch thick x 40 inches wide x 71 inches long.

VISIBILITY:

The shuttle car is typically loaded with a heaped load of coal to within 3 to 4 inches of the mine roof. The mining height in the No. 11 seam is approximately 60 to 68 inches. The operator's compartment was originally equipped with 8 ¼ inch x 48 inch bar grating with 1 inch x 4 inch slots positioned in the side board at the operator's compartment to allow visibility. The operator's compartment had been altered in the following manner: The bar grating had been partially blocked by seven pieces of roof bolting drill steel, ranging in lengths of 13 inches to 34 ½ inches, to prevent coal from spilling into the operator's compartment. Also wooden boards and a metal mounting bracket for the Matrix tracking system were installed and/or placed in the operator's field of view when traveling toward the ratio feeder. Testing showed that a person standing at the dump end of the loaded shuttle car, where the victim was struck, was not visible to the operator. The car operator's field of view for the original design of the shuttle car when loaded is limited. The results of the visibility study conducted by MSHA Technical Support in conjunction with OMSL and CMI Gardner reveal that the alterations further restrict the car operator's field of view from that of the original design (See Appendix C, Exhibits 1, 2 and 3).

LIGHTS:

The illumination system on the shuttle car has an MSHA Statement of Test and Evaluation (STE) No. 5004781-0. A copy of the MSHA STE letter was located in the operator's parts manual at the mine. The shuttle car was equipped with a STE plate. The lighting system is designed with two MCI 50 XP headlamps on the dump end, two MCI 50 XP headlamps on the load end, and one MCI 50 XP headlamp on each end of the operator's deck, a total of six headlamps.

The shuttle car, as found after the accident, was correctly equipped with six MCI 50 XP headlights. The dump end headlights (the direction of travel at the time of the accident) were installed at the front edge of the conveyor boom frame, 30 inches from the mine floor to the bottom of the light assembly. The load end headlights were installed at the edge of the frame of the shuttle car, 24 inches from the mine floor to the bottom of the light assembly. There was a headlight installed on each end of the operator's deck, 31 inches from the mine floor to the bottom of the light assembly. The locations of the lights conformed to the drawings for the illumination system documented in the MSHA STE No. 5004781-0 issued for this machine.

TRAMMING SYSTEM:

The shuttle car was equipped with a Variable Frequency Drive tram system, equipped with two accelerator pedals (to allow operator control when facing either direction) to

provide speed control from zero to approximately 5 mph. No tramming system defects were found.

STEERING:
The steering was found to be functioning properly when examined and tested.

BRAKING SYSTEM:
Operations of the service brake system, the emergency-park brake system, and the panic bars were tested. These tests were conducted with the shuttle car fully loaded, as conditions existed when the accident occurred. The shuttle car was equipped with panic bars that are easily accessible at each seat in the operator's deck. When actuated, the panic bars de-energized the pump motor and applied the emergency-park brake. The emergency-park brake stopped and held the shuttle car. The service brake would also quickly stop and hold the loaded shuttle car. No brake stopping performance defects were found.

AUDIBLE WARNING:
The shuttle car was equipped with a gong type bell installed on the bottom side of the top of the canopy with a wire rope attached to allow the operator to ring the bell.

TRAINING:
Falk had 4 years, 32 weeks and 1 day total mining experience, much of which was on working sections at three different underground mines. Falk had 10 weeks experience, mostly on working sections in the No. 9 seam, at the River View Mine. Falk had received "Hazard Training" on August 13, 2010, which consisted of a check list of general safety rules that included two statements: "stay clear of all moving equipment; make yourself visible to all equipment operators." October 27, 2010, was Falk's second shift to work in the No. 11 seam and his first shift to be assigned the duties of a Miner Helper. Falk was to be trained in a new task as Miner Helper, which he had not performed previously. Falk did not receive adequate instruction in the safe procedures to be followed while performing required work duties in the active haulageways as a Miner Helper. Falk's instructions consisted of being told to maintain the section ventilation and to get familiar with the section. The Hazard Training checklist was not effective, nor did it satisfy the requirements of 30 CFR § 48.7(c), which requires a miner to be instructed in the safe work procedures for a newly assigned task. Falk had told Hays, Kingston, Collins and Burke that he was not familiar with split air ventilation. Falk was attempting to gain knowledge by talking to miners on the section concerning his job duties for the day.

