

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

COAL MINE SAFETY AND HEALTH

REPORT OF INVESTIGATION

Underground Coal Mine

Fatal Fall of Roof or Back
September 26, 2012

Double Mountain Mine
Kopper Glo Mining, LLC
Clairfield, Claiborne County, TN
ID No. 40-03365

Accident Investigators

Jack Harris
Coal Mine Safety and Health Inspector

Jim Vadnal
Geologist, Roof Control Division
Pittsburgh Safety and Health Technology Center

Kevin Doan
Roof Control Specialist

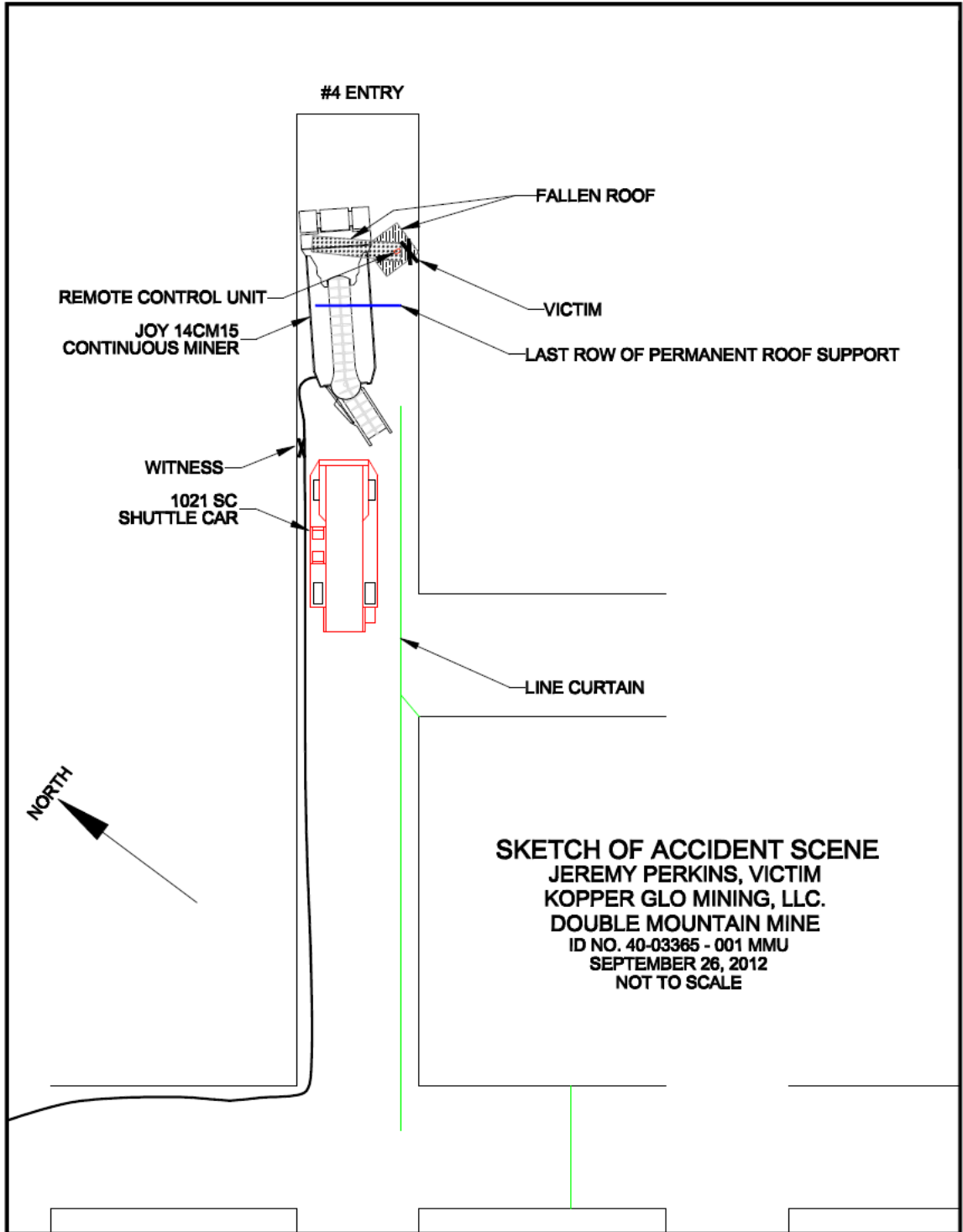
Alice Blanton
Educational Field Services

