

UNITED STATES  
DEPARTMENT OF LABOR  
MINE SAFETY AND HEALTH ADMINISTRATION

COAL MINE SAFETY AND HEALTH

REPORT OF INVESTIGATION

Underground Coal Mine

Fatal Fall of Face, Rib, or Pillar Accident  
June 29, 2011

Manalapan Mining Co., Inc.  
P-1 Mine  
Smith, Harlan County, Kentucky  
ID No. 15-19102

Accident Investigators

Jack Harris  
Coal Mine Safety and Health Inspector

Paul J. Hollar  
James Vadnal  
Mining Engineers, Roof Control Division  
Pittsburgh Safety and Health Technology Center

Kevin Doan  
Roof Control Specialist

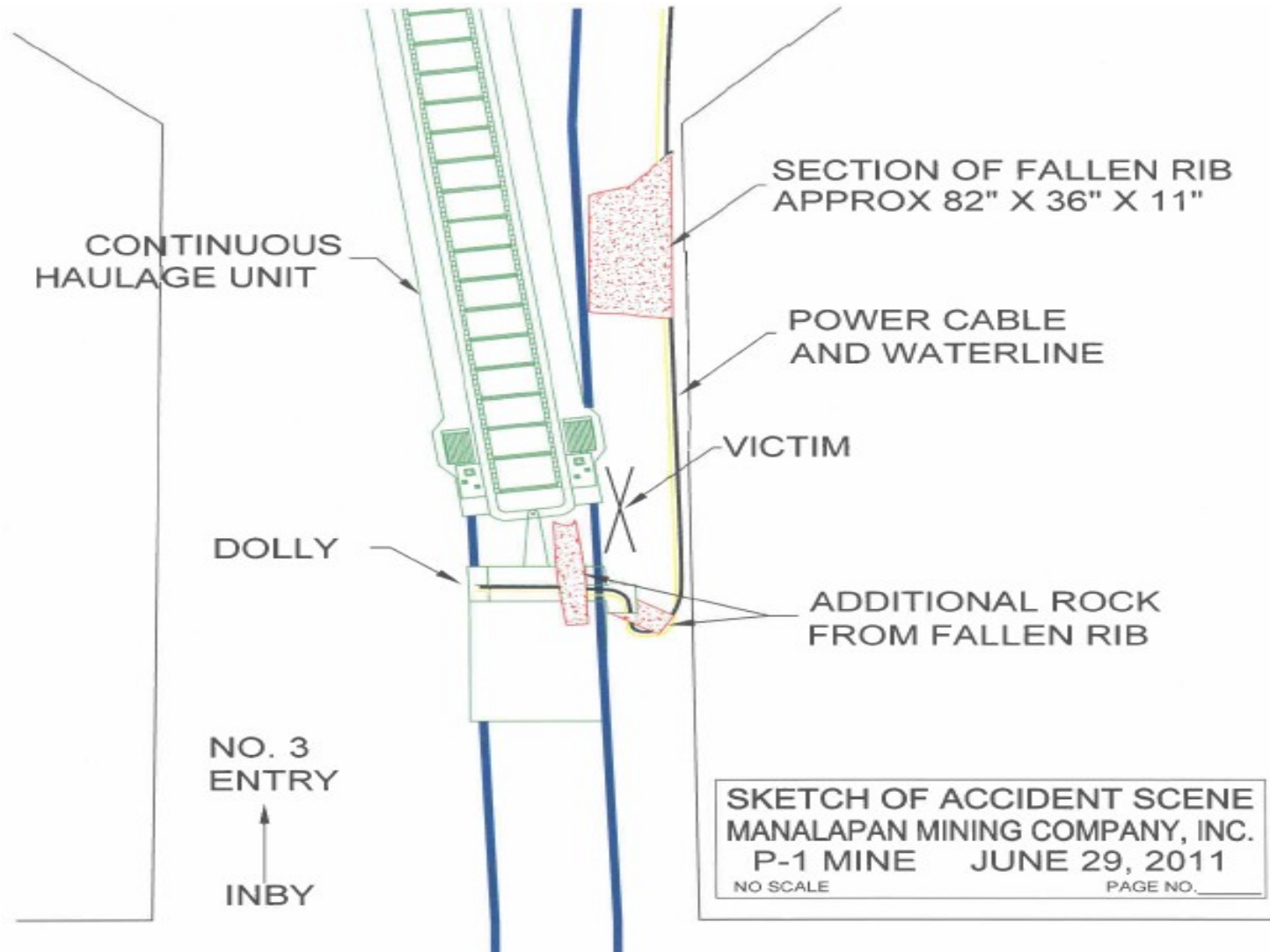
Deborah B. Combs  
Educational Field Services