A review of Justin Butts' training records was also conducted. Butts had 4 years, 12 weeks, 2 days total mining experience, with 3 months, 15 days at the River View Mine. Butts had four weeks experience operating a shuttle car at the River View Mine and a total of at least 2 years 8 months total experience at this work activity.

PHYSICAL DESCRIPTION OF THE ACCIDENT SITE:
The accident site is located in the No. 7 Entry, approximately 36 feet outby Spad (survey station) 30+40 (Crosscut 38) and approximately 43 feet inby the No. 6 Section belt feeder (set in No. 6 Entry, Crosscut 37).

ROOT CAUSE ANALYSIS

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

The root causes listed below were identified during the analysis and the corresponding corrective actions were implemented by mine management to prevent a recurrence of the accident:

Root Cause: The mine operator failed to effectively task train and/or instruct Falk in the safe work procedures in order to perform the task of continuous miner helper safely, which included working in the active haulageways.

Corrective Action: The operator has revised their written safety policy to include the requirement that miners working in the active haulageways must first communicate directly with the mobile equipment operators and that communication must be verified with a response. All travel in the affected area is stopped until work has been completed. The preferred method of communication is by radio. All miners were trained in this safety policy prior to the mine resuming normal operations. The operator also developed and implemented a procedure to enhance the information provided on the MSHA 5000-23 training form. Additional information was provided concerning specific safe work procedures to be trained in for a new task on the working section. The miner is not considered to be task trained until he/she has demonstrated an adequate understanding of each standard identified for that specific task.

Root Cause: Alterations made to the cab compartment impaired the shuttle car operator's vision, when traveling toward the dumping point while the shuttle car was loaded.

Corrective Action: The operator restored all shuttle cars at the River View Mine to the original manufacturer's design.

CONCLUSION

The fatality occurred because of the mine operator's failure to insure that Falk was task trained properly to conduct the newly assigned task of miner helper in a safe manner. This training, at a minimum, if conducted would have included the instruction of safe work procedures, including the importance of communication with mobile equipment operators while performing work duties in the active haulageways. In addition, the shuttle car operator's limited vision, impaired by alterations made to the cab compartment, contributed to the accident. The absence of the instruction of safe work procedures and oversight of Falk's newly assigned activities, combined with the shuttle car operator's obstructed view, resulted in the fatal accident

Approved By:

Jim Langley
District Manager

7-13-2011
Date

ENFORCEMENT ACTIONS

103(k) Order, No. 8501366, – A fatality occurred on 10/27/2010 at River View Mine. A miner was struck by a shuttle car. This order is issued to assure the safety of all persons in the mine and preserve evidence. This order prohibits all activity in the mine except recovery operation of the miner. The mine operator shall obtain prior approval from an authorized representative for all actions to recover and restore operations to the mine.

A 104(a) Citation, No. 8502170, was issued for a violation of 30 CFR § 48.7(c). The operator failed to give effective instruction to James J. Falk concerning the safety and health aspects and safe work procedures of his newly assigned task as miner helper on the No. 6 Working Section. This task included the maintenance of all ventilation curtains on the section. Mr. Falk was struck by a shuttle car in the No. 7 Entry while attempting to repair a ventilation curtain in the active haulageway

A 104(a) Citation, No. 8502171, was issued for a violation of 30 CFR § 75.1725(a). The Shuttle Car, Serial No. 1109, was not being maintained in a safe operating condition. The operator's compartment was altered by metal tubing placed in the metal grating cover of the window area and wooden boards were placed between the canopy and the machines frame which further restricted or limited the operator's field of vision from that of the manufacturer's original design.

