

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 16, 2014

Mountain View Mine
Mettiki Coal WV, LLC
Davis, Tucker County, West Virginia
I.D. No. 46-09028

Accident Investigators

Franklin Thomas
Coal Mine Safety & Health Specialist (Electrical)

Stanley Skiles
Coal Mine Safety & Health inspector

Originating Office
Mine Safety and Health Administration
District 3
604 Cheat Road
Morgantown, West Virginia 26508

Carlos T. Mosley, Acting District Manager

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Photograph of Accident Scene



OVERVIEW

On Thursday, January 16, 2014, Daniel Lambka (victim), a 20-year-old general inside laborer, was struck by a coal feeder, resulting in fatal injuries. Lambka was on the off side of the belt conveyor, tightening a chain which connected the feeder to the section tailpiece. The tailpiece anchor, located between the rib and the tailpiece, came loose from the rib, allowing the tailpiece to shift, pinning Lambka between the frame of the feeder and the rib.

The cause of the accident was the mine operator's failure to block or secure the feeder against motion or have effective procedures in place to assure that miners knew the precautions to take.

GENERAL INFORMATION

The Mountain View Mine is located near Davis, in Tucker County, West Virginia. Mettiki Coal WV, LLC, a subsidiary of Alliance Resource Partners LP, operates this underground coal mine. The mine employs 180 persons, of which 156 are underground employees working two production shifts and one maintenance shift per day, seven days per week. The mine's production averages 13,500 tons per day. Coal is extracted by three advancing mechanized mining units (MMUs) using continuous mining machines and one retreating longwall unit. On developing sections, the coal is transported from the working faces by shuttle car to belt conveyors for transport to the surface. On retreating sections, the coal is transported from the working face by conveyor chain to belt conveyors. Diesel powered, rail-mounted, and rubber-tired vehicles are used to transport supplies and mine personnel.

The mine accesses the Freeport coal seam, which averages 96 inches in height, by four drift openings and two shafts. The mine liberates 13,568 cubic feet of methane every 24 hours.

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

Michael Burch General Manager, Mettiki Coal WV LLC
Terry Hanline..... Safety Director, Mettiki Coal WV LLC

A regular safety and health inspection (E01) by the Mine Safety and Health Administration (MSHA) was ongoing at the time of the accident. The previous E01 inspection was completed by MSHA on December 19, 2013. The Non Fatal Days Lost (NFDL) incident rate for this mine in 2013 was 3.80, compared to a National NFDL rate of 3.40.

DESCRIPTION OF ACCIDENT

On Thursday, January 16, 2014, the afternoon shift crew for the F-Mains Section entered the mine at 3:20 p.m., and traveled to the section. The miners were under the direction of Doug Corbin, Section Foreman. The crew was responsible for moving and advancing the conveyor belt, the feeder and tailpiece, and the auxiliary exhaust fan. The tailpiece and feeder were located between the No. 93 and No. 94 crosscuts and were to be advanced to just outby the No. 95 crosscut, a distance of approximately 140 feet. The crew arrived on the section at approximately 4:20 p.m. Corbin examined the faces and travelled the belt from the tailpiece to the power center where the crew was gathered. Corbin then made various work assignments.

Anthony Glover and William Demoss, Roof Bolter Operators, were assigned to install roof bolts and apply rock dust in the No. 3 entry. Dylan Simmons, Scoop Operator,

was assigned to supply the roof-bolting machine and assist with the belt move. Randy Murphy, Scoop Operator; Kenneth Friend; Jonathan Zinn; Aaron Friend; Bobby Morgan; and Rodney Rosier, General Inside Laborers, and Lambka were assigned to move the belt conveyor.