Originating Office  
Mine Safety and Health Administration  
District 7  
3837 South US Hwy 25E  
Barbourville, KY 40906  
Irvin T. Hooker, District Manager

## TABLE OF CONTENTS

SKETCH OF ACCIDENT SITE .....	ii
OVERVIEW.....	1
GENERAL INFORMATION .....	1
DESCRIPTION OF ACCIDENT.....	1
INVESTIGATION OF THE ACCIDENT .....	2
DISCUSSION .....	3
GEOLOGY.....	3
002 MMU PILLAR STABILITY .....	4
LOCAL PILLAR STABILITY .....	4
EXAMINATIONS ON 002 MMU .....	5
TRAINING.....	6
ROOT CAUSE ANALYSIS .....	6
CONCLUSION.....	8
ENFORCEMENT ACTIONS .....	9
Appendix A - Persons Participating in the investigation.....	11
Appendix B - List of Persons Interviewed.....	12
Appendix C - Photographs .....	13
Appendix D - 7000-50b .....	16

SKETCH of ACCIDENT SCENE



## OVERVIEW

On Wednesday, June 29, 2011, at approximately 11:15 a.m., a 49 year old continuous haulage cable attendant (dolly man) received fatal injuries when a large section of rock measuring approximately 82 inches long, 36 inches wide, and 11 inches thick fell from the rib and knocked him into the dolly. There were no witnesses to the accident. It appears that during the mining process, the continuous haulage system backed up, causing the dolly to move along the lo-lo (belt) structure and apparently dragging the victim from beneath the fallen material.

## GENERAL INFORMATION

The P-1 Mine is an underground coal mine owned and operated by Manalapan Mining Co. Inc. The mine is located in Harlan County, Kentucky, and is developed in the Path Fork coal seam. Mining height ranges from 42 to 90 inches and the mine is accessed by four drift openings. There were 48 miners employed on one production shift and one maintenance shift, five days per week, nine hours per shift. This mine has two working sections with an average production of 623 tons per day. Coal is extracted from the faces by a continuous miner and transported by a continuous haulage system and belt conveyors to the surface. Materials, supplies, and miners are transported via scoops and rubber tired mantrips.

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

Ben Bennett	President
Jefferson B. Davis	General Manager
Joseph Miniard	Superintendent
David J. Partin	Safety Director

The last regular safety and health inspection (E01) conducted by the Mine Safety and Health Administration (MSHA) prior to the accident was completed on June 24, 2011. The Non-Fatal Days Lost (NFDL) injury incidence rate for the P-1 Mine through the 2nd quarter of 2011 was 3.11, compared to a National NFDL rate of 3.58.

## DESCRIPTION OF ACCIDENT

On Wednesday morning, June 29, 2011, at approximately 6:00 a.m., ten members of the day shift production crew, under the direction of Larry Norris, Section Foreman, entered the mine via rubber tired mantrip. They arrived on the 002 Section or Mechanized Mining Unit (MMU) at approximately 6:20 a.m. Two members of the crew were already on the section, having begun work at 5:00

a.m. to perform pre-operational checks on equipment. Upon arrival, Norris began conducting an on-shift examination of the section and the remainder of the crew started normal production operations.

At approximately 11:15 a.m., the continuous miner completed the first lift in the face of the No. 4 Entry. The continuous mining machine and bridge units were then backed up to set over and mine the second lift. Kevin Daniels, #4 Bridge Carrier Operator, shut the carriers off and told the other carrier operators he thought his track had locked up while they were backing out. When the front carrier operator commented they were ready to pull forward, Daniels attempted to locate the dolly man, David A. Partin (victim) before proceeding. Not seeing Partin, Daniels engaged the panic bar to remove power from the bridge carriers, turned the belt off, and traveled toward the dolly to look for him. Daniels found Partin lying beside the lo-lo conveyor belt structure where the rib material had fallen and yelled that he needed a Mine Emergency Technician (MET). Jeremy Gambrel, #3 Bridge Carrier Operator, heard him and assuming something was wrong, also yelled out for a MET. Clark Stanton and Kevin Cox, Roof Bolter Operators and METs, ran to the accident site. Norris was in the immediate 3 Right Break and ran to see what was wrong. Norris told Cox to go to the phone and call for an ambulance. Cox called outside and notified Ryan O'Neal that a serious injury had occurred. First aid was administered to the victim by Stanton and George Adkins, Scoop Operator, who was also a MET. Partin was placed on a backboard and moved from the injury location because of the adverse coal rib conditions. Gambrel and Alex Stanton, Miner Helper, knocked out a brattice to allow quicker access to the rubber tired personnel carrier, which O'Neal brought from the surface to transport the victim. Partin was carried to the personnel carrier and transported to the surface. He was accompanied by O'Neal, Alex Stanton, Curt Lankfort, Daniels and Clark Stanton. Partin was pronounced dead at 12:53 p.m. at the mine site by Harlan County Deputy Coroner, Jim Rich.