A 314(b) Safeguard Notice, No.8502176, was issued for a violation of 30 CFR § 75.1403. The shuttle car Serial No. 1109 operating on the No. 6 Working Section did not come to a complete stop prior to passing through check curtains on the section. This is a Notice to Provide Safeguard requiring all mobile rubber tired haulage and personnel carriers on the active working section(s) to come to a complete stop and sound an audible warning device prior to proceeding through any ventilation curtain. This safeguard is written to prevent the hazard of person(s) being struck by and/or run over by mobile equipment on the working section. Failing to come to a complete stop creates the hazard. This safeguard applies to all working sections at the River View Mine.

A 314(b) Safeguard Notice, No.8502177, was issued for a violation of 30 CFR § 75.1403. A miner received fatal injuries, when struck by a shuttle car, while repairing a ventilation curtain in the No. 7 Entry active haulageway on the No. 6 Working Section. No visible warning devices were installed at the entrances to the work area to warn mobile equipment operators of a person('s) presence. This is a Notice to Provide Safeguards on all working sections at the River View Mine that when work is to be performed in the active haulageway, readily visible warning devices will be installed in such a manner at all entrances to the work area that oncoming mobile equipment operators will be warned of a person's presence during equipment operation.

APPENDIX A

Persons Participating in the Investigation

Management Personnel River View Coal, LLC

Richard W. Eagle.....Mine Foreman
James R. Hays.....Section Foreman

Miners from the River View Mine

Andrew L. Burke ..... Roof Bolter Operator
John R. Collins ..... Roof Bolter Operator
Calvin J. Wilson..... Shuttle Car Operator
Justin A. Butts..... Shuttle Car Operator
Scott Johnson ..... Shuttle Car Operator
Chris Kingston.....Continuous Miner Operator
Clayton J. Wall.....Scoop Operator

Mine Safety and Health Administration

Timothy Gardner .....Coal Mine Safety and Health Inspector
Louis Adams .....Coal Mine Safety and Health Inspector
Michael Moore..... Coal Mine Safety and Health Supervisor
Brian Winfrey .....Office of the Solicitor
Dale P Ingold, P.E.....MSHA Applied Engineering Division

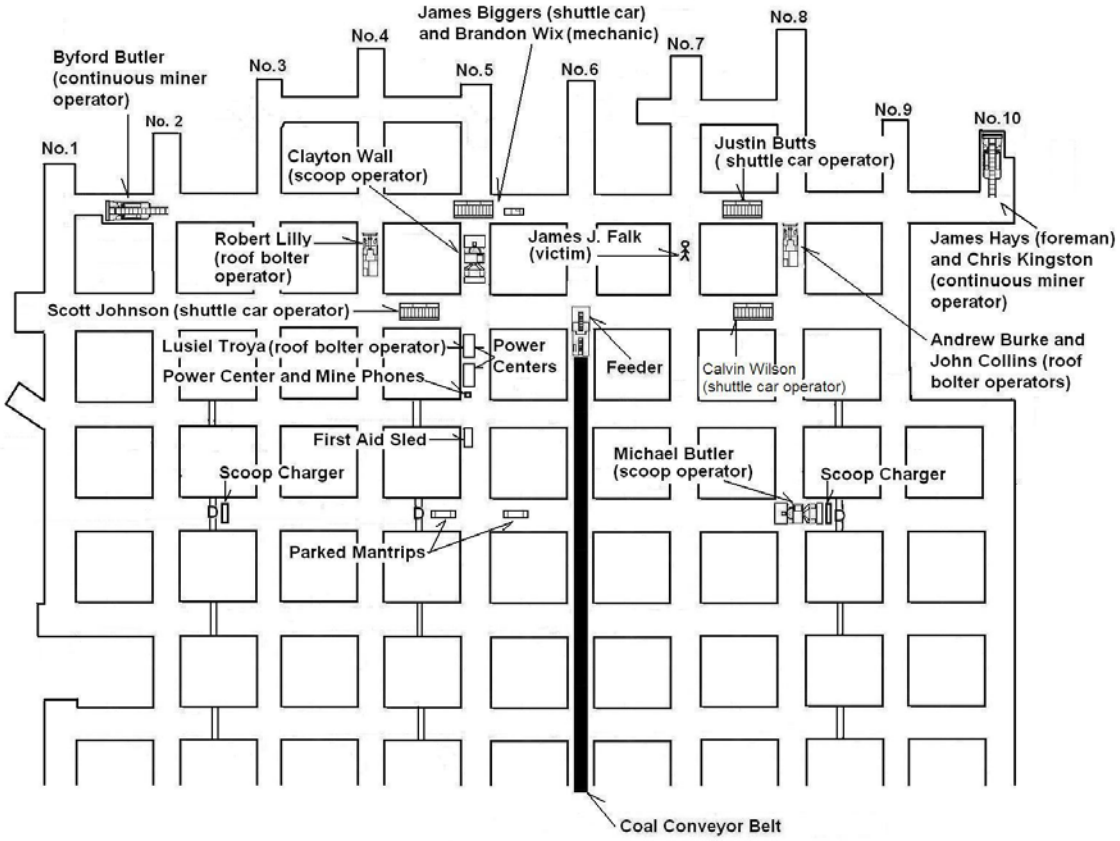
Kentucky Office of Mines Safety and Licensing