Rosier, Friend, and Lambka walked from the section power center to the belt entry. Murphy transported two skids of belt structure to the No. 94 crosscut, back-dragged the entry in preparation for the belt move and then attached the tailpiece to the battery-powered scoop. Although not a supervisor, Rosier acted as a crew leader and coordinated the belt move. Corbin periodically checked on the progress throughout the shift. Rosier started the belt and located a splice where the belt could be separated. He then contacted Perry McCure, Assistant Afternoon Shift Foreman, by radio and requested power to be removed and the belt to be locked out. Rosier, Friend, and Lambka began preparing for the belt move by removing the area lights, the carbon monoxide monitoring system, the waterline, the existing belt structure, and moving and re-anchoring shuttle car trailing cables. They backed the feeder inby; off the tailpiece and removed the tailpiece anchors. They trammed the feeder to the inby side of the No. 95 crosscut and rehung the feeder cable. Zinn and Friend began constructing a stopping between the belt and return entries at No. 94 block.

A roll of conveyor belt approximately 260 feet long was hung above the mine floor to remove the belt structure from a spool and the belt was placed along the rib at 10 foot intervals. The tailpiece was loaded into the scoop bucket and moved outby No. 95 block. Rosier, Friend, and Lambka installed eleven sets of belt structure between the previous feeder location and the tailpiece. They removed the conveyor belt from its spool and spliced it into the existing belt. Rosier determined three additional sets of belt structure needed to be installed between the tailpiece and the last set of installed structure. The feeder was backed onto the tailpiece and secured on each side with chains. Rosier, Friend, and Lambka installed the additional structure, three anchor posts for the tailpiece (two on the walk side and one on the tight side), the CO monitoring system, a belt crossover, area lighting, and the waterline. Rosier radioed James Bateman, Afternoon Shift Foreman, requesting that power be restored for the belt to set up the belt take up.

Demoss and Glover completed their roof bolting assignment and were assisting with the construction of the stopping. Rosier, Kenneth Friend, and Lambka travelled down the belt line, observed a dip in the belt, and raised it. Bateman radioed Rosier and told him the belt take-up was set and that the power was restored on the belt, and instructed him to radio Gary Steyer, Hoist Operator, to start the F-Mains No. 2 belt. Rosier radioed Steyer to start the belt and yelled that the belt was about to start. Morgan was attending the pull cord/key switch immediately outby the tailpiece. As the belt conveyor started, Rosier travelled inby toward the tailpiece where Lambka and Kenny Friend were waiting to align it. The belt did not reach full speed when Rosier noticed

slack in the chain connecting the feeder to the tailpiece on the off side of the belt and asked "someone to tighten it." Lambka travelled a short distance inby and started to tighten the chain. At approximately 9:00 p.m., as he started to tighten the chain, the off side tailpiece anchor post came loose, causing the tailpiece to pull against the feeder, shifting it, and pinning the victim between the rib and the frame of the feeder. His coworkers recognized Lambka was pinned and yelled for Morgan to shut down the belt.

Rosier instructed Glover to get one of the shuttle cars and use a chain to pull the feeder away from the rib. Glover pulled a shuttle car up to the feeder, connected to the feeder with a chain, and attempted to free Lambka. The one half-inch chain was too small and broke. Also during this time, Simmons attempted to tram the feeder with the manual tram but it would not tram due to the tension on the belt. A larger chain was available, but there was no hook to attach the chain to the feeder. Rosier left the area and went to the intake entry to the refuge alternative where he believed a hook was located. He phoned Steyer and informed him of the accident and requested an ambulance. Rosier was not able to locate a hook and travelled back towards the belt entry to the feeder. Corbin had completed an examination of the section, travelled to the power center and back into the belt entry at No. 92 block. He heard persons yelling near the feeder and headed towards it. Corbin climbed on top of the feeder and attempted to communicate with Lambka. Corbin recognized the amount of tension on the belt and gave instructions to cut the belt. The belt was cut, which took tension off the feeder. A hook was located and a chain attached to the shuttle car which pulled the feeder away from the victim. Lambka collapsed to the mine floor. Simmons and Corbin carried Lambka to the front of the feeder. Zinn and Rosier checked for vital signs, but none were detected. Corbin attempted cardiopulmonary resuscitation (CPR), but was unsuccessful. Simmons and Corbin retrieved the EMT supplies and connected an automated external defibrillator (AED) device which advised no shock. CPR was continued until Kevin White, EMT and Bateman arrived. The victim was placed onto a backboard and transported to the surface by mobile utility vehicle (MUV). CPR was continued until the victim arrived on the surface where the Tucker County Ambulance Service assumed care. Lambka was transported to Davis Memorial Hospital where he was pronounced dead upon arrival by Dr. Heather Harper, State Medical Examiner.

