CAI-2011-01

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

COAL MINE SAFETY AND HEALTH

REPORT OF INVESTIGATION

Underground Coal Mine

Fatal Powered Haulage Accident
January 27, 2011

Baylor Mining, Inc.
Jims Branch No. 3B Mine
New Richmond, Wyoming County, WV
I.D. No. 46-09243

Accident Investigators

Daris L. Barker, Jr.
Mining Engineer/Accident Investigator

Ronald J. Barber
Coal Mine Safety and Health Inspector

Robert Hatfield
Coal Mine Safety and Health Inspector/Electrical Specialist

Originating Office
Mine Safety and Health Administration
District 12
100 Bluestone Road
Mount Hope, West Virginia, 25880
Timothy R. Watkins, District Manager

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Photo of Reconstructed Accident Scene – Minus Discharge Roller Guarding

OVERVIEW

On Thursday, January 27, 2011, John C. Lester Jr. (victim), a 19 year old underground miner with a little over three months total experience, was killed when he became caught between the first outby belt conveyor loading surface and the discharge coal guide of the section belt conveyor. Both belt conveyors were operating at the time of the accident.

It is likely this accident occurred when the victim, who had little mining experience, attempted to cross the moving No. 3 conveyor belt just inby the No. 4 conveyor belt head and fell on top of the No. 3 conveyor belt. The No. 3 conveyor belt immediately carried him into the discharge coal guide boards, causing him to become caught in the structure.

GENERAL INFORMATION

The Jims Branch No. 3B Mine is an underground coal mine operating in the Sewell Coal seam, located near New Richmond, in Wyoming County, West Virginia. The mine is owned and operated by Baylor Mining, Inc.

Bituminous coal is mined at this operation using the room and pillar method with one continuous mining machine section. The mine normally operates two, nine hour production shifts per day, five to six days per week. The mine employs 29 people with 26 of these working underground and 3 on the surface. The employees at this operation are not represented by a labor organization. The mine produces on average 1,100 tons of raw material a day.

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

Robert Worley ……. President/Treasurer/Director
Larry Presley…….. Mine Foreman/Superintendent/VP
Carlos Privett …….. Vice President
Robbie Ortiz ……... Mine Engineer

Larry Presley was also in charge of safety and health. Prior to the accident the Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection on December 14, 2010. The Non-Fatal Days Lost (NFDL) injury incidence rate for this mine during the period of January through September 2010 was 21.06, compared to a National Rate of 3.92.

DESCRIPTION OF ACCIDENT

On Thursday, January 27, 2011, Ronnie E. Massie, Jr., Section Foreman, started underground at the Jims Branch No. 3B Mine, at 5:00 a.m., to conduct a pre-shift examination. The pre-shift examination fire boss report was called out to Larry Presley, Mine Foreman, at 5:55 am.

John C. Lester Jr., General Laborer, who had worked at this mine for a total of 109 days, arrived at work for the day shift prior to 6:00 a.m. At approximately 6:00 a.m., the day shift crew entered the mine and arrived on the 001-0 Section at 6:30 a.m. According to the testimony of those miners interviewed, Lester did not ride on the section man trip or any other man trip.

Jerry Lane, the miner Lester normally worked with, was assigned to operate a scoop on the section this day. Lane trammed a scoop from the surface to the section at the start of the shift. Mine management did not give instructions to Lester that morning before he entered the mine, did not direct him to travel with a foreman or other experienced miner, and did not assign him to the working section or other specific duty at the start of the shift. It is believed that Lester, by himself, took a rubber-tired conveyance that he and Lane normally rode on, into the mine and followed the crew underground at the start of the shift.

The mine tracking system shows that Lester followed Lane underground eight seconds later and proceeded from the surface to a location near the 3 Belt Head.

Lester spent approximately 20 minutes in this area before continuing and arriving at the 001-0 Section at approximately 6:42 a.m.

