CAI-2014-16

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

COAL MINE SAFETY AND HEALTH

# REPORT OF INVESTIGATION
Coal Dock Facility

Fatal Drowning Accident
April 18, 2014

Allied Security (J1M)
Dunbar, Kanawha County, West Virginia

at

Crown Hill Dock
Law River Company, LLC
Hansford, Kanawha County, West Virginia
ID No. 46-05382

Accident Investigator

Andrew J. Sedlock
Coal Mine Safety and Health Inspector

Originating Office
Mine Safety and Health Administration
District 4
100 Bluestone Road
Mount Hope, West Virginia, 25880

David S. Mandeville, District Manager

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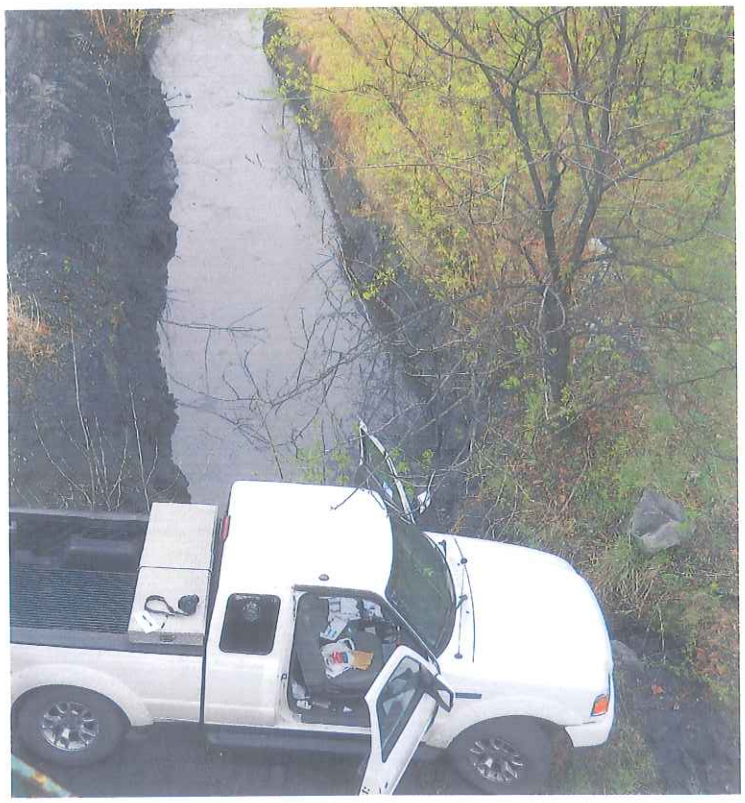

## OVERVIEW

On Friday, April 18, 2014, at approximately 5:30 a.m., Tommy E. Reynolds, a 58-year old security guard, was found face down in approximately 12 inches of water and sediment in a diversion ditch at the Law River Company, LLC, Crown Hill Dock. A pickup truck the victim had been operating was found "high-centered," from front to back, on a road berm that was constructed around the diversion ditch. The vehicle was found with the driver's side door open, the headlights on, the engine running, and the transmission in gear.

The victim apparently drove the truck onto the road berm where it became stuck. Evidence indicates that the victim exited the driver's side and slipped or fell into the diversion ditch, where he drowned.

## GENERAL INFORMATION

The Crown Hill Dock is operated by the Law River Company, LLC, and is located at Hansford, Kanawha County, West Virginia. The coal loading facility employs six production workers, which work 12- hour shifts on day shifts only. Allied Security provides security services to the operation, employing two guards who work 12-hour night shifts, three days per week, and one guard works one 12-hour night shift and two day shifts. The coal dock facility receives coal from various mining operations and loads coal into barges for transport on the Kanawha River.

The Principal Officers for the facility at the time of the accident were:

L. W. Hamilton ..... Manager
Marty Burke ..... Land Manager
Frank Linville ..... Foreman

The last regular Safety and Health Inspection (E01) conducted by the Mine Safety and Health Administration (MSHA), was completed on November 22, 2013. The Non-Fatal Days Lost (NFDL) injury incidence rate for the facility in fiscal year 2013 was 0.0, compared to the national NFDL rate of 1.55 for mines of this type.

