CAI-2014-15

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

COAL MINE SAFETY AND HEALTH

REPORT OF INVESTIGATION
(Underground Coal Mine)

Fatal Machinery Accident
December 16, 2014

Highland 9 Mine
Highland Mining Company LLC
Waverly, Union County, Kentucky
ID No. 15-02709

Accident Investigators

Adam Carlisle
Mine Safety and Health Inspector/Lead Investigator

Archie Coburn
Mine Safety and Health Inspector

Originating Office
Mine Safety and Health Administration
District 10
100 YMCA Drive
Madisonville, KY 42431

Robert Simms, District Manager

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OVERVIEW

On Tuesday, December 16, 2014, at approximately 10:55 a.m., Eli Eldridge (victim), a 34 year-old unit repairman, was fatally injured while traveling in the No. 7 entry on the No. 6 unit (MMU 067-0). The victim was walking across the No. 6 unit when he was struck by a coal hauler.

The accident occurred because management failed to provide adequate engineering controls, administrative controls, and acceptable work practices, to protect miners from the hazards of being struck by mobile equipment.

GENERAL INFORMATION

The Highland 9 Mine, I.D. 15-02709, is located in Waverly, Union County, Kentucky on French Road, approximately two miles west of US HWY 60. At the time of the accident, the mine employed 474 people, of which 450 worked underground. The mine is accessed via an intake slope. The mine also has one intake and two return air shafts. The mine is ventilated by two exhausting main fans, which are connected to the mine via vertical shaft openings from the coal seam to the surface. The mine operates 3 shifts per day, 6 days a week in the KY No. 9 coal seam. The seam averages 5½ feet in height. The mine produces 24,000 tons per day during two ten-hour production shifts and one eight-hour maintenance shift. The miners are represented by the United Mine Workers of America (UMWA).

Coal is extracted from the working faces with Joy continuous mining machines using battery-powered coal haulers and Flexible Conveyor Trains (FCT) to a conveyor belt that carries coal to the surface. An overland conveyor belt transports the coal from the Highland 9 Mine to the Camp 9 preparation plant where it is processed and then transported by an overland conveyor belt to the Patriot Coal Company Ohio River Terminal.

Although there was an ongoing inspection at the time of the accident, the last regular health and safety inspection, E01, by the Mine Safety and Health Administration was completed on September 23, 2014. The Non-Fatal Days Lost, (NFDL) rate for this mine in 2014, was 6.49. The NFDL rate for the Nation, for mines of this type in 2014, was 3.27.

The principal officers at the Highland 9 Mine at the time of the accident were:

Robert Bosch……President, Highland Mining Company
Les Hawkins……General Mine Superintendent
Brad Carlisle……Chief Maintenance Supervisor
Randy Duncan…….Safety Director
Andy Fields…….Regional Safety Director, Patriot Coal Corp.

DESCRIPTION OF THE ACCIDENT

Eldridge started his shift on Tuesday, December 16, 2014, at approximately 7:00 a.m. at the Highland 9 Mine. He attended the morning safety meeting conducted before miners traveled underground. He then traveled underground at 7:15 a.m., via the slope mantrip with his regular crew. Eldridge departed from the slope bottom at 7:24 a.m., operating a diesel service truck to the No. 6 section, arriving at the coal producing unit at 7:47 a.m. This unit is located at the Sixth Panel South off the Third

Main East. The remainder of the No. 6 unit crew traveled separately on a diesel mantrip to the section, arriving at 7:45 a.m.

Neil Caudill, Section Foreman, conducted an examination of the work areas on the unit. He determined that work started by the previous shift on ventilation controls and rib support had to be completed before coal production could begin. Caudill assigned specific work tasks to miners. These tasks included completing a brattice (ventilation control) at 3+20 between the No. 5 and No. 6 entries and installing rib bolts in the No. 6 entry, between crosscuts 2+40 and 3+20. After completion of these tasks, mining on the section began in the No. 6 left entry with the No. 1 left side continuous mining machine.

At approximately 8:45 a.m., Eldridge assisted Jim Courtney, Maintenance Foreman and Danny Young, Maintenance Foreman, in repairing the No. 2 continuous mining machine located on the right side of the section. After repairs were completed, the right side continuous mining machine was moved to the No. 7 right entry.

When mining was completed in No. 6 left entry with the No. 1 continuous mining machine, Eldridge and Caudill assisted Brian Looney, Left Side No. 1 Continuous Mining Machine Operator, move the machine to the No. 3 left entry. Eldridge then changed a defective water spray nozzle in the continuous mining machine drum before leaving the area.

The right side No. 2 continuous mining machine then began mining in the No. 7 right entry at approximately 10:35 a.m. Each coal hauler received a load of coal, except the No. 26 coal hauler operated by Wesley Coots. Coots was parked in the crosscut, between the No. 6 and No. 7 entries at crosscut 4+40, waiting for the No. 27 coal hauler, operated by Patrick Baker, to travel outby before he could pull into the No. 7 entry and proceed to the continuous mining machine (See Appendix C Figure 2).