According to interviews, Lester left the section at approximately 7:30 a.m., to assist other miners repairing the broken coupler on the No. 3 belt head. At 7:52 a.m., Gary Norman, Electrician and Eric Price, Shuttle Car Operator, left the section and headed outside because Price became ill. At approximately 7:53 a.m., Norman and Price arrived at the No. 3 belt head. Price then asked Lester to take him outside because he was sick and was going home. At 8:02 a.m., Lester and Price arrived outside on a rubber-tired conveyance. At 8:03 a.m., Lester started back underground alone and returned to the No. 3 belt head, where repairs to the coupler were still being made.

At approximately 9:01 a.m., Lester and Doug Smith, shuttle car operator, left the No. 3 Belt Head and returned to the 001-0 Section at 9:03 a.m. After arriving on the section the belt was restarted. Smith resumed operating his shuttle car and left Lester at the section tailpiece with Ronnie Massie, Section Foreman. Massie stated in his interview that he instructed Lester to stay at the section tailpiece, where someone could see him. Massie then went to the No. 4 Entry at approximately 9:10 a.m. Lester was only on the section a short time before he left the section again at approximately 9:18 a.m. At this time, Lane observed Lester sitting at a location one break outby the section tailpiece, at the corner of the pillar block in the No. 6 Entry roadway. The tracking system did not record Lester passing another receiver station, so it is believed that he went to the No. 4 belt head.

Sometime around 12:00 noon, Lane asked Norman, and then asked Massie, if they had seen Lester. They had not, and Norman and Massie left the section at approximately 12:17 p.m., to look for Lester.

Norman was the first to arrive at the No. 4 conveyor belt head. At first, he did not observe anything and was about to leave. Norman then noticed something was caught in the chute boards below the No. 4 belt head and on top of the No. 3 conveyor belt. At that point, Massie had just arrived at the No. 4 belt head and Norman yelled for Massie to turn the conveyor belts off. After the belt system was turned off, they immediately called for help and started removing the No. 4 belt head guarding and chute boards in order to get to Lester.

Norman was heard frantically calling for help on the mine intercom. Once Norman released the page button, Larry Presley, Mine Foreman, who was on the surface, asked Norman, "What is wrong?" Norman said, "JJ (Lester) is hurt, it's bad." Presley grabbed his mining gear and headed into the mine at 12:22 p.m. When Presley reached the air lock doors, he radioed back to Marvin D. Bailey, Chief Electrician, who was substituting as the communications person, and told him to call for an ambulance and to notify the state and federal agencies.

After being informed of the accident, Bailey contacted Roger Large, Underground Electrician, by radio to go to the scene of the accident to assist in recovery and render whatever aid he could. Large immediately left the section and traveled to the No. 4 conveyor belt head. He was the third person to arrive at the scene. Large had received significant first aid training during his training at the West Virginia State Police Academy and in his previous occupation as a policeman. When he arrived at the scene, he observed that Massie and Newman were still removing the expanded metal guarding from the No. 4 conveyor belt head. Large assisted in the removal of the guarding and the back board chute so they could reach Lester. Large then checked Lester for vital signs, however none were detected. Large requested that someone get the back board and first aid kit. Norman then left the scene to retrieve the section first aid kit and back board.

Presley was the fourth person to arrive at the accident scene. He assisted Large in the removal of the drip board chute. Presley, who is also an emergency medical technician (EMT), checked Lester for vital signs and found none. Presley and Large secured Lester to the back board and transported him, arriving on the surface at approximately 1:02 p.m.

Jan Care Ambulance arrived at the mine site at 12:57 p.m. John Stout, Medical Command Physician, confirmed the victim's death at 1:25 p.m. Jennifer Bennett, County Medical Examiner, arrived at the mine site at 3:05 p.m. On Bennett's instruction, Lester, was transported to the Tankersley Funeral Home in Mullens, West Virginia.