## DESCRIPTION OF THE ACCIDENT

Reynolds began his shift at approximately 4:30 p.m. on Thursday evening, April 17, 2014. Reynolds was the only person working on the site during the night shift. On Friday morning, April 18, 2014, Orville Ayers, a Crown Hill Dock electrician, reported to work at approximately 5:15 a.m. As Ayers approached the coal loading tipple he observed a Ford Ranger pickup truck located along the access road leading to the coal sampling building. This was the truck Reynolds used as the night shift security guard. Ayers did not see Reynolds in the truck, which was still running with the headlights on. Ayers went to investigate by walking around the truck and then shined his flashlight into the diversion ditch where he saw Reynolds face down in the water.

Ayers immediately called the "911" emergency phone number at approximately 5:25 a.m., and spoke with the emergency operator until the ambulance arrived. Shortly after the ambulance arrived at the site, a Crime Scene Investigator with the Kanawha County Sheriff's Department also arrived to conduct an investigation because the accident was determined to be an unwitnessed death.

The victim's body was recovered from the diversion ditch by the East Bank Volunteer Fire Department and subsequently taken to the West Virginia State

Medical Examiner's office in Charleston, West Virginia for autopsy. The Chief Medical Examiner concluded the cause of death to be asphyxia due to drowning. The toxicology report also showed "Marked alcohol intoxication causing work site impairment; judged contributory to fatal accident scenario." The victim had a blood alcohol (Ethanol) content of 0.27% at the time he died.

## INVESTIGATION OF ACCIDENT

On April 18, 2014 at 5:53 a.m., the accident was reported to MSHA's National Call Center by Frank Linville. At 6:13 a.m., Roy Baker, District 4 Health Supervisor, received notification from the call center that a night shift security guard had been found dead on the property by an employee who had reported for work on the day shift. Baker called the facility and at 6:30 a.m., issued a verbal 103(j) Order to Frank Linville in order to prevent the destruction of evidence and to preserve the accident scene. Martin Carver, Supervisory Mine Safety and Health Inspector from the Mt. Carbon Field Office, and Andrew Sedlock, Coal Mine Safety and Health Inspector/Accident Investigator from the Mt. Hope Field Office, were notified of the accident and dispatched to the site. Upon arrival at the facility, the 103(j) Order was reduced to writing and subsequently modified to a 103(k) Order to insure the safety of all persons during the investigation.

The accident was investigated in conjunction with the West Virginia Office of Miners' Health Safety and Training (WVOMHST), the Kanawha County Sheriff's Department, the operator of the facility, the contract operator, and the employees of the operator and contractor.

A list of the persons participating in the investigation is shown in Appendix A.

## DISCUSSION

The diversion ditch where the victim was found was constructed around the perimeter of the coal stockpile area and was approximately 10 feet wide at its base, near the water level. The top of the berm where the victim's pickup truck was located was approximately 6 to 7 feet above the bottom of the ditch, and the sides of the ditch sloped at less than a vertical angle into the bottom of the ditch. The ditch had been recently cleaned out and there was 4 to 12 inches of sediment and water in the bottom of the ditch. The diversion ditch was physically located between the coal stockpile area of the facility and the Kanawha River.

The victim's truck, a 2009 Ford Ranger extended cab pickup, had traveled approximately 15 feet up and onto a road berm (approximately 16 inches in

height), that had been constructed around the diversion ditch. The wheels of the truck had straddled the berm and become stuck with the left rear tire just above ground level on the inside of the berm. The truck was found still in gear with the engine running, the headlights on, and the driver's side door open directly above the diversion ditch. The ground slope from the top of the road berm down to the bottom of the diversion ditch was vegetated and less than vertical in grade. The victim was working alone at the time of the accident. There were no witnesses. Based on observations during the investigation, it appears that the victim exited his truck from the driver's side and slid or fell down the slope into the water at the bottom of the diversion ditch where he was found face down.