INVESTIGATION OF THE ACCIDENT

The MSHA Emergency Call Center was notified of the accident on January 16, 2014, at 9:05 p.m., who then notified Greg Fetty, District 3 Staff Assistant, who issued a 103(j) order by telephone that was later modified to a 103(k) order upon MSHA's arrival at the mine site. He notified District 3 personnel and then notified MSHA Headquarters.

Stanley Skiles, MSHA Coal Mine Safety and Health Inspector, initiated an investigation immediately. The investigation was conducted in conjunction with mine management and the West Virginia Office of Miners Health, Safety and Training (WVOMHST).

Upon arriving at the mine, Skiles was briefed regarding the circumstances of the accident. The parties agreed to conduct interviews with miners having knowledge of the accident prior to traveling underground. After the interviews were completed, the parties traveled underground to the accident site and began the physical investigation. A preliminary investigation of the accident scene included digital photographs of the accident area. Franklin D. Thomas, Coal Mine Safety and Health Specialist (Electrical), and Fetty travelled to the mine and collected additional information on Friday, January 17, 2014.

DISCUSSION

Accident Scene

The accident occurred on the F-Mains-2 Continuous Mining Machine Section (MMU-002), a three-entry system that began production on June 25, 2013. Mining height varies between 96 and 120 inches. Coal blocks are staggered during development mining and typically mined on 150-foot centers. The belt conveyor is advanced after each block is mined.

General Machine Information

The feeder involved in the accident was manufactured by Oldenburg Stamler Group, Inc., (Model No. BF-14-37-74C, Serial No. 13746). The feeder is self-propelled and positioned either by an umbilical cord remote control or by controls mounted on the frame. The tailpiece was manufactured by Fairfax Machine, located in Davis, West Virginia, and does not have a serial number or model number. Both pieces of equipment were inspected during the accident investigation and no deficiencies were found.

Belt Move Procedures

The company has written and established standard operating procedures for belt conveyor moves. Information obtained during interviews revealed that the established procedures were not followed. Specifically, the established procedures require anchoring of the feeder with four jack pipes or posts. The accident investigation revealed that two posts were installed on the walkway side of the feeder, but only one post was installed on the solid rib side. Additionally, the mine operator's belt move procedures did not prohibit persons between the feeder and the rib during the initial startup of the belt.

Anchoring the Tailpiece and Feeder

The mine operator uses five-inch by seven-inch wooden posts to anchor the tailpiece to the rib. Wooden posts are generally reused unless damaged. The physical inspection of the accident scene revealed the notch for the anchor post on the solid side rib was 5 to 6 inches deep by 10 inches high. The anchor post measured 73 inches in length and was secured to the rib with wooden cap wedges. Company procedures do not specify a minimum distance in which the anchor posts for the feeder must extend into the rib.

Training and Experience

Lambka received experienced miner training on September 17, 2013. He had approximately two years of experience as a miner and 18 weeks of experience at this mine as a general inside laborer (See Appendix C). The accident investigation team reviewed the training records for the victim.

ROOT CAUSE ANALYSIS

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

Listed below are the root causes identified during the analysis and the corresponding corrective action being implemented to prevent a recurrence of the accident.

Root Cause:

The mine operator failed to assure the newly moved tailpiece was secured and blocked against shifting prior to starting the belt conveyors. The mine operator did not have effective procedures in place to assure that miners knew the precautions to take and were trained in initial start-up of the belt.

Corrective Action:

The mine operator revised its standard operating procedures to require the installation of four posts, hitched into the ribs at least 8 inches deep, and two flag pins anchored into the mine floor at least 3 feet deep and secured to the tailpiece with a chain to prevent motion of the feeder. The mine operator trained all affected miners regarding the revised installation procedures (See Appendix D, Revised Belt Installation Procedures).