INVESTIGATION OF ACCIDENT

The Mine Safety and Health Administration (MSHA) was notified of the accident at 12:38 p.m. Marvin D. Bailey, Chief Electrician, notified the call center, who then notified District 4 at approximately 12:56 p.m. Luther Marrs, Assistant District Manager, called the mine and verbally issued a 103(j) Order at approximately 12:56 p.m. Mr. Marrs then notified the Pineville Field Office, where Ron Barber, Coal Mine Safety and Health Inspector, was dispatched and arrived at the mine at 1:15 p.m. Barber issued the 103(j) Order and immediately modified it to a 103(k) Order, to insure the safety of all persons during the accident investigation and to preserve all evidence at the accident scene.

At approximately 1:00 p.m., Mike Dickerson, Acting Technical Assistant District Manager, notified Daris L. Barker Jr., Roof Control Specialist, of the accident and assigned him as the lead accident investigator. Barker gathered the required information and equipment and traveled to the mine site arriving at 3:00 p.m. The investigation was conducted in cooperation with the West Virginia Office of Miner's Health, Safety and Training (WVOMHST), the mine operator, and employees at the mine. The accident scene was photographed, sketched, and

surveyed. Interviews were conducted with persons considered to have knowledge of the facts and circumstances concerning the accident. A list of the persons who participated in the investigation is contained in Appendix A. The victim's information is contained in Appendix B. The on-site portion of the accident investigation was completed and the 103(k) Order was terminated on February 3, 2011.

DISCUSSION

Experience and Training

John C. Lester Jr. started his mining career on June 28, 2010, by attending a two-week (80 hr.) course at Triangle Safety and was instructed by Don Cook, an approved instructor. Lester received his West Virginia Underground Apprentice Miner's card on July 20, 2010. The MSHA District 4 Accident Investigation Coordinator and Staff Assistant reviewed the materials used in this training. Belt conveyor safety was covered in multiple areas and there was a section of the training dedicated specifically to working around belt conveyors and methods of crossing belt conveyors.

Lester started to work for Jims Branch No. 3B Mine, on October 11, 2010. He received Newly Employed Experienced Miner and General Labor New Task Training, which was conducted by Larry Presley, Mine Foreman. On January 15, 2011, Lester received an eight hour annual refresher training class, which was also conducted by Don Cook. Following the accident, the mine operator conducted additional belt conveyor safety training with all employees and maintained a roster of attendees. At the investigative team's request, MSHA Educational Field Services (EFS) conducted an in-depth review of the mine operators training program. The mine operator was found to be in compliance and up-to-date with MSHA training requirements.

During his new miner apprenticeship (State requirement) at the mine, Lester normally worked with Jerry Lane as a general laborer. Their regular duties were supplying materials to the section and taking care of the outby conveyor belt system. Normally, on the days that Lane was required to run the section scoop, Lester would work for Massie as a brattice man on the section.

Time of Accident

On the day of the accident, Lane had been assigned to operate the 001-0 Section scoop, because the regular day shift scoop operator had just been transferred to the evening shift. Based on testimony, Lester had not been assigned any specific duties that day. However, on the day of the accident he was working alone, outby on the conveyor belt system.

The mine tracking system places the victim outby the 001-0 Section in the vicinity of the No. 4 conveyor belt head from 9:18 a.m., until he was found caught in the No. 4 conveyor belt head chute boards, shortly before the call for help was made at approximately 12:21 p.m. Although the accident occurred between 9:18 a.m. and 12:21 p.m., the exact time of the accident is unknown. Evidence at the scene indicates that Lester was present and had been working at this location for a significant amount of time.

Accident Scene

The mining height around the No. 4 Conveyor Belt Head was approximately 6 feet 8 inches high, while the mining height adjacent to the Conveyor Belt Head averaged just 42 inches. See Drawing of the Accident scene in Appendix C.