## INVESTIGATION OF THE ACCIDENT

The MSHA District 7 Office was notified on the day of the accident at approximately 11:50 a.m. by Jerry Pearson of Manalapan Mining. Pearson reported that a life-threatening injury had occurred at the Manalapan Mining P1 Mine. A verbal 103(j) Order was issued to Jefferson Davis, Mine Manager, immediately thereafter by Samuel Creasy, Barbourville Field Office Supervisor. Creasy dispatched Jack Harris, MSHA Accident Investigator, to the mine site. The 103(j) Order was modified to a 103(k) Order after MSHA arrived at the mine. Pearson notified the MSHA National Call Center at approximately 11:55 a.m.

The accident investigation was conducted in coordination with the Kentucky

Office of Mine Safety and Licensing (OMSL), with assistance from the mine operator and employees. Representatives of MSHA, OMSL, and the operator traveled underground to the accident site to examine the scene and begin an investigation of the existing physical conditions. A representative of MSHA's Educational Field Services reviewed training records. On July 01, 2011, representatives from MSHA's Pittsburgh Technical Support office provided assistance with evaluation of the geologic conditions on the 002 MMU.

In conjunction with OMSL representatives, interviews were conducted by MSHA with seven persons on June 30, 2011, and one person on July 5, 2011, at the OMSL Office in Harlan, Kentucky. A list of persons participating in or present during the investigation is included in Appendix A.

## **DISCUSSION**

The mining height in the #3 Entry is approximately 83 inches and crosscuts average 20 feet wide at the accident site. The portion of rib that struck the victim measured approximately 82 inches long, by 36 inches wide, by 11 inches thick (See Photograph #1 of Appendix C). The average mining height is normally 42 to 44 inches. However, in this particular area, a coal rider seam is within the immediate roof strata. The operator increased the mining height so that permanent support could be anchored in solid roof strata above the coal rider seam. The increased mining height contributed to the loose rib conditions on the 002 MMU.

## **GEOLOGY**

Manalapan Mining Co. Inc., P-1 Mine extracts coal from the Pathfork, (or Imboden) seam. The mining interval at the P-1 Mine is normally 42 to 44 inches thick, consisting of approximately 28 to 32 inches of coal at the bottom of the interval and 8 to 10 inches of interbedded soft shale and coal bands on top. This results in an immediate roof consisting of hard gray sandy shale or sandstone.

At the accident site, the interval of interbedded coal and shale between the top of the Pathfork seam and the immediate roof had thickened dramatically, from 8 to 10 inches at the mouth of the section to nearly six feet at the faces. As the interval between the top of the coal and the immediate roof thickened, a 3 to 4 inch-thick coal "rider" formed at the top of the interval. Because the coal rider seam was close to the mine's immediate roof, it was mined as a part of the normal mining process, playing a part in the increased mining height of the 002 MMU. Historically in mining, increased mining height increases the potential for rib instability. Immediately below the coal rider was a medium hard, dark gray to black shale, with coal lamina and abundant coal plant fossils. The number of

fossils and coal lamina decrease downward and the shale grades into a hard gray shale, with siderite bands and nodules. The rock between the hard gray shale and the top of the main coal seam was very similar to the rock immediately below the rider; a dark gray to black, medium hard shale with coalified plant fossils and coal lamina.

### **002 MMU PILLAR STABILITY**

The 002 MMU was developed initially with 20 ft. wide entries on 60 ft., by 60 ft. centers and with 80 degree crosscuts, to accommodate the bridge system used in the mine. Seven entries were developed a distance of 33 crosscuts, at which point development was reduced to five entries due to the volume of rock being mined. The operator developed one row of pillars on 60 ft., by 60 ft. centers (crosscut 34) with 5 entries, and then lengthened the crosscut centers to 70 ft. for one crosscut (crosscut 35). Mining was then resumed on 60 ft., by 60 ft. centers, with plans to drop two additional entries to speed up mining in this area. The accident occurred between 34 and 35 Crosscut in the area of the longer block; total mining height was approximately 83 inches.

The elevation in 002 MMU is approximately 1,685 ft. and had been over mined by works in the Harlan Seam, 200 ft. above. Cover over the Pathfork seam at the location of the accident was approximately 720 feet. Examination of the Harlan seam mine maps indicated that there were no gob-solid boundaries, isolated pillars, or pillar remnants above 002 MMU. Harlan seam mining was reported to be approximately 5 ft. thick and approximately five years old.