While the coal haulers were waiting, Eldridge walked to the No. 29 coal hauler, operated by David Dukes, and asked if the tire had been changed. It was learned during the investigation that this tire needed to be replaced due to torn tread. This had been reported to Eldridge on a prior occasion. After a brief conversation, Eldridge proceeded through the ventilation curtain and Dukes lost sight of him. Eldridge stopped and sat on the off-side of the No. 26 coal hauler, to ask Coots if he had any problems or oil leaks on his coal hauler. While Eldridge was sitting and writing notes in his book, the No. 27 coal hauler traveled back toward the dumping point. Coots told Eldridge that he had to go get a load. As Eldridge traveled by the battery end of the coal hauler, heading inby in the No. 7 entry, he asked Coots if he was going down (outby) the No. 7 entry. Coots said he was. At this point, Coots lost sight of Eldridge and pulled his coal hauler outby in the No. 7 entry. Coots, then stopped, changed directions, and began traveling inby in the No. 7 entry with

loading end first to the No. 2, right side continuous mining machine. Coots traveled inby approximately 10 feet when he heard an unusual sound. He immediately stopped the coal hauler using the service brakes. Realizing that Eldridge had been struck by the coal hauler, Coots began yelling for help. Terry Steeley, No. 28 Coal Hauler Operator, and Dukes traveled on foot to the accident scene and saw Eldridge's leg from beneath the No. 26 coal hauler.

Steeley and Coots ran to the mine phone located near the power center and Steeley called outside for help. Carlos Ewing, No. 2 Continuous Mining Machine Operator; Mike Jones, No. 1 Scoop Operator; Shawn Howard, No. 8 Roof Bolting Machine Operator; and Brian Looney arrived at the accident scene. Dukes asked Looney to go get the section foreman and Brandon LaMond, Production Coordinator, who was already on the section as part of his normal routine. At approximately 10:58 a.m., Howard checked Eldridge for a pulse and reported to the group that he could not detect a pulse.

LaMond and Caudill arrived at the accident scene at approximately 11:05 a.m. From observation and report of no pulse, they realized Eldridge was deceased. LaMond asked Caudill and the rest of No. 6 unit miners to leave the area. LaMond went to the mine phone to notify mine management of the accident and to have them call for EMS personnel and notify MSHA. At approximately 11:40 a.m. LaMond sent Coots outside with another miner to aid him. At approximately 11:45 a.m., LaMond, Darrin Browning, Maintenance Foreman, and Young pulled Eldridge from beneath the coal hauler and placed him on a stretcher. Eldridge was then transported out of the mine. At 12:23 p.m. Eldridge arrived on the surface and was loaded into the awaiting ambulance.

The Union County Coroner determined that the victim died instantly when the accident occurred at 10:55 a.m.

INVESTIGATION OF THE ACCIDENT

At 11:09 a.m., on Tuesday, December 16, 2014, Andy Fields, Regional Safety Director, Patriot Coal Corp., notified Ron Burns, Technical Assistant District Manager, an accident had occurred at the mine property on the No. 6 unit. Fields stated that an employee has been hit by a coal hauler and an ambulance was on the way to the mine. Fields said he did not know the extent of his injuries. At 11:15 a.m., Burns issued a verbal 103(j) order to Fields, to insure the safety of the miners, and to preserve evidence. Burns dispatched an investigation team to the mine.

Jeff Winders, Coal Mine Safety and Health Inspector, was underground at the mine conducting inspections at the time of the accident. Winders was notified of the accident by mine management at approximately 11:25 a.m. Winders traveled to the

accident scene with Josh Gibson, Highland Safety Department. After Winders arrived at the accident scene he issued a 103(k) order to Gibson, secured the accident scene, and took pictures and measurements of the accident scene. The 103(k) order issued by Winders was later vacated because Burns had already issued the 103(j) order. The 103(j) order was later modified to a 103(k) order by Carlisle when he arrived at the mine.

Various MSHA personnel including Bill Barnwell, Enforcement Assistant District Manager; Curtis Hardison, Field Office Supervisor; and Archie Coburn and Adam Carlisle, Accident Investigators, traveled to the mine. Carlisle and Coburn, along with inspectors from Kentucky Division of Mine Safety (KDMS) conducted interviews with witnesses of the accident. The investigation party was comprised of Carlisle, Coburn, Barnwell and Hardison, along with the Kentucky Office of Mine Safety personnel, the company officials, and union representatives of the miners (see Appendix A). The investigation party traveled underground to begin the scene investigation.

On Wednesday, December 17, 2014, Carlisle and Tim Fugate, Chief Accident Investigator, Kentucky Division of Mine Safety, conducted formal interviews of the witnesses at the Kentucky State Office building in Madisonville, Kentucky. Also present during the formal interviews were representatives of Highland Mining Company, the UMWA, and Malia Holzberger, Solicitor for MSHA (see Appendix B).