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

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ACCIDENT SITE



OVERVIEW

At 5:40 a.m. on Wednesday, September 26, 2012, a 32-year-old section foreman with 12 years of mining experience was fatally injured at Kopper Glo Mining, LLC's Double Mountain Mine. The victim received fatal injuries when a portion of the mine roof fell, pinning him to the mine floor.

GENERAL INFORMATION

The Double Mountain Mine is an underground coal mine owned and operated by Quintana Energy Partners, L.P. The mine is located in Claiborne County, Tennessee and is developed in the Rich Mountain Coal Seam. The mining height ranges from 55 to 63 inches and the mine is accessed by five drift openings. A total of 84 miners are employed on two producing sections, with two production shifts and one maintenance shift. This mine is in operation five days per week and has an average production of 2,632 tons per day. Coal is extracted from the faces with continuous mining machines and transported by shuttle cars on the 001 section and a continuous haulage system on the 002 section. Belt conveyors then transport the coal to the surface. Materials, supplies, and miners are transported via rail mounted personal carriers and rubber tired man trips.

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

Keith D. DykePresident
Ronald Helton.....Manager/Underground Operations
Robert BrandenburgSuperintendent

Prior to the accident, the Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection on September 4, 2012. The Non-Fatal Days Lost (NFDL) injury incidence rate for the Double Mountain Mine in the year prior to the accident was 5.63 compared to a National NFDL rate of 3.36.

DESCRIPTION OF ACCIDENT

On Tuesday, September 25, 2012, at approximately 10:10 p.m., five members of the 3rd shift 001 MMU section crew, under the direction of Jeremy Perkins, Section Foreman, entered the mine via rail mounted mantrip. They arrived on the 001 section at approximately 10:25 p.m. The crew began their normal work which was checking ventilation controls, scooping, rock dusting, roof bolting, and maintenance.

The #4 entry had been advanced to its intended depth and Perkins, operating the continuous mining machine, began cutting the mine roof higher than the normal

mining height in preparation for installation of a belt head drive. The right side had been cut and approximately one foot of the mine roof remained to be cut on the left side. The shuttle car, operated by Tony Asher, lost power while being loaded by the continuous mining machine at approximately 5:00 a.m. John Capps, Electrician/Repairman, was notified of the shuttle car being inoperable and determined that it was due to a splice being pulled apart in the trailing cable. Travis Slaven and Andrew Lowe, Roof Bolters, assisted Capps with the repair of the cable. Repairs to the cable were nearing completion around 5:30 a.m., when Perkins asked Asher to watch the continuous mining machine cable as he resumed cutting the mine roof. Asher stated that approximately 10 seconds had elapsed after Perkins started the continuous mining machine, when he saw the mine roof fall on Perkins who was located in by permanent roof support. The mine roof fell at approximately 5:40 a.m. Asher immediately traveled to the location of Capps, Slaven, and Lowe and advised them that Perkins had been covered up by a roof fall. Capps and Slaven went to the accident scene. Capps told Asher and Lowe to call for help and to bring timbers and crib blocks from the emergency sled. Asher called Christopher McDowell, Dispatcher, advising him they needed assistance on the 001 section and explained that Perkins had been covered up by a roof fall. McDowell proceeded to contact Ronnie Hamrick, 3rd shift 002 Section Foreman, who was conducting his pre-shift exam of the outby area of the mine. Hamrick picked up Kenneth Phillips, 002 Section Roof Bolter, who was working on the belt line and proceeded to the 001 section to provide assistance. According to interview statements Hamrick was 10 to 15 minutes away from the section when he received information of the accident.