The following is a list of the physical evidence at the scene of the accident: Lester's jacket was found placed on the offside rib, evidence of belt cleaning, fresh grease on a grease fitting at the offside of the No. 4 Conveyor Belt Head, a wrapper from a package of crackers, and the presence of two coal shovels; one on each side of the tail piece for the No. 3 Conveyor Belt.
In addition, there were signs of recent work at the scene of the accident, which included fresh grease on the grease fitting, located on the off side of the No. 4 Conveyor Belt Head. This was evidenced by very little dust accumulations on the application of fresh grease. However, a grease gun was not found at the accident scene. There was also evidence that the No. 3 Conveyor Belt, between the tail piece and the No. 4 Conveyor Belt Head, had been cleaned recently (shoveled).

Cause of Accident

Based on the evidence at the accident scene, along with the victim's location and position, when located, the most likely cause of the accident was that Lester fell onto the No. 3 conveyor belt, while attempting to cross the moving belt, just inby the No. 4 conveyor belt head. This caused the victim to be pulled under the expanded metal guarding and become lodged on the inby edge of the drip board chute attached to the No. 4 conveyor belt head.

ROOT CAUSE ANALYSIS

A root cause analysis was conducted to identify the cause(s) of the accident that were correctable through reasonable management controls. Listed below are root causes identified during the analysis and the corresponding corrective actions implemented to prevent a recurrence of the accident.

Root Cause: The mine operator demonstrated inadequate oversight of an employee in that a miner with little mining experience was working alone and attempted to cross a moving conveyor belt.

Corrective Action: A Safeguard Notice was issued requiring that persons shall not cross moving conveyor belts, except where suitable crossing facilities have been provided.

Corrective Action: The operator has included a requirement in the company's safety plan that when conveyor belts are installed that are not in line of the receiving belt or if cross belts are not dumping directly over the receiving belt tailpiece, and height allows, a belt crossover will be installed on the receiving belt inby and outby the belt head dumping point. An additional crossover was installed inby the number 4 belt conveyor discharge roller and inby the number 2 belt conveyor discharge roller.

Corrective Action: Training was conducted and documented for all persons at the mine, in the hazards associated with working around and crossing moving conveyor belts.

CONCLUSION

It is likely this accident occurred because a miner with little mining experience attempted to cross a moving conveyor belt where a suitable belt crossing facility was not provided.

Approved By:

Robert G. Hardman Jr

Timothy R. Watkins
District Manager
Coal Mine Safety and Health, District 12

June 28, 2011
Date

ENFORCEMENT ACTIONS

1. A 103(j) Order, No. 8123521, was issued over the phone verbally at approximately 12:56 p.m. on January 27, 2011, to prevent the destruction of any evidence which would assist in the investigation of the cause or causes of the accident. The 103(j) Order, No. 8123521–01, was modified on January 27, 2011 to a 103(k) order and was reduced to writing at 8:28 p.m.

2. A 314(b) Safeguard Notice, No. 7257532, was issued on February 1, 2011 at 1:00 p.m., requiring that persons shall not cross moving conveyor belts, except where suitable crossing facilities are provided.

APPENDIX A
Persons participating in the investigation

Baylor Mining Inc.

Robert Worley..... President/Treasurer/Director
Larry Presley.....Mine Foreman/Superintendent/Secretary
Robbie Ortiz..... Mine Engineer
Ronnie Massie, Jr.....Section Foreman
Marvin D. Bailey ..... Chief Electrician
Robert Whitt..... Roof Bolter Operator
Terence Salmons..... Roof Bolter Operator
Douglas Smith ..... Shuttle Car Operator
Jerry Lane .....Scoop Operator
Gary Norman.....Section Electrician
Roger Large.....Electrician
Eric Price..... Shuttle Car Operator
Willie Johnson.....Continuous Miner Operator
Christopher Pence.....Allen Guthrie & Thomas, Attorney at Law