Greg Goins ..... Accident Investigator
Bill Millay ..... Accident Investigator
Larry Fuller …….Accident Investigator
Kenny Mitchell ……...Accident Investigator

APPENDIX B

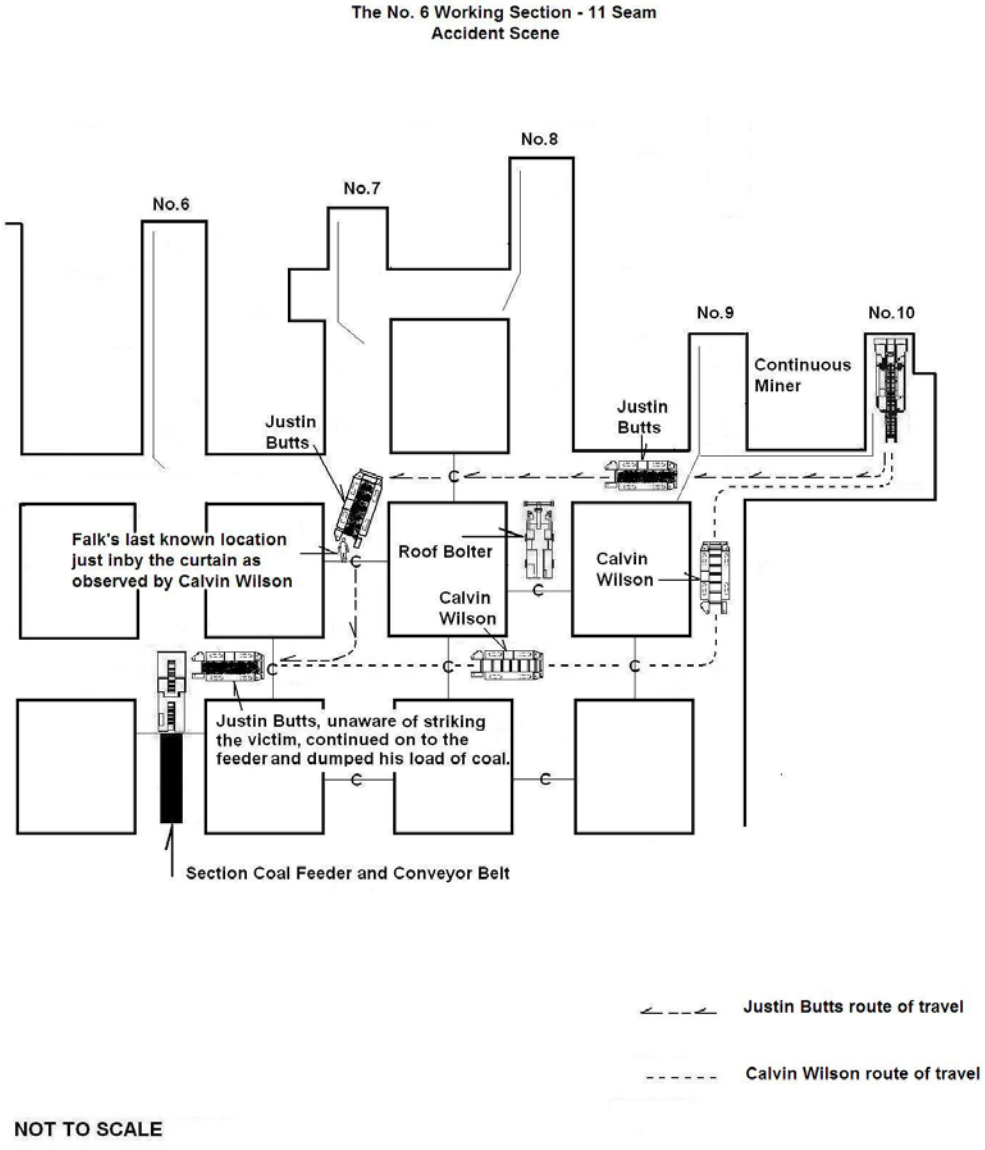
Exhibit 1