A computerized, pillar stability software, Analysis of Multiple Seam Stability (AMSS), version 2.0.26, developed by the National Institute for Safety and Health (NIOSH) was utilized to evaluate pillar stability and potential multiple seam interaction at the accident location. The AMSS analysis shows that the pillar Stability Factor of 1.67 on 002 MMU exceeds the NIOSH recommended minimum of 1.46 and that multiple seam interaction between the Harlan seam works and the P-1, 002 MMU works were unlikely.

### **LOCAL RIB STABILITY**

No widespread pillar instability was observed by members of the MSHA, Technical Support, Roof Control Division during the accident investigation. Localized rib cracking and instability were observed in the area of the accident and adjacent crosscuts and entries. The tall ribs in the area of the accident were

subjected to normal pressures associated with mining and susceptible to cracking and damage.

### EXAMINATIONS ON 002 MMU

The June 29, 2011, preshift examination was conducted between 4:10 a.m. and 4:30 a.m. by Darrin Stephens, Day Shift Outby Foreman for the P-1 Mine, and brought outside at 4:50 a.m. The only hazardous condition noted in the preshift record for the 002 MMU was "Not Bolted," and the corrective action was "Tagged." The preshift examination did not identify any specific hazardous rib or roof conditions and no corrective actions for rib and roof conditions were recorded. The examiner either ignored or did not recognize the hazardous rib conditions. As a result, the day shift crew was directed to proceed underground to begin production without hazardous conditions being recorded or corrective actions taken.

Numerous hazardous conditions were present on the 002 MMU at the time of the preshift examination. There were recurrent locations with loose coal/rock ribs on the 002 MMU, including the rib in the No. 3 Entry at #33 Crosscut which fell, causing fatal injuries to the victim. There were also violations of the Approved Roof Control Plan at multiple locations on the 002 MMU. No specific hazardous rib or roof conditions were recorded for any preshift examinations, dating back to June 17, 2011, for any shift. No corrective actions for any rib or roof conditions were recorded in the preshift examination report in the books reviewed.

No hazardous conditions were noted in the on-shift examination conducted by Bryant Massingale, Foreman, on the second shift on June 28, 2011. The hazardous roof and rib conditions present on the 002 MMU were not identified, corrected or posted. Mine management directed work to be performed in the #3 Entry where the accident occurred and other locations on the 002 MMU where hazardous rib conditions were present. The ten previous on-shift and preshift examinations, and the pre-shift examination on the morning of the fatal accident for the 002 MMU did not identify any hazardous rib or roof conditions or corrective actions. Miners were exposed to loose rib conditions throughout the duration of these shifts. Not only did Stevens perform an inadequate pre-shift examination prior to the fatal accident, Norris performed an inadequate on-shift examination on the 002 MMU prior to the occurrence of the fatal accident.



## TRAINING

The company's training records were examined by representatives of MSHA's Educational Field Services (EFS). Records were provided by the company for the victim which, upon examination, indicated that all required training had been conducted, and no deficiencies were found. The training records were also reviewed for the foremen and mine examiners employed at the mine. Again, the records provided were found to be current and indicated that all required training had been conducted. Because of the fatal accident, additional training was conducted for the foremen, examiners, and other miners to assure that hazards are recognized properly, reported, and corrected safely. The company also provided documentation of this training being completed. The additional hazard recognition training was incorporated into the mine operator's training plan.

Training on the provisions of the Company's approved Roof Control Plan, along with specific additional training on the recognition and correction of hazardous roof and rib conditions, has been provided to all miners currently employed at the mine. This additional emphasis has been further provided at all mines and to all miners employed by the company. Miners have been instructed to report all hazardous conditions observed to mine management, so the conditions can be corrected.

## 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, would have either prevented the accident or mitigated its consequences. Listed below are root causes identified during the analysis and their corresponding corrective actions implemented to prevent a recurrence of the accident:

1. *Root Cause:* The operator failed to support or control the mine rib to prevent the large rib failure, which resulted in fatal injuries to the continuous haulage cable handler  
*Corrective Action:* The operator has developed and submitted an update with comprehensive rib control measures as a portion of the Roof Control Plan.
2. *Root Cause:* The operator failed to instruct foremen adequately with regard to properly identifying hazardous conditions.

*Corrective Action:* The operator conducted and documented training on the proper identification of hazardous conditions with the miners as well at all other company-controlled mines. The miners were instructed to report to mine management immediately any hazardous conditions observed.

3. *Root Cause:* The operator failed to have in place an adequate roof control plan addressing proper support of mine ribs in changing geological conditions and to support the ribs properly on the 002 MMU.

*Corrective Action:* The operator has developed and submitted a revision to the current roof control plan, which has been approved. The revision states the corrective actions that will be taken to support rib conditions when encountering various heights and geological conditions.