McDowell contacted Claiborne County EMS at 5:43 a.m. and notified them of the accident. Capps and Slaven installed temporary roof support (timbers) to safely travel to Perkin's location and were in the process of lifting the rock as Hamrick and Phillips arrived approximately 10 to 15 minutes after the accident had occurred. Resuscitation was attempted after Perkins was removed from the fall. He was then placed on an emergency backboard for preparation to be transported out of the mine. Wayne Ward, 1st Shift (day shift) 002 Section Foreman, along with Mickey Gibson, 1st Shift Shuttle Car Operator, and other members of the 1st shift crew responded from the surface of the mine and arrived on the 001 section to provide assistance. Perkins was transported to the surface by Phillips, Ward, and Gibson via the combination of rubber-tired and rail-mounted mantrips. Upon arrival on the surface at 6:46 a.m., care was transferred to Claiborne County EMS. Paramedics found the victim unresponsive and they were unable to obtain any vital signs. Perkins was transported via ambulance to Claiborne County Hospital where he was pronounced dead in the emergency department at 8:30 a.m. on September 26, 2012.

INVESTIGATION OF THE ACCIDENT

The MSHA National Call Center was notified at 6:07 a.m. by Ronald Massengale that a life threatening injury had occurred at the Kopper Glo Mining, LLC's Double Mountain Mine. A noncontributing citation was issued because MSHA was not notified at once, without delay, and within 15 minutes as required by 30 CFR § 50.10. The MSHA District 7 Office was notified by the National Call Center at 6:20 a.m. A verbal 103(j) order was issued to Ronald Massengale, Safety Director at approximately 6:30 a.m. by Kevin Brunner, Jacksboro Field Office Supervisor. Jack Harris, MSHA Accident Investigator, was dispatched to the mine site. The 103(j) order was modified to a 103(k) order after MSHA arrived at the mine.

The accident investigation was conducted with assistance from the mine operator and employees. A list of persons participating in or present during the investigation is included in Appendix A.

Representatives of MSHA and the operator traveled underground to the accident site to examine the scene and begin an investigation of the existing physical conditions.

Fifteen persons were interviewed on September 27, 2012, at the Jacksboro Field Office. An additional person was interviewed on October 3, 2012, at the mine office.

DISCUSSION

The underground investigation confirmed that the reason for the shuttle car losing power prior to the accident was because a splice in the trailing cable had been pulled apart during normal mining. This was confirmed through observation of the repair work completed to the splice as well as witness testimony.

The investigation determined that at the time of the accident, the victim was located seven feet and four inches in by the last row of permanent support. The remote control for the continuous mining machine was found under the roof fall eight feet and five inches in by permanent support. The fall consisted of two pieces of rock. The rock that was directly on top of the victim measured 6 feet 6 inches long by 6 feet wide and ranged up to 8 inches in thickness. Another rock which was lying on the rock which pinned the victim, measured 14 feet, 7 inches long, by 4 feet 8 inches wide, and ranged up to 3 feet in thickness. This second rock slid down the boom of the mining machine and came to rest upon the rock

which first pinned the victim. A photograph of the accident scene is provided in Appendix C.

No other miners were located in by the last row of permanent roof support. While the victim was in by the last row of permanent roof support, Asher was at the shuttle car watching the continuous mining machine cable at a location approximately 20 feet out by the end of permanent roof support. During this time, Capps, Slaven, and Lowe, were completing the splice in the shuttle car cable and were under permanent roof support at a location approximately 75 feet away from Asher.

Evidence and testimony indicated that the victim energized and operated the continuous mining machine while he was located in by permanent support and within the machine's turning radius. Testimony further indicated that the victim had been observed traveling in by supported roof on other occasions and that other miners had told him that he should not be subjecting himself to this hazard. Employees stated during interviews that safety meetings were held on Mondays and various subjects were discussed including the hazards associated with traveling in by permanent roof support.