Following the recovery of the victim's body, the truck involved was moved by a wrecker to a safe location where it was inspected and tested for any defects. A brake service function test was conducted while the vehicle was in gear at an engine speed of 2000 revolutions per minute (rpm). Steering components on the pickup were also inspected for defects. No mechanical deficiencies with the brakes or steering functions were identified by the inspection.

Items inside the cab of the pickup truck were examined during the investigation by the Sheriff's office criminal investigator. These included miscellaneous clothing, a hand held radio, a flashlight, several personal items, and an empty whiskey bottle (approximately 4/5 quart).

Reynolds was an employee of Allied Security. He had worked at this location for 12 years as a security guard/supervisor. Reynolds had received Hazard Training for this mine site.

## ROOT CAUSE ANALYSIS

A root cause analysis was conducted to identify the basic causes of the accident that were correctable through reasonable management controls. Listed below is the cause that was identified by the analysis and the corrective action which was implemented to prevent a recurrence of the accident.

*Root Cause*: A substance abuse screening program which is conducted to check for alcohol or drug abuse on a regular basis, but unannounced, was not in place for security personnel employed at this operation. The victim's blood alcohol content was found to be 0.27% at the time of his death.

*Corrective Action*: The contractor has put into effect a Drug and Substance Abuse Policy for its employees, including the contract employees utilized at this facility.

## CONCLUSION

A contract security guard drowned in a diversion ditch containing 4 to 12 inches of sediment and water. The investigators concluded that the victim exited the driver's side of the truck he was operating and slipped or fell into the diversion ditch where he drowned. Alcohol intoxication causing work site impairment was also identified as a contributing factor. The employer of the security guard did not have in place a substance abuse screening program for its employees at this facility.

Approved By:

David S Mandeville

David S. Mandeville
District Manager

1/27/15

Date

## APPENDIX A
## Persons Participating in the Investigation

### Law River Company, LLC

Frank Linville.....Foreman
Orville Ayers.....Electrician

### Allied Security

Brian Biesenkamp.....Operations Manager

### West Virginia Miner's Health, Safety and Training

Eugene White .....Director
McKennis Browning .....Inspector-at-Large
Steve Lafferty.....Assistant Inspector-at-Large
William Stewart..... District Inspector
George Malcomb.....District Inspector

### Mine Safety and Health Administration

Martin Carver..... Supervisory Coal Mine Safety and Health Inspector
Andrew Sedlock.....Accident Investigator

# APPENDIX B
## Victim Information

Accident Investigation Data - Victim Information
Event Number: 6 3 0 2 6 8 1

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: |
|---|---|---|---|
| TOMMY E. REYNOLDS | M | 58 | 01 Fatal |

5. Date(MM/DD/YY) and Time(24 Hr.) Of Death: a. Date: 04/18/2014 b.Time: 5:30

6. Date and Time Started: a. Date: 04/17/2014 b.Time: 6:00

7. Regular Job Title: 199 SECURITY

8. Work Activity when Injured: 098 SECURITY

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

| 10. Experience | Years | Weeks | Days | | Years | Weeks | Days | | Years | Weeks | Days | | Years | Weeks | Days |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| a. This Work Activity: | 12 | 0 | 0 | b. Regular Job Title: | 12 | 0 | 0 | c: This Mine: | 12 | 0 | 0 | d. Total Mining: | 12 | 0 | 0 |

11. What Directly Inflicted Injury or Illness? 126 DROWNING

12. Nature of Injury or Illness: 390 DROWNING

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

14. Company of Employment: (if different from production operator) ALLIED SECURITY

Independent Contractor ID: (if applicable) J1M

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

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

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

**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 | | Years | Weeks | Days | | Years | Week | Days | | Years | Weeks | Days |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| a. This Work Activity: | | | | b. Regular Job Title: | | | | c: This Mine: | | | | 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 | | Years | Weeks | Days | | Years | Week | Days | | Years | Weeks | Days |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| a. This Work Activity: | | | | b. Regular Job Title: | | | | c: This Mine: | | | | 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

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