No. 6 Working Section - No. 11 seam
Location of miners prior to accident

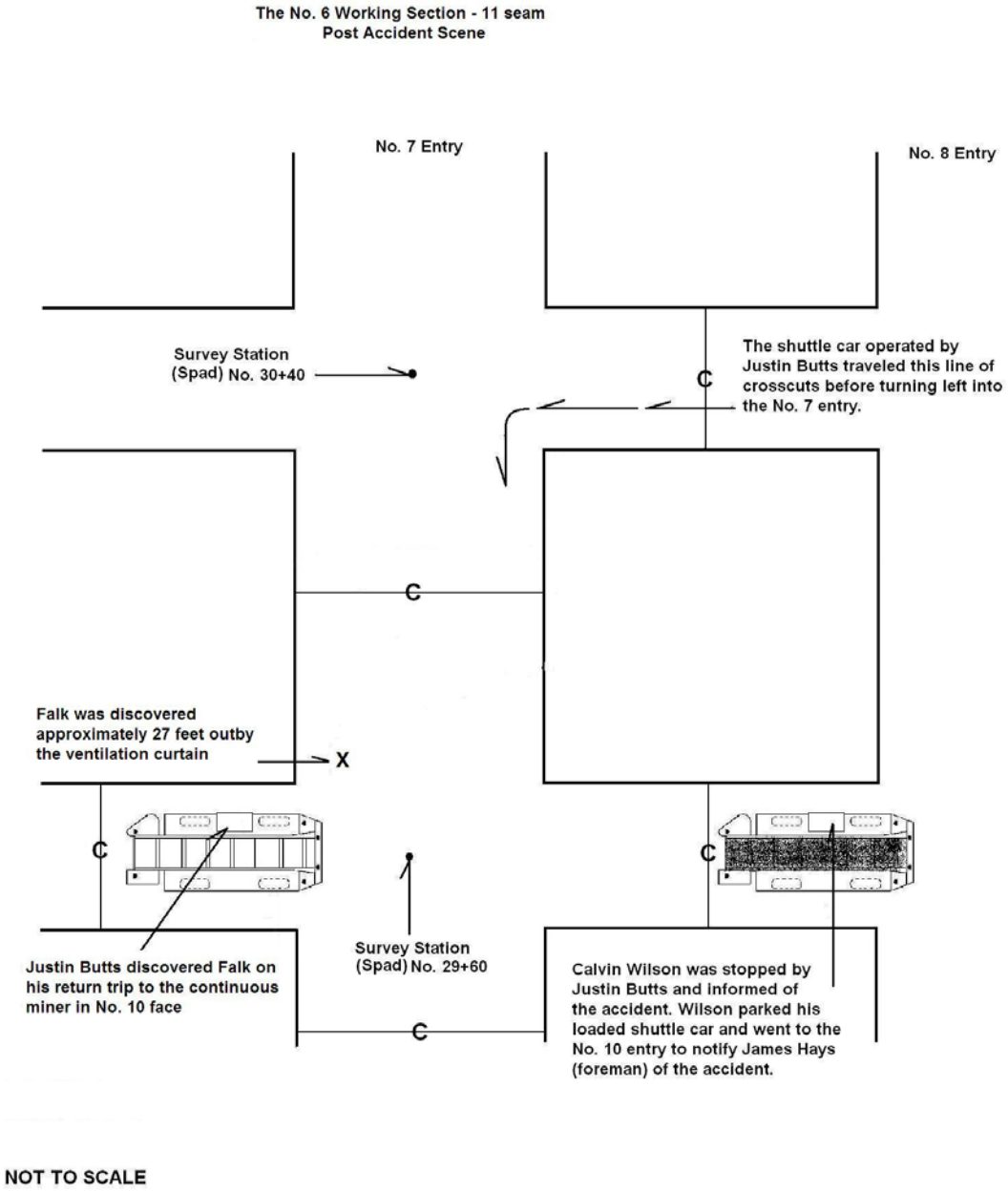


SKETCH
NOT TO SCALE

APPENDIX B (cont.)
Exhibit 2



APPENDIX B (cont.)
Exhibit 3



APPENDIX C
Exhibit 1