Evidence found during this investigation clearly indicated a failure to comply with 30 CFR § 75.202(b), which states, "No person shall work or travel under unsupported roof unless in accordance with this subpart." The mine operator also failed to comply with the approved roof control plan. On page 8 of the approved roof control plan it states in Item No.1 a) Under permanently supported roof: and b), miners are allowed to be, "No closer than the second "full row" of installed roof bolts out by the face."

Also, the approved roof control plan specifically requires that, "While using remote controls, the continuous mining machine operator and all other persons will position themselves: (c) When the continuous mining machine is in operation, in a safe location away from such machine and away from pinch points created by either the continuous mining machine and/or haulage equipment."

To alert miners of locations where permanent roof support ends, 30 CFR § 75.208 requires that such locations be posted with a readily visible warning or physical barrier. Investigators found two reflectors, installed to provide a visible warning of the end of permanent roof supports, hanging on the last row of permanent roof supports (roof bolts). The reflectors were coated with coal dust but could still be seen.

Geology

The mined material at the Double Mountain Mine normally is approximately 60 inches thick. It consisted of approximately 38 to 42 inches of coal at the bottom, and 18 to 20 inches of medium hard, dark gray, thin bedded shale containing coal plant fossils at the top. Examination of the accident site and other areas of the mine showed that this shale formed both the immediate roof and the main roof in that portion of the mine.

2 East Mains, Pillar Stability

The accident occurred in the 2 East Mains off of the 1 North Mains. Initially, five entries were developed for one crosscut at the beginning of the section. One additional entry was developed on either side of the development, making 2 East Mains seven entries wide. Entries and crosscuts were designed to be 20 ft. wide, on 80 ft. by 60 ft. centers with 90 degree crosscuts. At the time of the accident, seven entries had been driven a distance of 5 crosscuts. Cover over 2 East mains is approximately 800 ft.

Local Roof Stability

In areas where the roof was supported, there was no roof instability observed by MSHA's Technical Support Roof Control Division personnel during the accident investigation. The medium hard, dark gray, thin bedded shale formed an acceptable roof when roof bolts were installed. At the accident site, as the continuous mining machine excavated into the mine roof to develop a location for a future belt head drive, it intersected the bedding planes, allowing large slabs of shale to fall.

Training and Experience

Jeremy Perkins was hired by Kopper Glo Mining, LLC's Double Mountain Mine on May 14, 2012. He had 19 weeks and 2 days of experience at this mine. Perkins had 4 years of experience as a foreman, and 4 years of experience in operating a continuous mining machine, and 12 total years of mining experience.

A review of training records revealed that Perkins had received all required training except task training for the operation of the continuous mining machine at this mine.

Testimony indicated that Perkins had been operating the continuous mining machine prior to the shuttle car losing power. Perkins had also begun operation of the continuous mining machine when he was fatally injured by the roof fall. Prior to operation of the continuous mining machine, Perkins should have received task training on the performance of this machine in these particular

mining conditions. Perkins had previously worked at another mine where he operated a Joy 12-12 series continuous mining machine and he was operating a Joy 14 series continuous mining machine at the time of the accident. Furthermore, the previous mine also had a mining height that was in excess of 7 feet in all areas which did not require additional cutting of the mine roof for belt drive setups.

The review of training records also included a complete review of all third shift miners as well as a random check of other miners employed at this mine. No additional training deficiencies were found during this review.

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:

Root Cause: The mine operator failed to comply with the provisions of 30 CFR § 75.202(b), which requires that “No person shall work or travel under unsupported roof...” This failure directly contributed to the death of the victim.

Corrective Action: An action plan was submitted by Kopper Glo Mining, LLC on October 10, 2012, which provides that additional training with all miners will be given on the requirements of 30 CFR § 75.202(b).

The mine operator will increase the length of warning devices required by 30 CFR § 75.208 to a minimum of 15 inches long and a minimum of 3 warning devices will be required at each location. These requirements have been approved as a supplement to the approved Roof Control Plan and all miners have been trained in this plan modification.