On December 18, 2014, Carlisle, Coburn, and Abe DeLeon, Supervisory Inspector, returned to the mine to take additional photos of the area and to recreate the accident seen.

On December 21, 2014, Carlisle, Coburn, and DeLeon, returned to the mine and accompanied Dustin Hinchman and Justin A. Daniels, Engineers from MSHA Approval and Certification Center. The group performed an equipment illumination survey and an electrical examination on the coal hauler involved in the accident.

DISCUSSION

Coal Haulage

On the coal producing units that utilize battery-powered coal haulers, a unique system of haulage is used to facilitate loading and minimize routes of travel. The coal hauler operator's seat is on the battery end of the coal hauler. Typically, the coal hauler will travel in the direction of the battery end. Each coal hauler runs in a circular route that begins at the dumping point and continues to the continuous mining machine where it is loaded with coal and then returns to the dumping point. The coal is unloaded at the dumping point, and then carried by belt conveyor to the surface. In this circular route of travel, the coal hauler operator must change the direction of travel prior to receiving or dumping a load of coal. This puts the machine loading end either at the continuous mining machine to load coal or at the dumping point to unload coal. To accomplish this task, the coal hauler operator travels through a crosscut, battery end first into the connected entry, turns and then proceeds to the continuous mining machine. Once loaded, the operator will tram the coal hauler to the dumping point, battery end first, into a crosscut and back into the entry with the loading/dumping end toward the dumping point (see Appendix C, Figure 1).

Accident Scene

The accident occurred on the right side of the No. 6 unit (MMU 067-0) in the No. 7 entry, approximately 6 feet inby the inby left corner of crosscut 4+40 (see Appendix C, Figure 3). The mine floor in the area of the accident scene had irregularities. This was created when the continuous mining machine cut into the mine floor when developing the right crosscut. Although the coal height was 5½ feet, the actual mining height fluctuated up to 84 inches because of loose roof, soft mine floor, and cutting by the continuous mining machine operator. The uneven floor began in the No. 7 entry intersection at crosscut 4+40 and extended into the right crosscut toward the No. 8 entry. This uneven floor presented itself as a very large pot hole with sloping side walls. The hole was sloped from the left to right side in the No. 7 entry, and extended into the right crosscut. At the location of the accident, the No. 7 entry measured 18' 6"wide and 7' in height.

When investigators arrived at the accident scene, the No. 26 coal hauler was located in the intersection of the No. 7 entry at crosscut 4+40. The loading end of the coal hauler was located twenty five inches from the left inby rib (see Appendix C, Figure 4). The battery end of the coal hauler was angled toward the right outby rib corner into the hole cut in the mine floor. The right corner of the coal hauler machine batteries were located thirteen inches from the rib corner.

The investigators determined the accident occurred as the coal hauler was traveling out of the left crosscut into the No. 7 entry to align the loading end for travel to the continuous mining machine.

The coal haulers were traveling through the hole cut into the mine floor in the No. 7 entry intersection. This caused the machine to tilt to the right on the operator's side, raising the left corner of the bed as the coal hauler traveled through the intersection (see Appendix D). The elevated position of the bed contributed to the hazard and limited visibility for the coal hauler operator. After it was determined that the coal haulers had difficulty passing through the area, further grading was performed in the area of the intersection to reduce the slope of the grade. No other corrections had been made to reduce the hazard of reduced visibility in the intersection.

Equipment

The No. 26 battery-powered coal hauler involved in the accident was manufactured by Caterpillar, model number LAR816, serial number 816-1151 and had MSHA approval number 18-A060013-0. The coal hauler was put into service at Highland 9 Mine on August 6, 2012, after being transferred from a mine in West Virginia. The coal hauler measured 38 feet and 10 inches in length, 12 feet wide, and a maximum canopy height of 84 inches.

Testing and Examination

The No. 26 coal hauler was examined by the investigation team and functional tests of the braking and steering systems were performed at the accident scene. No operational irregularities or deficiencies were observed or detected during the functional testing.

Strobe Light

Information obtained during the accident investigation revealed that the victim had a personal strobe light. The strobe light was attached to the front lower portion of his belt suspenders. The interviews indicated that the victim did not have his strobe light turned on at the time of the accident. The strobe light worked properly when it was tested. During the investigation, it was determined that the location of the victim's strobe light would have been ineffective to warn the coal hauler operator due to the raised position of the bed when the victim was struck.

Previous Accident

This fatal accident involving the No. 26 coal hauler is the second serious accident, and the first fatality, where a battery-powered coal hauler was being operated on an active mining section at the Highland 9 Mine. The first injury accident occurred on December 5, 2013, when a miner, while walking beside a de-energized coal hauler, walked through a ventilation curtain where the coal hauler was parked beneath the curtain. Not realizing that the miner on foot had not cleared the coal hauler, the coal hauler operator started the coal hauler and engaged the steering, which pinned the miner between the machine's bed and coal rib, breaking his leg.