West Virginia Office of Miner's Health, Safety and Training

Eugene White.....Deputy Director
Dwight McClure.....District Roof Control Specialist
John O'Brian.....Assistant Inspector-at-Large
Greg Norman.....Inspector-at-Large
Bill Tucker ..... Assistant to Director
Doug Depta.....District Inspector
Elaine Skorich ..... Assistant Attorney General

Mine Safety and Health Administration

Michael Dickerson .....Acting Assistant District Manager/Technical Programs
Scott Mandeville..... Acting Staff Assistant
Daris Lee Barker, Jr. ..... Mining Engineer/Accident Investigator
Ronald Barber.....Coal Mine Safety and Health Inspector
Robert Hatfield..... Coal Mine Safety and Health Inspector/Electrical Specialist

APPENDIX B
Victim Information

Accident Investigation Data - Victim Information
Event Number: 4 1 1 9 5 7 9

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. Last Four Digits of SSN:	5. Degree of Injury:
John C. Lester, Jr.	M	19	6516	01 Fatal

6. Date(MM/DD/YY) and Time(24 Hr.) Of Death: a. Date: 01/27/2011 b.Time: 12:00

7. Date and Time Started: a. Date: 01/27/2011 b.Time: 6:00

8. Regular Job Title: 016 General Laborer

9. Work Activity when Injured: 017 Crossing Over Conveyor

10. Was this work activity part of regular job? Yes X No

11. Experience	Years	Weeks	Days
a. This Work Activity:	0	15	4
b. Regular Job Title:	0	15	4
c: This Mine:	0	15	4
d. Total Mining:	0	15	4

12. What Directly Inflicted Injury or Illness? 033 Coal Raw Run of Mine

13. Nature of Injury or Illness: 110 Asphyxiation

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

15. Company of Employment:(If different from production operator) Operator

Independent Contractor ID: (if applicable)

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

17. Part 50 Document Control Number: (form 7000-1)

18. Union Affiliation of Victim: 9999 None (No Union Affiliation)

Victim Information:

1. Name of Injured/Ill Employee:	2. Sex	3. Victim's Age	4. Last Four Digits of SSN:	5. Degree of Injury:

6. Date(MM/DD/YY) and Time(24 Hr.) Of Death:

7. Date and Time Started:

8. Regular Job Title:

9. Work Activity when Injured:

10. Was this work activity part of regular job? Yes | No

11. Experience:	Years	Weeks	Days
a. This Work Activity:			
b. Regular Job Title:			
c: This Mine:			
d. Total Mining:			

12. What Directly Inflicted Injury or Illness?

13.Nature of Injury or Illness:

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

15. Company of Employment: (If different from production operator)

Independent Contractor ID: (if applicable)

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

17.Part 50 Document Control Number: (form 7000-1)

18. Union Affiliation of Victim:

Victim Information:

1. Name of Injured/Ill Employee:	2. Sex	3. Victim's Age	4. Last Four Digits of SSN:	5. Degree of Injury:

6. Date(MM/DD/YY) and Time(24 Hr.) Of Death:

7. Date and Time Started:

8. Regular Job Title:

9. Work Activity when Injured:

10. Was this work activity part of regular job? Yes | No

11. Experience:	Years	Weeks	Days
a. This Work Activity:			
b. Regular Job Title:			
c: This Mine:			
d. Total Mining:			

12. What Directly Inflicted Injury or Illness?

13. Nature of Injury or Illness:

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

15.Company of Employment:(If different from production operator)

Independent Contractor ID: (if applicable)