The action plan required that a thorough record of all training listed must be kept with no more than 30 persons attending each training session.

The action plan was received and acknowledged by MSHA. The training required, as part of the action plan, was conducted and completed by the mine operator. All said training was monitored by MSHA’s Educational Field Services.

Root Cause: The mine operator failed to comply with the provisions of the approved roof control plan required under 30 CFR § 75.220(a)(1). Two provisions of the approved roof control plan were not followed. The failure to comply with these provisions directly contributed to the death of the victim.

1. While using remote controls, the continuous mining machine operator and all other persons will position themselves under permanently supported roof and no closer than the second “full row” of installed roof bolts outby the face.

2. While using remote controls, the continuous mining machine operator and all other persons will position themselves, when the continuous mining machine is in operation, in a safe location away from such machine and away from pinch points created by either the continuous mining machine and/or haulage equipment.

Corrective Action: An action plan was submitted by Kopper Glo Mining, LLC on October 10, 2012, which provides that additional training with all miners will be given on the requirements of the approved Roof Control Plan. The mine operator will explain and conduct visual demonstrations of the “Red Zone” area of the continuous mining machine as well as the requirement to be no closer than the second “full row” of installed roof bolts outby the face.

The mine operator will increase the length of warning devices required by 30 CFR § 75.208 to a minimum of 15 inches long and a minimum of 3 warning devices will be required at each location. These requirements have been approved as a supplement to the approved Roof Control Plan and all miners have been trained in this plan modification.

The action plan required that a thorough record of all training listed must be kept with no more than 30 persons attending each training session.

The action plan was received and acknowledged by MSHA. The training required, as part of the action plan, was conducted and completed by the mine operator. All said training was monitored by MSHA’s Educational Field Services.

Root Cause: The mine operator failed to comply with the requirements of 30 CFR § 48.7(a), which requires miners to be task trained when, assigned a new work task. The failure to ensure that the victim was properly task trained on the operation of the continuous mining machine directly contributed to the death of the victim.

Corrective Action: An action plan was submitted by Kopper Glo Mining, LLC on October 10, 2012, which included a plan of precautionary measures that has been approved as a supplement to the approved Roof Control Plan for implementation when cutting out for belt drives, rock dust holes, battery stations, overcasts, etc. All miners have been trained in these measures.

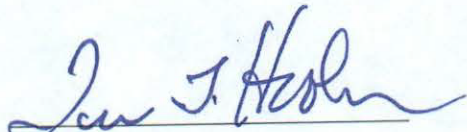
The action plan required that a thorough record of all training listed must be kept with no more than 30 persons attending each training session.

The action plan was received and acknowledged by MSHA. The training required, as part of the action plan, was conducted and completed by the mine operator. All said training was monitored by MSHA's Educational Field Services.

CONCLUSION

This accident occurred as a result of the mine operator failing to ensure that miners were complying with the requirements of 30 CFR § 75.202(b) and the related provisions of the approved roof control plan. The victim, who had not been properly task trained, was operating the continuous mining machine while located inby permanent roof support when the fall occurred, resulting in fatal injuries.

Approved By:


Irvin T. Hooker
District Manager

3/18/2013
Date

ENFORCEMENT ACTIONS

1. **A 103(j) Order, No. 8352041**, was issued over the phone verbally at approximately 6:35 a.m. on September 26, 2012, to Kopper Glo Mining, LLC.

Condition or Practice:

A fatal accident occurred at this mine on 9/26/12 at approximately 5:40 a.m. This order is being issued, under section 103(j) of the Federal Mine Safety and Health Act of 1977, to prevent the destruction of any evidence which would assist in investigating the cause or causes of the accident. It prohibits all activity at the mine until MSHA has determined that it is safe to resume normal mining operations at the mine. This order was initially issued orally to Ronald Massengale at 6:35 a.m. this date and has now been reduced to writing.