Root Cause:

The mine operator failed to assure persons were clear of the belt tail area during the startup of the belt conveyors.

Corrective Action:

The mine operator revised its standard operating procedures to require persons to remain one block outby during the initial startup of the belt and trained all affected miners regarding the provision (See Appendix D, Revised Belt Installation Procedures).

CONCLUSION

The accident was caused by the mine operator's failure to block or secure the feeder against motion prior to starting the belt conveyor. The operator did not have effective procedures in place to assure that miners knew the precautions to take and were trained in initial start-up of the belt.

Carlos Mosley
Carlos T. Mosley
Acting District Manager

5-12-14
Date

ENFORCEMENT ACTIONS

1. A 103(k) Order was issued to ensure the safety of the miners until the investigation could be completed.
2. A safeguard notice was issued to the mine operator for 30 CFR §75.1403:
A fatal accident occurred at this mine on January 16, 2014, when a miner was struck by a coal feeder during a belt move on the F-Mains No. 2 section. The accident investigation revealed the mine operator failed to properly anchor and block the feeder against motion prior to start-up. Just as the belt started, the victim was instructed to tighten slack in a chain connecting the tailpiece to the feeder on the off side of the belt. As the victim started to tighten the chain, the off side tailpiece anchor loosened, causing the tailpiece to pull against the feeder, shifting it and pinning the victim between the rib and the frame of the feeder. This mine uses mobile tailpieces and coal feeders to transport coal from the working sections outby as part of the production process. Failure to adequately anchor the coal feeders presents the potential for injury to miners travelling or working between the tailpiece or feeder and the rib.

This is a Notice to Provide Safeguards requiring the mine operator to: Securely anchor each tailpiece at this mine prior to start up. When an "engineered" tailpiece is used, the tailpiece will be securely anchored with two inby jacks notched at least 8" into the coal rib and the jacks will not be able to extend past 30 to 60 degree angle range with the tailpiece. The jacks will be locked into place with pins and the stiff-arms, once anchored. When not using an engineered tailpiece, the tailpiece will be securely anchored with two inby jacks or posts and two flag pins. The inby jacks or posts will make 30 to 60 degree angles with the belt tailpiece, posts will be notched 8" into the coal rib, and flag pins will be installed inby the tailpiece, a minimum of 3 feet into the ground, and the tailpiece securely chained to them. All personnel shall be clear of the belt tail area, and outby the belt tail for at least one block or in a crosscut, at the initial start-up of the belt. After the initial start-up of the belt, miners may train the belt and assure it is dumping and running correctly. Once the belt has been ensured to be running correctly, two outby jacks or posts will be set.

APPENDIX A - Persons Participating in the Investigation

Listed below are the persons furnishing information and/or present during the investigation:

MINE SAFETY AND HEALTH ADMINISTRATION

Gregory Fetty..... Supervisory Coal Mine Safety & Health Specialist
Frank Thomas..... Coal Mine Safety & Health Inspector (Electrical)
Stanley Skiles Coal Mine Safety & Health Inspector

WEST VIRGINIA OFFICE OF MINERS, HEALTH, SAFETY AND TRAINING

Ed Peddicord Inspector at Large
Barry Fletcher Inspector

MINING COMPANY OFFICIALS

Mike Burch..... General Manager
Kenny Murray Vice President, Alliance Coal
Terry Savage Manager of Safety and Human Resources
Terry Hanline..... Safety Director

APPENDIX B - Persons Interviewed

Doug Corbin	Section Foreman
Rodney Rosier.....	General Inside Laborer
Kenny Friend	General Inside Laborer
Randy Murphy	General Inside Laborer
Anthony Glover.....	Roof Bolter Operator
William Demoss	Roof Bolter Operator
Dylan Simmons	General Inside Laborer
John Phillips.....	Emergency Medical Technician