Training and Experience

Eldridge had 15 years of underground mining experience. Eldridge received his Kentucky underground mining card on July 8, 1999. He received his Kentucky underground mine foreman certification on October 28, 2010. He had also received his electrical worker certification from the State of Kentucky. A non-contributory citation was issued to the mine for not having a record showing that Eldridge had received task training as a unit repairman. An examination of the company training records indicated Eldridge last received the required 8-hour annual refresher training for underground miners on November 18, 2014. Eldridge had been employed at the Highland No. 9 mine for 35 weeks. He received his mine specific training on March 17, 2014.

Coots earned his underground miners certification on September 21, 2004. He had 8 years of underground mining experience at the time of the accident. Coots began his employment at Highland Mine on December 16, 2013, and received his mine specific training December 16, 2013. Coots' received annual refresher training for underground miners on November 11, 2014.

The investigation revealed that the mine had no record of the required task training on the safe operation of the coal hauler. After questioning Coots, the section foreman, and other miners on the section, it was determined that Coots had been task trained properly on the coal hauler and had demonstrated that he could operate that piece of equipment safely. Coots had been the operator of a coal hauler for approximately 2 months on this section, at the time of the accident. Coots had previous coal hauler and shuttle car operating experience on other sections at Highland 9 Mine as well as at other coal mines. A citation was issued for the mine operator not having a record of task training for Coots. Also, a citation was issued to the mine operator for seven other miners assigned to the section for not having a record of task training. These citations were considered non-contributory to the accident.

ROOT CAUSE ANALYSIS

An analysis was conducted to identify the underlying cause or causes of the accident that were correctable through reasonable management controls. Listed below are the root causes identified during the analysis and the corrective actions implemented to prevent recurrence of the accident.

Root Cause: The mine operator did not have effective engineering controls, policies, programs, or procedures to protect miners on the working section from the hazards of being struck by battery-powered coal haulers and the mine operator had not trained the miners on engineering controls, policies, or procedures.

Corrective Actions: Commercially available and permissible engineering controls, such as proximity detection devices, cameras, or other engineering controls, will be installed on the coal haulers to protect the miner from the hazards of battery-powered haulage equipment operating on the working sections. The miners will be trained on the installed engineering controls.

Root Cause: The mine operator did not have effective policies, programs, or procedures that assure all miners properly utilize the personal strobe light issued to the miners and that the miners were trained.

Corrective Actions: All miners will be provided a personal strobe light. The strobe lights shall be worn when traveling by foot inby the loading point on all working sections. The strobe light shall be positioned on the rear of the miners' hard hat or the upper third of the miners back to ensure maximum visibility. The strobe lights shall be turned on while miners are traveling by foot inby the tail piece and shall be properly maintained at all times. All miners were trained on the use of personal strobe lights.

Root Cause: The mine operator did not have effective policies, programs, or procedures that assure all miners on the working section had an effective means to communicate their presence on the unit, intended activities, and routes of travel and that the miners were trained.

Corrective Actions: The mine operator provided all miners working or traveling inby the loading point with two-way radios to use to communicate their presence on the unit, their intended activities, and route of travel. All miners were trained in the use of the two-way radios.

Root Cause: The mine operator did not have effective policies, programs, or procedures that assure all miners on the working section operating mobile equipment adequately communicated to other miners their intentions to move the equipment or change direction of travel and that the miners were trained.

Corrective Actions: The mine operator has instituted a policy that all rubber-tired equipment operators on the working section shall sound an audible warning device

before tramming the equipment in any direction. All affected miners were trained on the use of the audible warning devices established by the mine operator for use.

CONCLUSION

The accident occurred because the mine operator failed to provide adequate engineering controls, administrative controls, and acceptable work practices to protect miners from the hazards of being struck by mobile equipment.

In addition, the mine operator failed to maintain the condition of the mine floor free of preventable bottom irregularities. The bottom irregularities present in the intersection of the No. 7 entry greatly reduced the coal hauler operator's field of view, until the coal hauler was clear of the bottom irregularities.

Approved By:

_____ _____

Robert A. Simms **Date**
District Manager

ENFORCEMENT ACTIONS

A 103(j) Order, No. 9043105, was issued to protect the miners and to help preserve the accident scene. It affected everything inby the No. 6 unit loading point. Carlisle modified the 103(j) order to a 103(k) order upon his arrival at the mine site.

Four Notices to Provide Safeguards were issued to the mine to protect miners on all sections from being struck and injured by mobile equipment in the future.