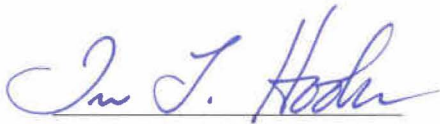
4. *Root Cause:* The operator failed to conduct adequate pre-shift and on-shift examinations on the 002 MMU. Uncorrected roof and rib conditions existed during the shift, which posed hazards to the miners. None of the hazardous conditions, including hazardous ribs, were recorded in the preshift or on-shift examination books.

*Corrective Action:* The operator conducted and documented safety meetings with all employees on identifying and recording hazardous conditions properly.

## CONCLUSION

This fatal accident occurred because the operator failed to support or control the rib(s) to protect the miner(s) on the 002 MMU where persons work or travel. Additionally, the operator failed to conduct adequate preshift and on-shift examinations and ignored the hazardous rib conditions on the 002 MMU. Finally, the operator failed to revise and upgrade the Roof Control Plan to address the changing geological conditions which occurred on the 002 MMU.

Approved by:



Irvin T. Hooker  
District Manager



Date

## ENFORCEMENT ACTIONS

Order No. 8365394 was issued verbally to Manalapan Mining Co. P-1 Mine on June 29, 2011, at 11:50 a.m. under the provisions of Section 103(j) of the Mine Act. This order was modified to a 103(k) Order at 14:00 p.m. on the same day.

104(d)(1) Citation, No. 8368206, for a violation of 30 CFR, § 75.202(a) – The ribs on the 002 MMU were not supported to protect miners from hazards associated with loose ribs. Loose rib material struck the victim and resulted in a fatal accident. The investigation of this fatal accident, which occurred on June 29, 2011, revealed that the operator failed to support the loose coal/rock ribs in the following locations: (1) at #34 and #35 Crosscut on the sides and inby corners of the coal pillar blocks in the #3 and #4 Headings, (2) at #33 Crosscut in the #3 Belt Heading where the upper inby corners of the left and right ribs were separated from the coal pillar and, (3) at #34 Crosscut between #4 and #5 entries on both left and right sides. The operator has engaged in aggravated conduct constituting more than ordinary negligence in that management did not take measures to ensure safe working conditions around ribs. This violation is an unwarrantable failure to comply with a mandatory standard.

104(d)(1) Order, No. 8368207, for a violation of 30 CFR, § 75.360(a)(1) – The operator failed to conduct an adequate pre-shift exam on June 29, 2011 for the 002 MMU located on 2 left panel. Loose ribs in various sizes were found at: (1) #34 and #35 Crosscuts on the sides and inby corners of the coal pillar blocks in the #3 and #4 Headings, (2) at #33 Crosscut in the #3 Belt Heading, the upper inby corners of the left and right ribs were separated from the coal pillar and top approximately ½ inch, and (3) at #34 crosscut between #4 and #5 entries both left and right sides cracks with ½ inch openings 6" into the coal rib were observed. These conditions were found during a fatal investigation. None of these hazardous conditions were recorded in the 002 MMU exam book. The hazardous conditions existed when the preshift examination was conducted. The operator has engaged in aggravated conduct constituting more than ordinary negligence in that the hazardous rib conditions were found, but should have been found, and no action was taken, which led to the exposure of the continuous haulage cable attendant (dollyman) resulting in a fatality. This violation is an unwarrantable failure to comply with a mandatory standard.

104(d)(1) Order, No. 8368208, for a violation of 30 CFR, § 75.362(a)(1) – During the course of MSHA's Fatal Accident Investigation which began on June 29, 2011, it was found that adequate on-shift examinations were not performed on June 28 and 29, 2011, on the 002 MMU. The following deficiencies were noted: (1) the 1st shift on-shift report for June 28, 2011 did not identify the hazardous rib conditions, and (2) the 2nd shift on-shift report recorded on June 28, 2011 did not

identify the hazardous rib conditions. On-shift examiners recorded "Not Bolted" in the on-shift record for the #3 Belt Heading. Refer to Citation #8368206, as it will reflect the conditions observed on the 002 MMU. These hazardous conditions were present when the on-shift examinations were conducted on June 28 and 29, 2011 but the hazardous conditions were not corrected or documented. The operator has engaged in aggravated conduct constituting more than ordinary negligence in that the hazardous rib conditions were found, but should have been found, and no action was taken, which led to the exposure of the continuous haulage cable attendant (dollyman) resulting in a fatality. This violation is an unwarrantable failure to comply with a mandatory standard.