The 103(j) Order, No. 8352041, was modified to a 103(k) Order at 7:48 a.m., to ensure the safety of workers until the investigation could be completed.

Condition or Practice:

The initial Order 8352041 is modified to reflect that MSHA is now proceeding under the authority of Section 103(k) of the Federal Mine Safety and Health Act of 1977. This Section 103(k) Order is intended to protect the safety of all persons on-site including those involved in the investigation of the accident. The mine operator shall obtain prior approval from an Authorized Representative of the Secretary for all actions to restore the mine to normal operations. Additionally, the mine operator is reminded of its existing obligations to prevent the destruction of evidence that would aid in investigating the cause or causes of the accident.

2. A 104(d)(1) Citation, No. 8368398, is being issued to Kopper Glo Mining LLC for a violation of 30 CFR § 75.220(a)(1).

The mine operator failed to comply with two provisions of the approved roof control plan.

1. Item No. 1 of the approved roof control plan (page 8) states:

While using remote controls, the continuous mining machine operator and all other persons will position themselves:

- a) Under permanently supported roof; and
- b) No closer than the second "full row" of installed roof bolts outby the face.

2. Item No. 1 of the approved roof control plan (page 8) also states:

While using remote controls, the continuous mining machine operator and all other persons will position themselves:

- c) When the continuous mining machine is in operation, in a safe location away from such machine and away from pinch points created by either the continuous mining machine and/or haulage equipment.

On September 26, 2012, a mine foreman, who was operating a remote controlled continuous mining machine, was fatally injured when he was struck by a roof fall while being located inby the second full row of installed roof bolts outby the face and standing under unsupported roof in the #4 entry of the 001 MMU. The victim was remotely operating the continuous mining machine in preparation for installation of a belt head drive. The victim energized and operated the continuous mining machine while he was located inby permanent support and within the machines' turning radius.

This violation is an unwarrantable failure to comply with a mandatory standard, constituting more than ordinary negligence.

3. A 104(d)(1) Order, No. 8368397, is being issued to Kopper Glo Mining LLC for a violation of 30 CFR § 75.202(b).

As required by 30 CFR §75.202(b), "No person shall work or travel under unsupported roof... ." During a fatal accident investigation, evidence collected from the accident scene and testimony from miners interviewed during the investigation indicated that the foreman (victim) traveled inby permanent roof support for a distance of seven feet and four inches. While the foreman was located inby permanent roof support, a portion of the unsupported roof fell, killing him.

This violation is an unwarrantable failure to comply with a mandatory standard, constituting more than ordinary negligence.

4. A 104(d)(1) Order, No. 8378818, is being issued to Kopper Glo Mining LLC for a violation of 30 CFR § 48.7(a).

On September 26, 2012, a fatal fall of roof accident occurred on the 001 MMU. The victim was remotely operating a continuous mining machine when the roof fall occurred resulting in fatal crushing injuries. A review of the victim's training was conducted and the operator did not have documentation indicating that the victim had been task trained in the operation of the continuous mining machine. This violation is an unwarrantable failure to comply with a mandatory standard.

**Appendix A
Persons Participating in the Investigation**

Mining Company Officials

<u>Name</u>	<u>Title</u>
Keith D. Dyke	President
Ronald Helton.....	Manager/Underground Operations
Robert Brandenburg	Superintendent
Charles Burnett.....	Electrician
Wendell Ward.....	General Mine Foreman
Ron Massengale.....	Safety Director