1. Safeguard No. 9043109, was issued citing 30 CFR § 75.1403 on December 12, 2014. This is a notice to provide safeguard(s) that engineering controls be installed on all battery-powered coal haulers that operate on any working section at this coal mine. Engineering controls, such as proximity detection devices, cameras, or other engineering controls which are permissible and commercially available will be installed to protect the miner from the hazards of battery powered haulage equipment operating on the working section. Drivers of rubber-tired mobile equipment and persons walking on foot cannot maintain visual contact and/or oral communication with each other at all times which creates the hazard of persons being struck by rubber-tired mobile equipment.

2. Safeguard No. 9043110, was issued citing 30 CFR § 75.1403 on December 12, 2014. This is a notice to provide safeguard(s) that all miners be provided a personal strobe light. The strobe lights shall be worn when traveling by foot inby the loading point on all working sections. The strobe light shall be positioned on the rear of the miners' hard hat or the upper third of the miners back to ensure maximum visibility. The strobe lights shall be turned on while miners are traveling by foot and the lights shall be properly maintained at all times. Drivers of rubber-tired mobile equipment and persons walking on foot cannot maintain visual contact and/or oral communication with each other at all times which creates the hazard of persons being struck by rubber-tired mobile equipment.

3. Safeguard No. 9043111, was issued citing 30 CFR § 75.1403 on December 12, 2014. This is a notice to provide safeguard(s) that all rubber tired mobile equipment operating inby the loading point, on all working sections, be equipped with two way radios. All miners traveling inby the loading point such as but not limited to the repairman, section foreman, or other section support personnel shall be provided two way radios. Additionally, two-way radios shall be provided at the section power center for persons not normally assigned to that unit to use to communicate their presence on the unit, intended activities, and route of travel. Drivers of rubber-tired mobile equipment and persons walking on foot cannot maintain visual contact

and/or oral communication with each other at all times which creates the hazard of persons being struck by rubber-tired mobile equipment.

4. Safeguard No. 9043112, was issued citing 30 CFR § 75.1403 on December 12, 2014. This is a notice to provide safeguard(s) requiring all rubber-tired mobile equipment that operate on any working section at this coal mine to sound an audible warning device before tramming in any direction. Drivers of rubber-tired mobile equipment and persons walking on foot cannot maintain visual contact and/or oral communication with each other at all times which creates the hazard of persons being struck by rubber-tired mobile equipment.

APPENDIX A

PERSONS PARTICIPATING IN THE INVESTIGATION

Mine Safety and Health Administration

William Barnwell	Enforcement Assistant District Manager
Abe DeLeon	Supervisory Mine Safety and Health Inspector
Curt Hardison	Supervisory Mine Safety and Health Inspector
Adam Carlisle	Accident Investigator
Archie Coburn	Accident Investigator
Jeff Winders	Inspector
Malia Holzberger	Solicitor
Joe Fritz	Training Specialist (EFS)
Dustin Hinchman	Engineer, Technical Support, Approval and Certification Center
Justin Daniels	Engineer, Technical Support, Approval and Certification Center

State of Kentucky Division of Mine Safety

Tim Fugate	Chief Accident Investigator
Bill Mallay	Inspector
Brad Thomas	Inspector
Lee Vincent	Inspector

Highland Mining Company, LLC

Joe Evans	Vice President Western Kentucky Operations, Patriot Coal Corp.
Bob Bosh	President, Highland Mining Company
Les Hawkins	General Mine Superintendent
Brad Carlisle	Chief Maintenance Supervisor
Rodney Alvey	Maintenance Supervisor
Brandon LaMond	Production Coordinator
Randy Duncan	Safety Director
Josh Gibson	Safety Department
David Self	Safety Department
Neal Mosley	Senior Mine Engineer
Tyler Gilreath	Mine Engineer
Mark Messamore	Mine Engineer
Andy Fields	Regional Safety Director, Patriot Coal Corp.

United Mine Workers of America

Daryl Bradshaw..... UMWA Representative
Richard Creager..... UMWA Representative
Butch Oldham..... UMWA Representative
Tim Miller..... UMWA Representative

Rajkovich, Williams, Kilpatrick, & True, PLLC

Melanie J. Kilpatrick……..Attorney

APPENDIX B

Interview List

Wesley Coots	No. 26 Coal Hauler Operator
Shawn Howard	No. 8 Roof Bolter Operator
Terry Steeley	No. 28 Coal Hauler Operator
Carlos Ewing	No. 2 Continuous Mining Machine Operator
Neal Caudill	Section Foreman
David Dukes	No. 29 Coal Hauler Operator
Darrin Darnell	Mine Manager
Danny Young	Maintenance Foreman
Darren Browning	Maintenance Foreman
Brandon LaMond	Production Coordinator