APPENDIX C - Victim Information

Accident Investigation Data - Victim Information

U.S. Department of Labor



Mine Safety and Health Administration

Event Number: 6 2 5 9 5 9 8

Victim Information: 1

1. Name of Injured/ill Employee: Daniel Lambka		2. Sex: M	3. Victim's Age: 20	4. Degree of Injury: 07 Fatal	
5. Date(MWDD/YY) and Time(24 Hr.) Of Death: a. Date: 01/16/2014 b. Time: 21:10			6. Date and Time Started: a. Date: 01/16/2014 b. Time: 15:00		
7. Regular Job Title: 016 General Inside Laborer		8. Work Activity when Injured: 008 Tightening a Belt Chain		9. Was this work activity part of regular job? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
10. Experience a. This Work Activity: 2 20 0		b. Regular Job Title: 0 78 0		c. This Mine: 0 16 0	
11. What Directly Inflicted Injury or Illness? 077 Underground mining machines		12. Nature of Injury or Illness: 170 Crushing			
13. Training Deficiencies: Hazard: New/Novely-Employed Experienced Miner: Annual: Task:					
14. Company of Employment (if different from production operator) Operator			Independent Contractor ID: (if applicable)		
15. On-site Emergency Medical Treatment: Not Applicable First-Aid: CPR: <input checked="" type="checkbox"/> EMT: <input checked="" type="checkbox"/> Medical Professional: None:					
16. Part 50 Document Control Number: (form 7000-1) 220140210076			17. Union Affiliation of Victim: 9999 None (No Union Affiliation)		

APPENDIX D - Revised Belt Installation Procedures



January 17, 2014

Mr. Robert Cornett
District Manager
MSHA District 3
604 Cheat Road
Morgantown, WV 26508

Mountain View Mine
ID# 46-09028

Dear Mr. Cornett,

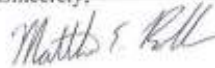
Mountain View Mine is hereby requesting to proceed with work on the F-Mains developmental section. The mine will carry out the following actions:

1. All Developmental Section tailpieces will utilize 2 Inby Jacks or Posts on 30 - 60 degree angles and notched at least 8" into the coal rib, 2 Inby Flag Pins driven a minimum of 3" into the mine floor, and 2 Outby Jacks or Posts against the coal rib.
2. All Miners will be trained on Mountain View Mines's revised Developmental Section Belt Installation Procedure prior to their next scheduled shift, and a record will be made.

Mountain View Mine's Belt Installation Procedure, and a sketch of the correct section developmental tailpiece anchoring have been attached.

Thank you in advance for your prompt attention to this matter; if additional information is needed, please feel free to call me at any time.

Sincerely,



Matthew Robb

293 Table Rock Road - Oakland, Maryland 21550
An Equal Opportunity Employer
Phone (304) 259-4925
Fax (304) 259-4262

Mountain View Mine's

Developmental Section Belt Installation Procedure

1. Make visual examination of belt entry, ensuring that all slip, trip, and fall hazards have been removed. Make sure belt entry has been scooped in belt move area.
2. Clean feeder
3. Lock and tag out the belt at the drive.
4. When moving the feeder, use the remote box. Never stand beside feeder while tramping.
5. Install structure (lined and leveled).
6. Securely anchor tailpiece with 2 inby jacks or posts and 2 flag pins.
 - a. Inby jacks or posts will make 30 to 60 degree angles with the belt tailpiece.
 - b. Posts will be notched 8" into the coal rib.
 - c. Flag pins will be installed inby the tailpiece, a minimum of 3' into the ground, and the tailpiece securely chained to them.
7. Set the feeder over the tailpiece where it will dump correctly, and in the center of the belt. Feeder is to be set solidly to the ground with stabilizing jacks up.
 - a. Ensure feeder discharge boom is set solidly on the tailpiece. Use crib and/or capping material, if needed.
 - b. Secure safety chains from feeder to the tailpiece.
8. Ensure that the tail roller is guarded.
9. Person performing the belt work will unlock the belt and re-energize the Belt Drive. Ensure all personnel are clear of the belt tail area, and outby the belt tail for at least one block or in a crosscut, at the initial start-up of the belt.
10. Train the belt and make sure it is dumping and running correctly.
11. Once the belt has been ensured to be running correctly, the 2 outby jacks or posts will be set.

Anchoring of Tailpiece

(Sketch: Not to Scale)