State Agency

<u>Name</u>	<u>Title</u>
Oscar Fredric.....	Director Tennessee Mine Safety

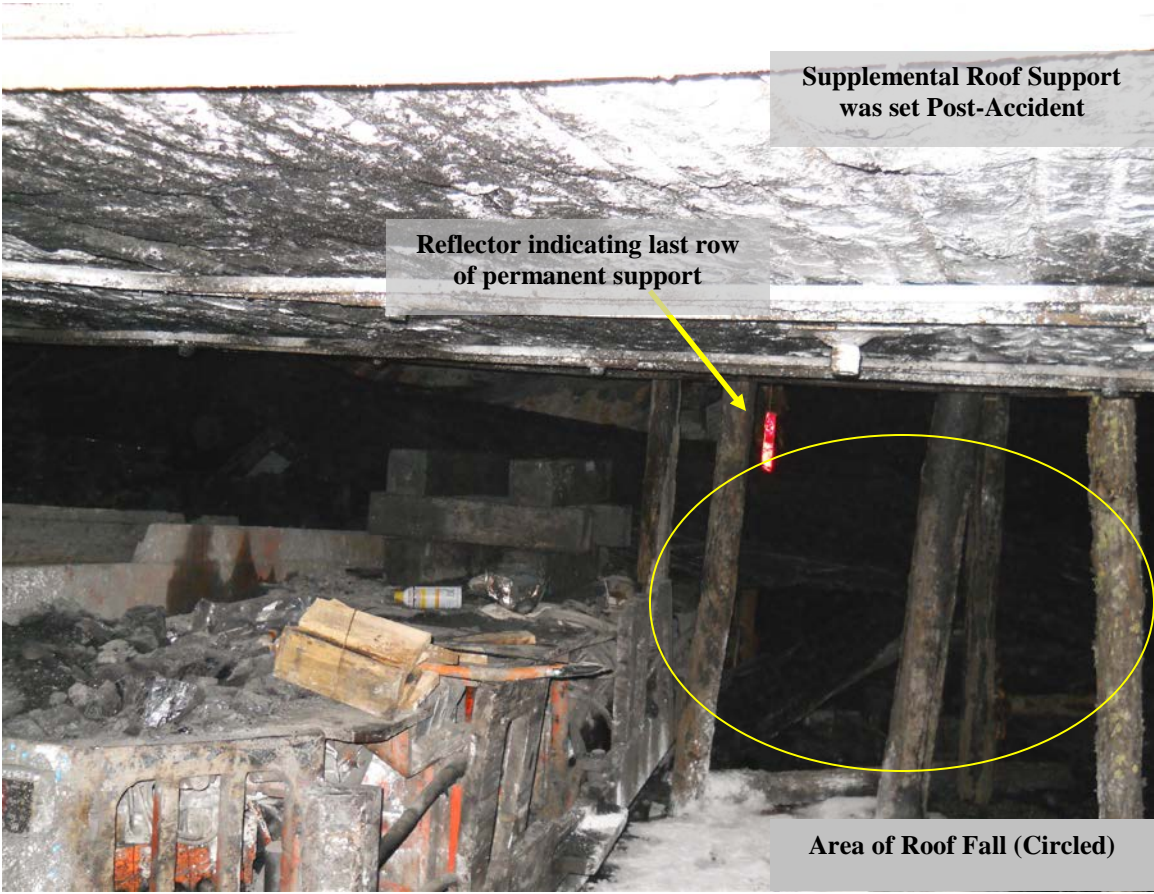
Mine Safety and Health Administration

<u>Name</u>	<u>Title</u>
Tommy Hooker	District Manager
Dennis Cotton.....	Assistant District Manager
Eddie Sparks	Assistant District Manager
Sam Creasy.....	Roof Control Supervisor
Jack Harris.....	Accident Investigator
Kevin Doan	Accident Investigator
Jim Vadnal.....	Pittsburgh Technical Support
Alice Blanton.....	EFS Specialist