APPENDIX C

Drawings of the Accident Scene

Figure 1

Overview of Equipment on the Section

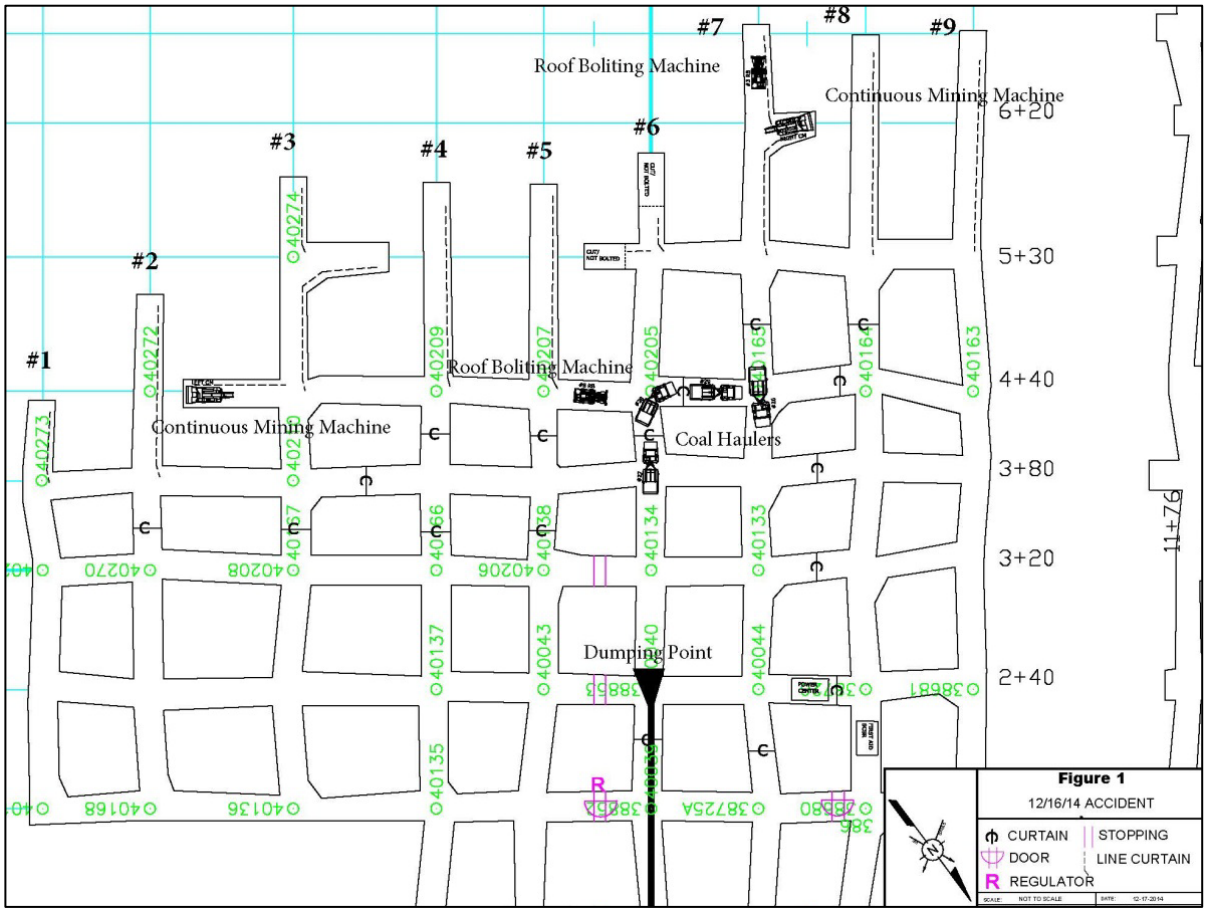


Figure 2

Location of Equipment Prior to Accident