(Car involved in accident CO# 1109)

Cab Modifications – bolter steels placed in the grating to prevent coal from entering operator's cab

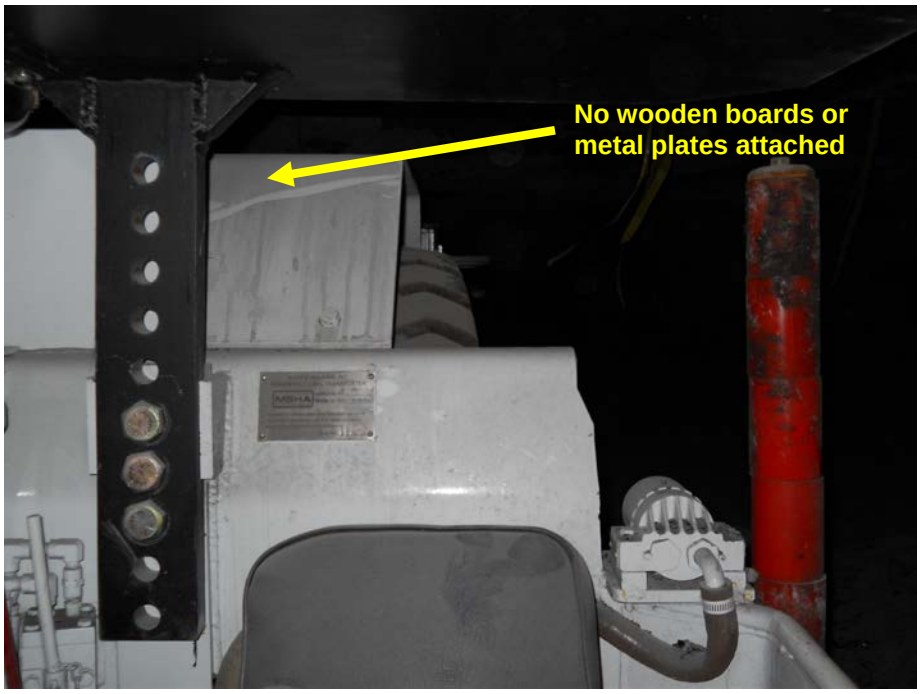
Metal mounting bracket for Matrix Tracking System