Appendix B
List of Persons Interviewed

<u>Name</u>	<u>Title</u>
Eldon D. Ward.....	Foreman 002 MMU 1 st shift
Keith Marlow	Miner Operator 002 MMU 3 rd Shift
David Norris.....	Carrier Operator 002 MMU 1 st Shift
Dan Lowe	Miner Operator 001 MMU 1 st Shift
Jason Richardson.....	Electrician 002 MMU 3 rd Shift
Lester Marlow Jr.....	Foreman 001 MMU 1 st Shift
Kenneth Phillips.....	Roof Bolter Operator 002 MMU 3 rd Shift
Wendell Ward.....	General Mine Foreman 1 st Shift
Ronnie Hamrick	Foreman 002 MMU 3 rd Shift
Christopher McDowell.....	Tracking Outside 3 rd Shift
Ron Massengale.....	Safety Director
Travis Slaven.....	Roof Bolter Operator 001 MMU 3 rd Shift
Andrew Lowe.....	Roof Bolter Operator 001 MMU 3 rd Shift
Tony Asher.....	Shuttle Car Operator 001 MMU 3 rd Shift
John Capps	Repairman 001 MMU 3 rd Shift
Robert Brandenburg	Superintendent 1 st Shift

**Appendix C
Accident Scene Photograph**



Appendix D Victim Information Form - 7000-50b

Accident Investigation Data - Victim Information

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



Event Number:

4	4	5	1	8	8	6
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Victim Information: 1																																				
1. Name of Injured/Ill Employee: <i>Jeremy Perkins</i>				2. Sex <i>M</i>		3. Victim's Age <i>32</i>		4. Degree of Injury: <i>01 Fatal</i>																												
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death: <i>a. Date: 09/26/2012 b. Time: 5:40</i>						6. Date and Time Started: <i>a. Date: 09/25/2012 b. Time: 22:00</i>																														
7. Regular Job Title: <i>049 Supervisory/management/foreman/boss</i>				8. Work Activity when Injured: <i>049 Operating Continuous Miner</i>					9. Was this work activity part of regular job? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>																											
10. Experience																																				
a. This																																				
Work Activity: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><th>Years</th><th>Weeks</th><th>Days</th></tr><tr><td style="text-align: center;">4</td><td style="text-align: center;">0</td><td style="text-align: center;">0</td></tr></table> b. Regular Job Title: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><th>Years</th><th>Weeks</th><th>Days</th></tr><tr><td style="text-align: center;">4</td><td style="text-align: center;">0</td><td style="text-align: center;">0</td></tr></table> c. This Mine: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><th>Years</th><th>Weeks</th><th>Days</th></tr><tr><td style="text-align: center;">0</td><td style="text-align: center;">19</td><td style="text-align: center;">2</td></tr></table> d. Total Mining: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><th>Years</th><th>Weeks</th><th>Days</th></tr><tr><td style="text-align: center;">12</td><td style="text-align: center;">0</td><td style="text-align: center;">0</td></tr></table>													Years	Weeks	Days	4	0	0	Years	Weeks	Days	4	0	0	Years	Weeks	Days	0	19	2	Years	Weeks	Days	12	0	0
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11. What Directly Inflicted Injury or Illness? <i>090 Fall of Immediate Mine Roof</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 type="checkbox"/> CPR: <input checked="" 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)						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"/>																											
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16. Part 50 Document Control Number: (form 7000-1)						17. Union Affiliation of Victim:																														

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10. Experience																																				
a. This																																				
Work Activity: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><th>Years</th><th>Weeks</th><th>Days</th></tr><tr><td style="text-align: center;"> </td><td style="text-align: center;"> </td><td style="text-align: center;"> </td></tr></table> b. Regular Job Title: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><th>Years</th><th>Weeks</th><th>Days</th></tr><tr><td style="text-align: center;"> </td><td style="text-align: center;"> </td><td style="text-align: center;"> </td></tr></table> c. This Mine: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><th>Years</th><th>Weeks</th><th>Days</th></tr><tr><td style="text-align: center;"> </td><td style="text-align: center;"> </td><td style="text-align: center;"> </td></tr></table> d. Total Mining: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><th>Years</th><th>Weeks</th><th>Days</th></tr><tr><td style="text-align: center;"> </td><td style="text-align: center;"> </td><td style="text-align: center;"> </td></tr></table>													Years	Weeks	Days				Years	Weeks	Days				Years	Weeks	Days				Years	Weeks	Days			
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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:																														