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

17. Part 50 Document Control Number: (form 7000-1)

18. Union Affiliation of Victim:

MSHA Form 7000-50b, Dec 1994

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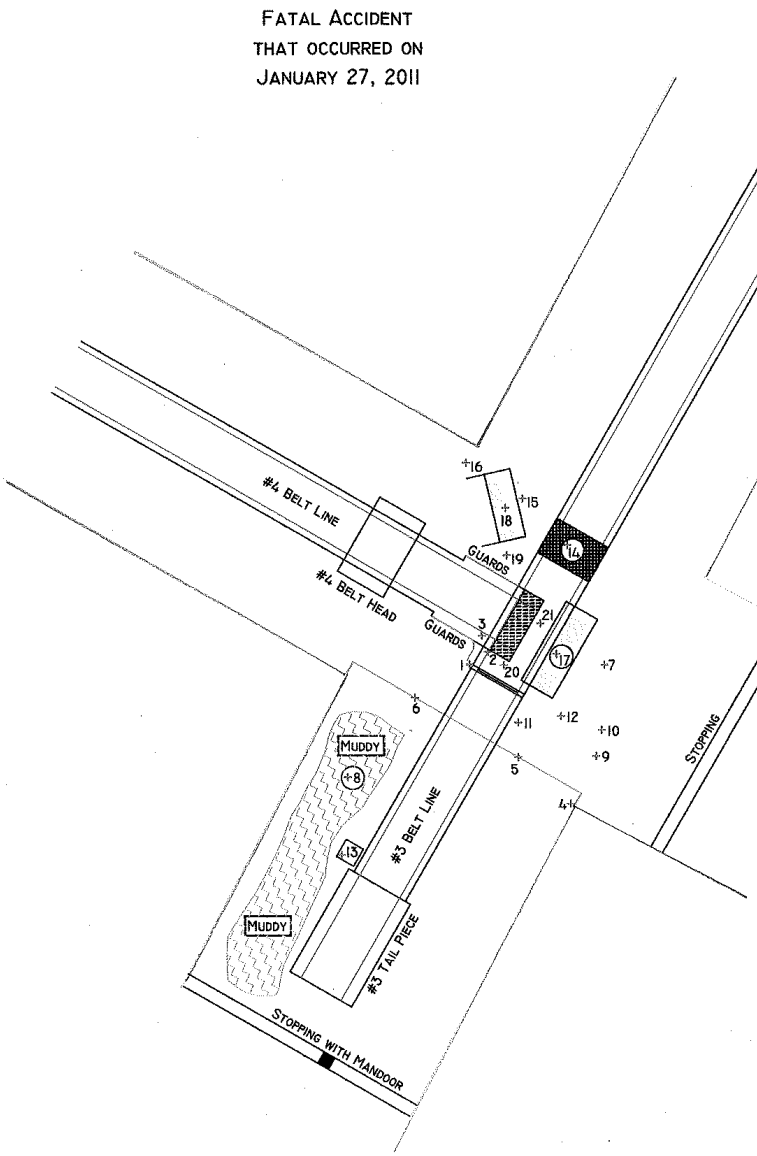
APPENDIX C
Sketch of the Accident



1	TOP ROLLER
2	VICTIM'S HARD HAT UNDER BOTTOM BELT
3	VICTIM'S SCSR CSE100
4	VICTIM'S CAMO JACKET RIGHT POCKET NAILS LEFT POCKET SAFETY GLASSES
5	HEIGHT 43"
6	HEIGHT 41"
7	APPROX.HEIGHT OF INTERSECTION 80"
8	SHOVEL
9	SHOVEL
10	SCREW DRIVER
11	CHANNEL LOCKS
12	GLOVES
13	LANDMINE
14	BELT CROSSOVER
15	#3 BELT SWITCH
16	MINE PHONE
17	BACK BOARD "CHUTE" HAD BEEN TAKEN DOWN FROM TOP TO REMOVE VICTIM
18	DRIP BOARD THAT HAD BEEN REMOVED TO REMOVE VICTIM
19	GUARDS THAT HAD BEEN REMOVED TO REMOVE VICTIM
20	APPROX. LOCATION OF VICTIM HEAD
21	APPROX. LOCATION OF VICTIM FEET

Note: Item13 Landmine refers to a floor level spillage gob switch.