104(d)(1) Order, No. 8368209, for a violation of 30 CFR, § 75.223(a)(1) – The operator failed to revise the roof control plan in effect at this mine when conditions indicated that the plan was no longer suitable to control the rock and coal ribs that were encountered on the 002 MMU, located on the 2 left panel. The following conditions were observed on the 002 MMU; (1) A portion of rib, which measured 3 to 11 inches thick x 82 inches long x 36 inches wide, was not supported properly on the corner of the right pillar inby #34 crosscut in the #3 Belt Entry on the 2 left panel, (2) at Crosscut #33 in the #3 Belt Entry on the 2 Left Panel on the inby corners of the left and right rib the upper corners of the rib were separated from the coal pillar, and (3) at Crosscut #34 on the 2 Left Panel between the #4 and #5 Entries the coal and rock ribs have cracked and separated from the pillar. Due to changing geological conditions in this area, including increased mining height and a sharp increase in the coal height meeting with shale roof rock, this condition allowed the rib to slide out and strike the continuous haulage cable attendant (dolly man) resulting in a fatality. Refer to Citation #8368206, as it will reflect the conditions observed on the 002 MMU. The operator has engaged in aggravated conduct constituting more than ordinary negligence. This violation is an unwarrantable failure to comply with a mandatory standard.

314(b) Safeguard, No. 8368210, for 30 CFR, § 75.1403 – The area between Crosscuts 33 and 34 on the #2 left panel belt was measured to be 18" from the batwing to the coal rib. The area on both sides of the belt was used as a travelway. It is necessary in this mine to have 24" clearance to reduce hazards of traveling in areas alongside belt conveyors. A clear travel way of at least 24" is required to be maintained along both sides of all belts in this mine. This is a notice to provide safeguards requiring the #2 panel belt, and all other belts at this mine, to have 24" clearance on both sides of each belt.

APPENDIX A

**Persons Participating in the Investigation**

**Mining Company Officials**

Ben Bennett .....President  
Jefferson B. Davis .....General Manager  
Joseph Miniard ..... Superintendent  
Darrin Stephens .....Foreman  
David J. Partin ..... Safety Director  
Larry Norris .....Foreman  
Melanie Kilpatrick .....Attorney

**Kentucky Office of Mine Safety and Licensing**

Tim Fugate ..... Accident Investigator  
Ernest Hawkins ..... Inspector  
Tracy Stumbo .....Chief Accident Investigator

**Mine Safety and Health Administration**

Irvin T. Hooker .....District Manager  
Clayton E. Sparks ..... Assistant District Manager  
Dennis J. Cotton ..... Assistant District Manager  
Steve Sorke ..... Roof Control Supervisor  
Lester Cox .....Field Office Supervisor  
Jack E. Harris ..... Accident Investigator  
Kevin L. Doan ..... Accident Investigator  
Paul J. Hollar.....Pittsburgh Technical Support  
James Vadnal .....Pittsburgh Technical Support  
Deborah B. Combs ..... EFS Specialist

## APPENDIX B

### List of Persons Interviewed

Darrin Stephens ..... Outby Foreman/Mine Examiner  
Larry Norris ..... Foreman  
Clark Stanton ..... Roof Bolter Operator/MET  
Kevin Cox ..... Roof Bolter Operator/MET  
George Adkins ..... Scoop Operator/MET  
Larry Hensley ..... Bridge Carrier Operator  
Kevin Daniels ..... Bridge Carrier Operator  
Alex Stanton ..... Miner Helper