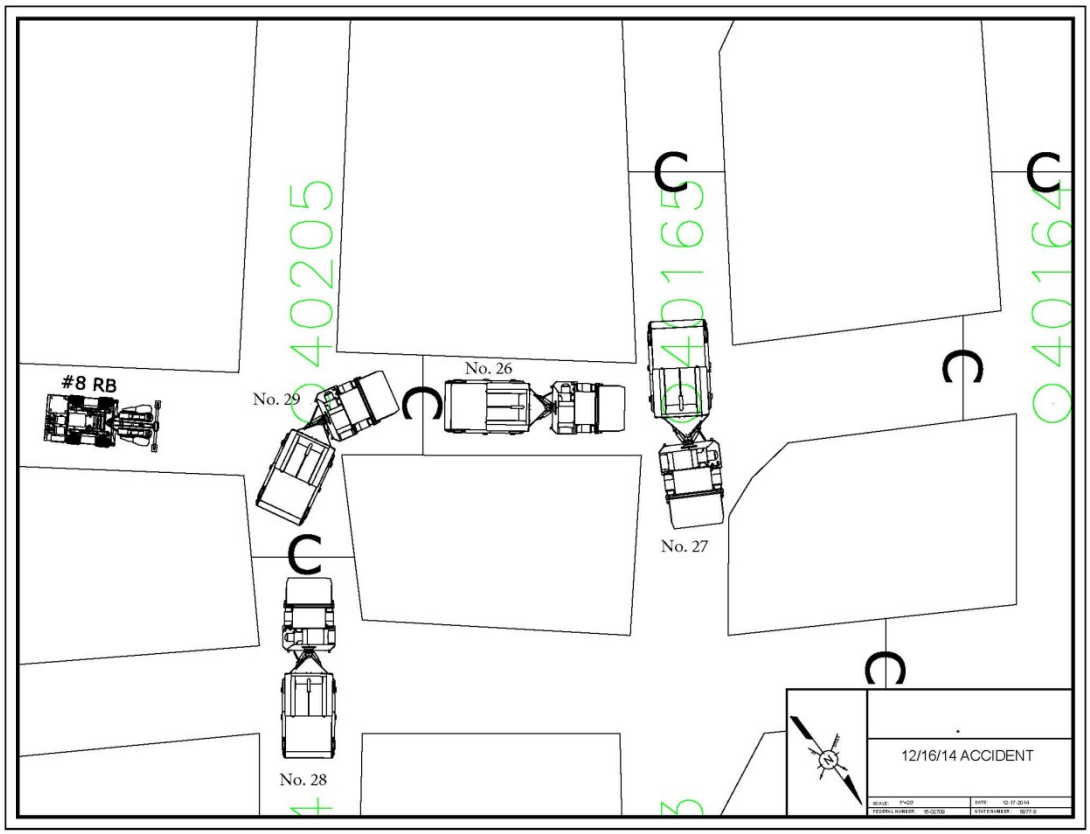


Figure 3

Location of Equipment after the Accident

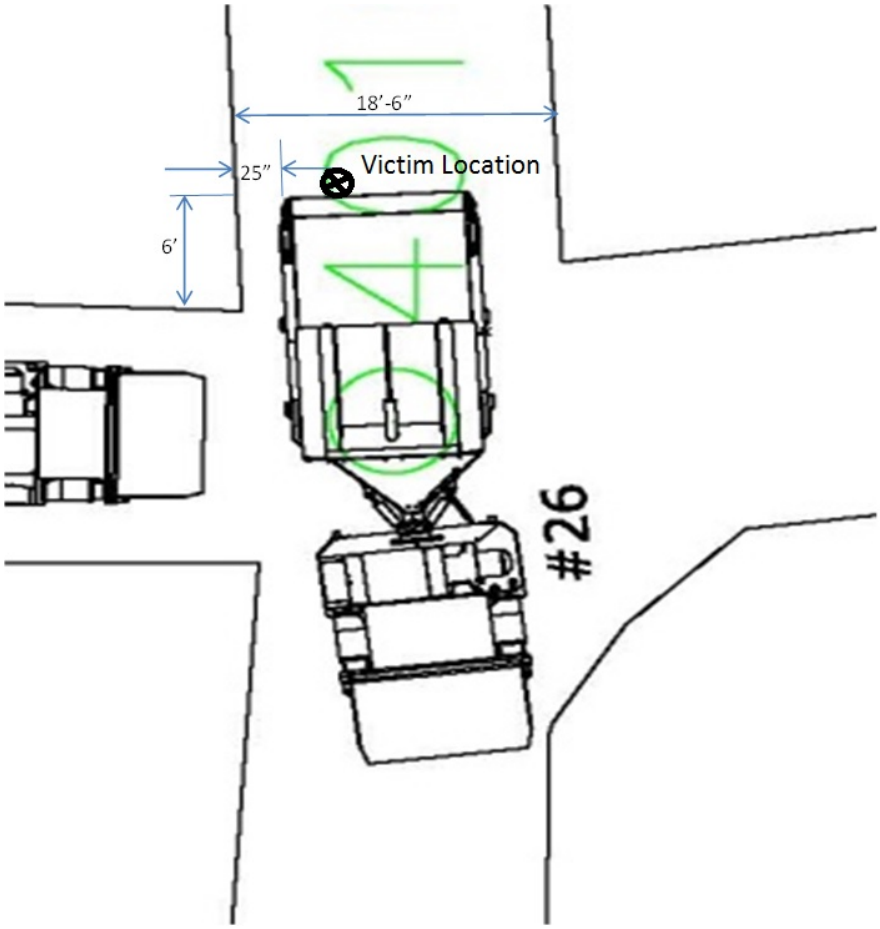
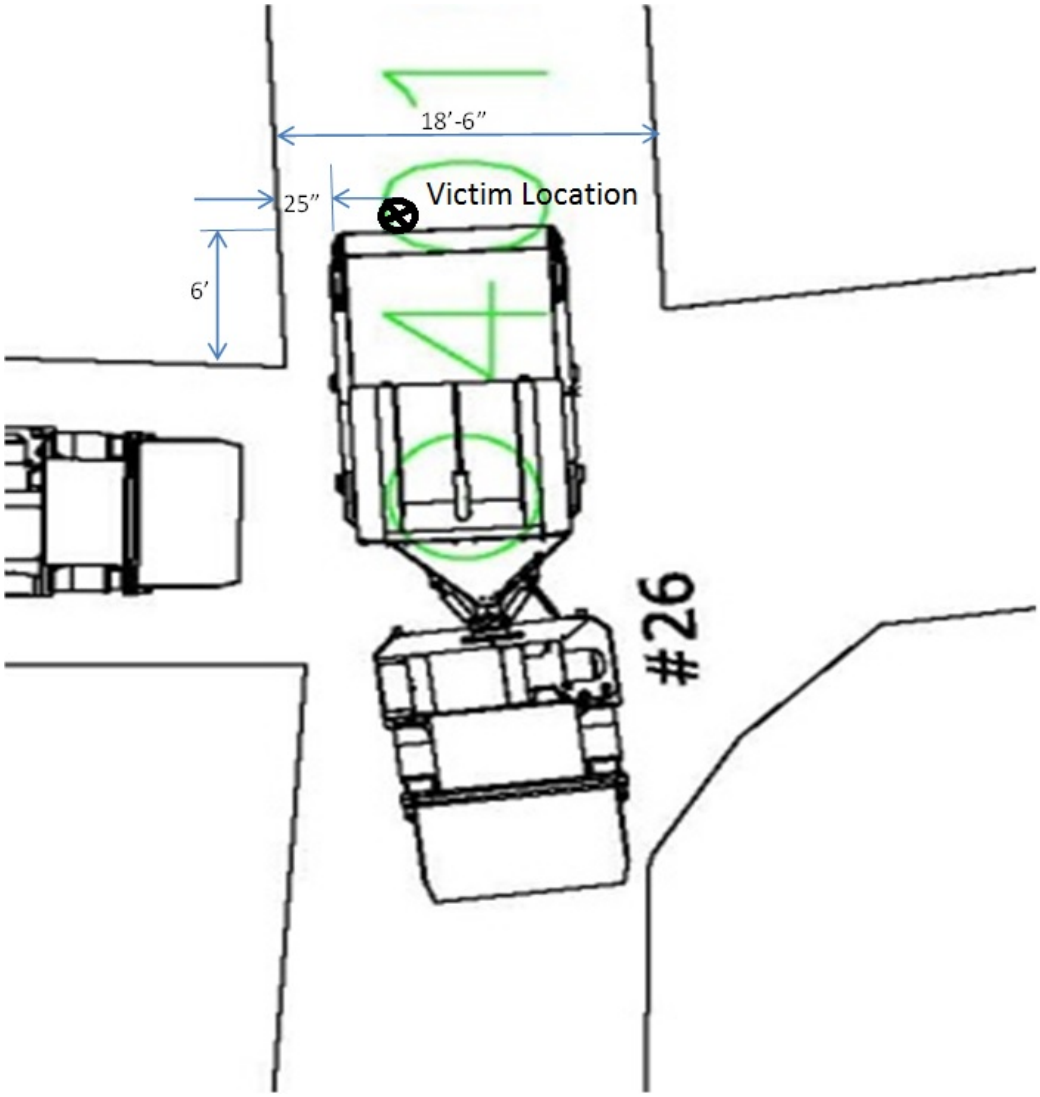