Wooden boards to prevent coal spillage into operator's compartment

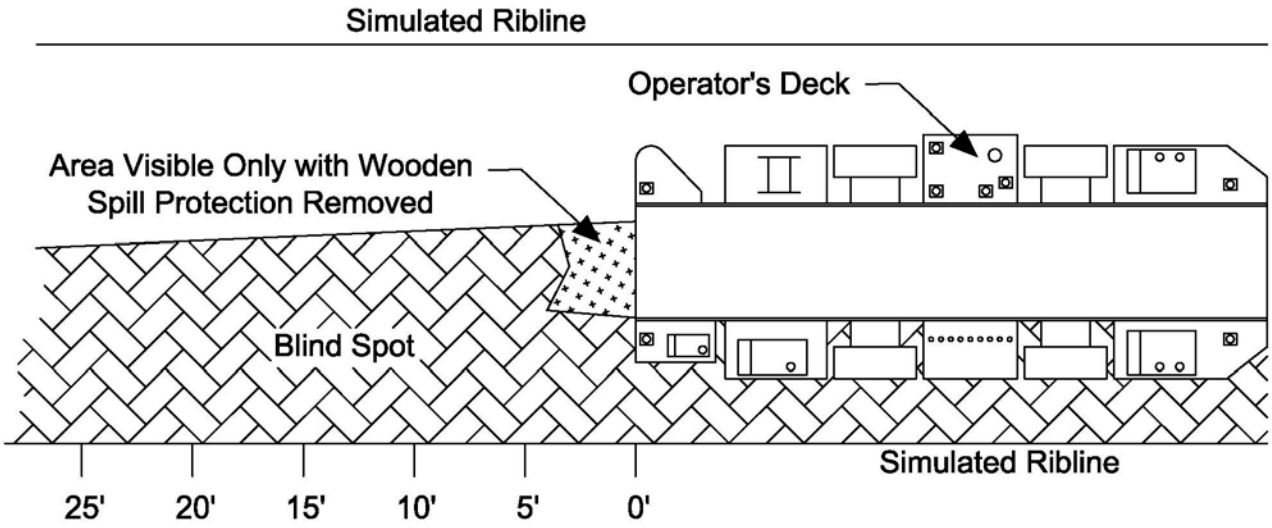
(Operator's Visibility traveling toward dump point)

APPENDIX C (cont.)
Exhibit 2
(Original car design as delivered)

Grating is not modified



APPENDIX C (cont.)
Exhibit 3



RIVER VIEW MINE
MSHA ID: 15-19374
VISIBILITY SURVEY
Auxier Coal Transporter - SN 1109
Simulated Load
Target: 63 Inches from Bottom

APPENDIX D
MSHA Form 7000–50(b)

Accident Investigation Data - Victim Information
Event Number: 4 4 8 5 8 3 2

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

Victim Information: 1

1. Name of Injured/Ill Employee:	2. Sex	3. Victim's Age	4. Degree of Injury:
James J. Falk	*M*	*39*	*01 Fatal*

5. Date(MM/DD/YY) and Time(24 Hr.) Of Death:	6. Date and Time Started:
a. Date: 10/27/2010 b.Time: 7:50	*a. Date: 10/27/2010 b.Time: 6:00*

7. Regular Job Title:	8. Work Activity when Injured:	9. Was this work activity part of regular job?
028 Scoop Operator	*098 Continuous Miner Helper*	Yes | | No | X |

10. Experience	Years	Weeks	Days		Years	Weeks	Days		Years	Weeks	Days		Years	Weeks	Days
a. This Work Activity:	*0*	*0*	*0*	b. Regular Job Title:	*0*	*10*	*0*	c: This Mine:	*0*	*10*	*0*	d. Total Mining:	*4*	*32*	*1*

11. What Directly Inflicted Injury or Illness?	12. Nature of Injury or Illness:
077 Struck by Shuttle Car	*370 Traumatic Blunt Force Injuries*

13. Training Deficiencies
Hazard: | | New/Newly-Employed Experienced Miner: | | Annual: | | Task: | X |

14. Company of Employment: (If different from production operator)
Operator
Independent Contractor ID: (if applicable)

15. On-site Emergency Medical Treatment
Not Applicable: | X | First-Aid: | | CPR: | | EMT: | | Medical Professional: | | None: | |

16. Part 50 Document Control Number: (form 7000-1)
17. Union Affiliation of Victim: *9999* *None (No Union Affiliation)*