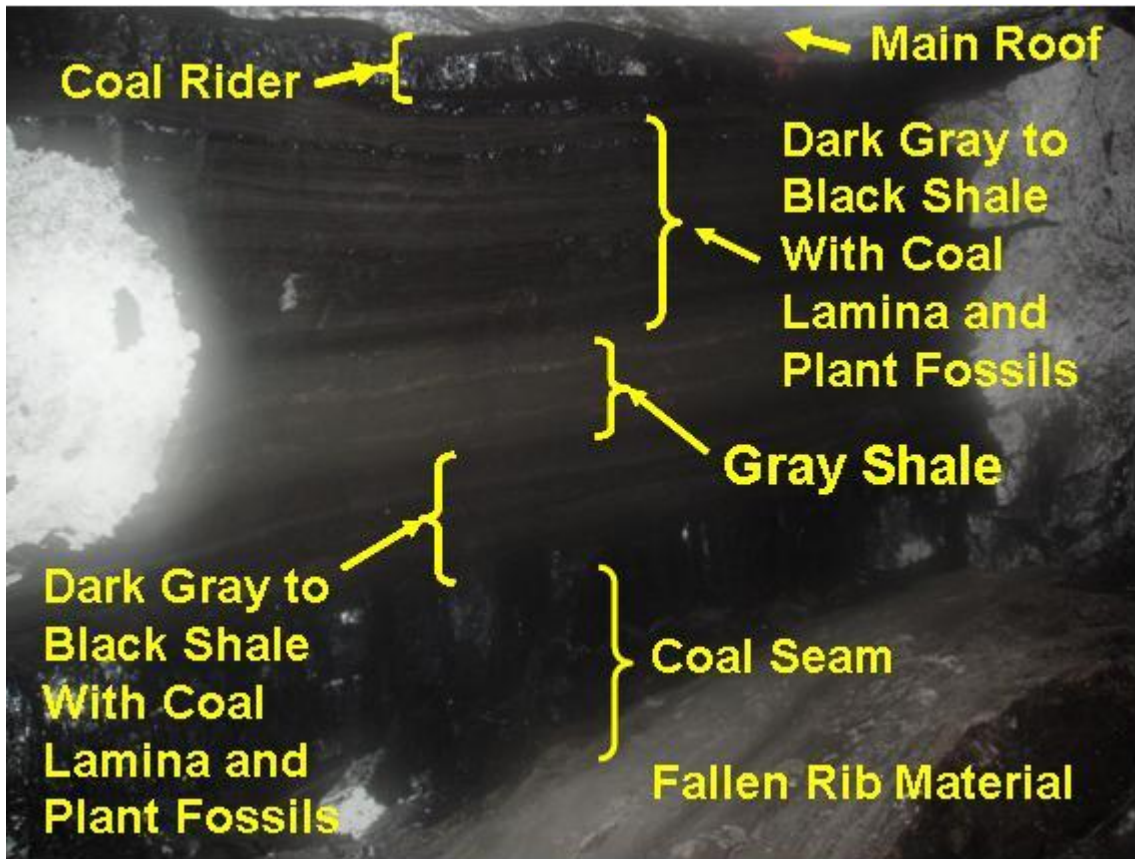
APPENDIX C

Photograph #1

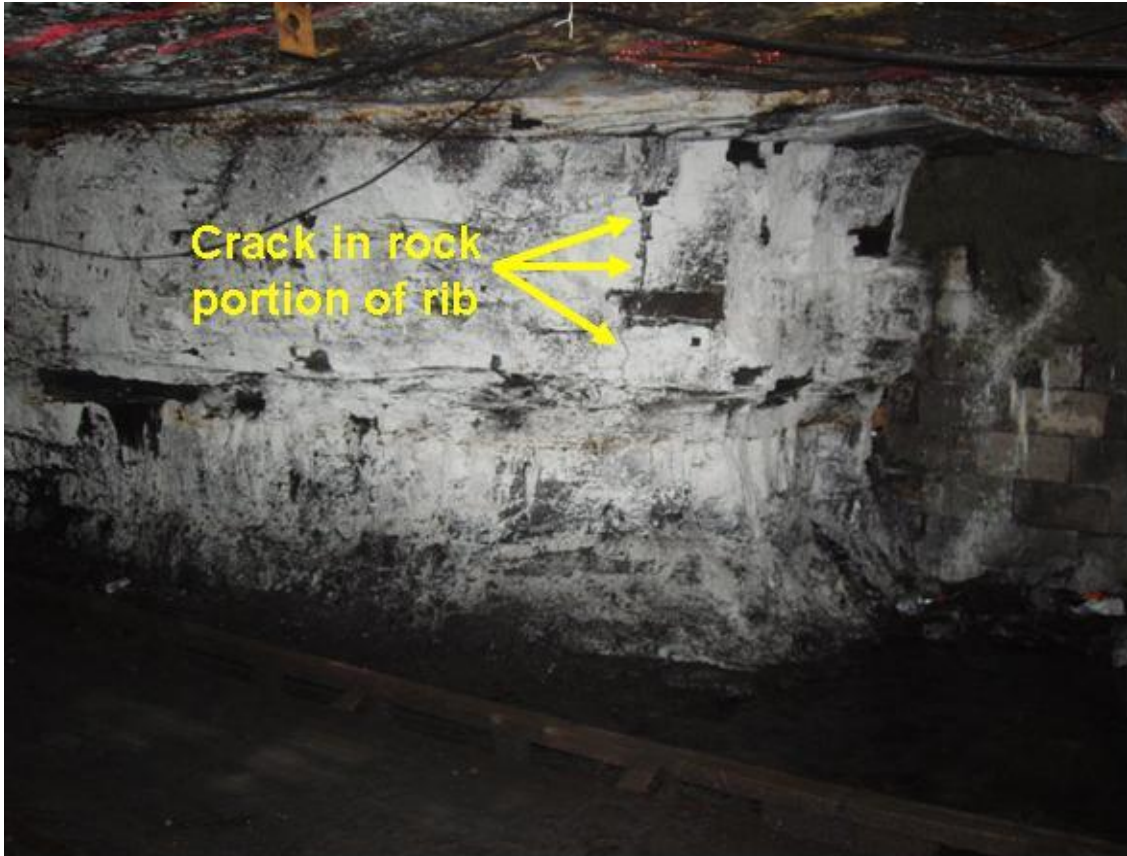




Photograph #2



Photograph #3



## APPENDIX D

### Accident Investigation Data - Victim Information

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



Event Number:

**Victim Information: 1**

1. Name of Injured/Ill Employee: <i>David A. Partin</i>		2. Sex: <i>M</i>	3. Victim's Age: <i>49</i>	4. Degree of Injury: <i>01 Fatal</i>											
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death: <i>a. Date: 06/29/2011 b. Time: 12:53</i>				6. Date and Time Started: <i>a. Date: 06/29/2011 b. Time: 11:15</i>											
7. Regular Job Title: <i>016 Continuous Haulage Cable Attendant</i>			8. Work Activity when Injured: <i>040 Watching the cable on the dolly</i>			9. Was this work activity part of regular job? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
10. Experience a. This	Years	Weeks	Days	b. Regular Job Title:	Years	Weeks	Days	c. This Mine:	Years	Weeks	Days	d. Total Mining:	Years	Weeks	Days
Work Activity:	<i>0</i>	<i>2</i>	<i>0</i>	<i>0</i>	<i>46</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>48</i>	<i>5</i>	<i>0</i>	<i>0</i>	<i>16</i>	<i>0</i>	<i>0</i>
11. What Directly Inflicted Injury or Illness? <i>122 Fall of Rib</i>				12. Nature of Injury or Illness: <i>170 Crushing</i>											
13. Training Deficiencies: Hazard: <input type="checkbox"/> New/Newly-Employed Experienced Miner: <input type="checkbox"/> Annual: <input type="checkbox"/> Task: <input type="checkbox"/>															
14. Company of Employment: (If different from production operator) <i>Operator</i> Independent Contractor ID: (if applicable)															
15. On-site Emergency Medical Treatment: Not Applicable: <input type="checkbox"/> First-Aid: <input checked="" type="checkbox"/> CPR: <input type="checkbox"/> EMT: <input checked="" type="checkbox"/> Medical Professional: <input type="checkbox"/> None: <input type="checkbox"/>															
16. Part 50 Document Control Number: (form 7000-1) <i>220111890030</i>				17. Union Affiliation of Victim: <i>9999 None (No Union Affiliation)</i>											

**Victim Information:**

1. Name of Injured/Ill Employee:		2. Sex:	3. Victim's Age:	4. Degree of Injury:											
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death:				6. Date and Time Started:											
7. Regular Job Title:			8. Work Activity when Injured:			9. Was this work activity part of regular job? Yes <input type="checkbox"/> No <input type="checkbox"/>									
10. Experience a. This	Years	Weeks	Days	b. Regular Job Title:	Years	Weeks	Days	c. This Mine:	Years	Weeks	Days	d. Total Mining:	Years	Weeks	Days
Work Activity:															
11. What Directly Inflicted Injury or Illness?				12. Nature of Injury or Illness:											
13. Training Deficiencies: Hazard: <input type="checkbox"/> New/Newly-Employed Experienced Miner: <input type="checkbox"/> Annual: <input type="checkbox"/> Task: <input type="checkbox"/>															
14. Company of Employment: (If different from production operator) Independent Contractor ID: (if applicable)															
15. On-site Emergency Medical Treatment: Not Applicable: <input type="checkbox"/> First-Aid: <input type="checkbox"/> CPR: <input type="checkbox"/> EMT: <input type="checkbox"/> Medical Professional: <input type="checkbox"/> None: <input type="checkbox"/>															
16. Part 50 Document Control Number: (form 7000-1)				17. Union Affiliation of Victim:											

**Victim Information:**

1. Name of Injured/Ill Employee:		2. Sex:	3. Victim's Age:	4. Degree of Injury:											
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death:				6. Date and Time Started:											
7. Regular Job Title:			8. Work Activity when Injured:			9. Was this work activity part of regular job? Yes <input type="checkbox"/> No <input type="checkbox"/>									
10. Experience a. This	Years	Weeks	Days	b. Regular Job Title:	Years	Weeks	Days	c. This Mine:	Years	Weeks	Days	d. Total Mining:	Years	Weeks	Days
Work Activity:															
11. What Directly Inflicted Injury or Illness?				12. Nature of Injury or Illness:											
13. Training Deficiencies: Hazard: <input type="checkbox"/> New/Newly-Employed Experienced Miner: <input type="checkbox"/> Annual: <input type="checkbox"/> Task: <input type="checkbox"/>															
14. Company of Employment: (If different from production operator) Independent Contractor ID: (if applicable)															
15. On-site Emergency Medical Treatment: Not Applicable: <input type="checkbox"/> First-Aid: <input type="checkbox"/> CPR: <input type="checkbox"/> EMT: <input type="checkbox"/> Medical Professional: <input type="checkbox"/> None: <input type="checkbox"/>															
16. Part 50 Document Control Number: (form 7000-1)				17. Union Affiliation of Victim:											