Figure 4

No. 26 Coal Hauler Location in Intersection with Measurements



APPENDIX D

Picture of No. 26 Coal Hauler

View of the area from above the operator's deck

APPENDIX E

Victim Information

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

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

Victim Information: 1

1. Name of Injured/Ill Employee:	2. Sex	3. Victim's Age	4. Degree of Injury:
Eli Eldridge	M	34	01 Fatal

5. Date(MM/DD/YY) and Time(24 Hr.) Of Death: a. Date: 12/16/2014 b.Time: 11:55

6. Date and Time Started: a. Date: 12/16/2014 b.Time: 7:00

7. Regular Job Title: 004 Mechaonic

8. Work Activity when Injured: 092 Unit Mechanic

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

10. Experience	Years	Weeks	Days
a. This Work Activity:	8	0	0
b. Regular Job Title:	8	0	0
c. This Mine:	0	35	0
d. Total Mining:	15	0	0

11. What Directly Inflicted Injury or Illness? 077 Battery Coal Hauler

12. Nature of Injury or Illness: 170 Crushing

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

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

Independent Contractor ID: (if applicable)

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

16. Part 50 Document Control Number: (form 7000-1) 220143530034

17. Union Affiliation of Victim: 2555 United Mine Workers of Amer.

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 | No

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

11. What Directly Inflicted Injury or Illness?

12. Nature of Injury or Illness:

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

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

Independent Contractor ID: (if applicable)

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

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 | No

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

11. What Directly Inflicted Injury or Illness?

12. Nature of Injury or Illness:

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

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

Independent Contractor ID: (if applicable)

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

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

17. Union Affiliation of Victim:

MSHA Form 7000-50b, Mar 2008

Printed 03/02/2015 10:02:29 AM