CAI-2015-03

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

COAL MINE SAFETY AND HEALTH

REPORT OF INVESTIGATION

Underground Coal Mine

Fatal Fall of Face Accident
March 8, 2015

McElroy Mine
McElroy Coal Company
Cameron, Marshall County, West Virginia
I.D. No. 46-01437

Accident Investigators

Nicholas Blevins
Mining Engineer – Roof Control

Eric Case
Coal Mine Safety and Health Inspector

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

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OVERVIEW

On March 8, 2015, at approximately 8:55 p.m., John "Mike" Garloch (victim), Assistant Longwall Coordinator – West Side, was fatally injured while shoveling loose material between the longwall face and the panline. The accident occurred in the area near the No. 4 shield on the 12-East Longwall face. Garloch received crushing injuries when a section of coal and rock fell from the face area, striking him and pinning him against the mine floor. Three other miners sustained lost time injuries from this accident.

The accident occurred because the mine operator failed to adequately support the roof, face, and ribs. The mine operator did not have procedures or controls in place to protect miners from a fall of the longwall face or rib while miners were positioned on the panline or between the panline and the longwall face. Additionally, the mine operator did not have effective policies, procedures, or training programs in place to limit or prevent the longwall from mining out-of-seam.

GENERAL INFORMATION

The McElroy Mine is located in Marshall County, West Virginia. The mine is owned by McElroy Coal Company, a subsidiary of Ohio Valley Resources Incorporated. The mine accesses the Pittsburgh No. 8 coal seam by two slopes and four portals: the Fish Creek Portal located near the supply and production slopes, the Blake's Ridge Portal, the Grapevine Portal, and the Cameron Portal. Cameron is the closest to the active sections and used by the majority of miners.

Coal is mined from the 78-inch coal seam by six (6) continuous mining machine sections and two (2) longwall sections. The McElroy Mine employs 986 underground employees and 99 surface employees. The average production is approximately 29,150 tons per day. The mine typically operates three shifts a day, seven days a week. The shift lengths are scheduled for eight hours, but the oncoming shift miners change out with the previous shift miners at the face on the sections. Maintenance is conducted as needed. The mine is ventilated with nine main mine fans and two bleeder fans. Coal is transported from the working sections to the surface via conveyor belt. Battery, trolley, and diesel powered, rail-mounted vehicles are used to transport supplies and mine personnel. The mine liberates 12,625,615 cubic feet of methane every 24 hours.

The principal officials for the McElroy mine were:
Eric Grimm.....General Manager
Eric Koontz.....General Superintendent
Eric Lipinski.....Superintendent
Jeff Crowe.....Mine Foreman
Richard Marcavitch.....Director of Safety

A regular MSHA Health and Safety Inspection (E01) was in progress during the time of the accident. The Non-Fatal Days Lost (NFDL) incidence rate for the mine during the calendar year 2014 was 4.19, compared to the national average of 3.28 in 2014 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On the day shift, Friday, March 6, 2015, the 12-East longwall section was undergoing a power move. The electrical and hydraulic components for the longwall face were being moved outby to allow the longwall to continue retreating. During the power move, management noticed the shields and panline, from the No. 2 shield to approximately the No. 10 shield, beginning to ramp up on top of coal and that the longwall shearer was cutting out-of-seam by mining approximately one foot of roof rock in this area.

The section resumed production on the afternoon shift and attempted to realign the face to correct the out-of-seam (horizon) condition by taking cuts off the tailgate end of the longwall face. Nick Shanks, Assistant Longwall Coordinator – East Side, arrived on the section around 10:00 p.m., Saturday, March 7, 2015. He observed the panline and shields continuing to ramp up and the shearer cutting approximately five feet of roof rock and two feet of coal. The No. 2 shield was also fouled and would no longer pull in. Shanks made the decision to halt production to correct the condition. The tailgate end of the longwall face had retreated 38 feet outby the headgate at this time.

Shanks made phone calls to senior mine management officials to inform them of the situation. A plan was devised to bolt the roof between the longwall shield tips and the face, then drill and blast the coal in front of and under the panline. The goal was to remove the loose coal and material in front of the panline to allow the longwall to trend downward, back into the coal seam once mining resumed. After making the calls, Shanks talked to Ben Phillips, Shift Foreman, about getting the necessary supplies to the section.

Eric Koontz, General Superintendent, and Eric Lipinski, Superintendent, arrived at the mine at approximately 6:00 a.m., on Sunday, March 8, 2015. They travelled underground to the 12-East Longwall section to evaluate the out-of-seam condition. Matt Jarrett, Longwall Coordinator –East Side, arrived on the section shortly afterward. The necessary supplies arrived on the section and the midnight crew began roof bolting at 7:15 a.m. They started at the No. 6 shield using a hydraulic Z-drill and bolted toward the headgate until relieved by day shift.

Jason Drake, Shearer Operator, and Mike Rettinger, Longwall Utility Man, continued roof bolting on day shift. During the roof bolting process, they attempted to install a 6-foot point anchor bolt (with an expansion shell and two feet of resin) in the face at the No. 4 shield. The bolt bent as it was inserted in the hole. When it was removed, the expansion shell was left in the hole. An attempt to support the face was made in the same hole using a four-foot point anchor bolt with no resin. This bolt also bent during installation. The roof bolters were told not to continue installing support in the face since both attempts to install rib bolts into the face were unsuccessful. However, the roof of the area from No. 6 shield to the headgate was fully roof bolted by approximately 12:00 p.m.

Ron Koontz, Director of Longwalls for Murray Energy, arrived at the mine shortly after the start of day shift and traveled to the section. He was in charge of the blasting work. The crew began drilling two sets of holes in the mine floor for blasting. The first set of five holes was drilled in the area near the stage loader and the No. 3 shield. The second set of six holes was drilled in the area near the No. 5 and No. 6 shields. The miners

were moved outby the longwall face, and the first set of holes were loaded and blasted. After R. Koontz examined the area, the crew returned to the face to shovel. After approximately five minutes, the decision was made to remove the miners from the area again and blast the second set of holes. The first two blasts were completed at approximately 1:30 p.m. The area was examined again by R. Koontz, and the crew returned to the face to shovel the blasted material onto the panline. The crew loaded the face conveyor chain and ran it multiple times to transport the material off the face.

The crew continued to drill additional holes in the mine floor for blasting. A set of five holes and a set of six holes were drilled in the area near the No. 3 and No. 5 shields. The afternoon shift was scheduled to blast these holes upon arrival on the section. Lipinski, E. Koontz, and R. Koontz left the 12-East Longwall at 2:30 p.m. to meet with Brian Hennebert, Longwall Production Foreman, Mike Kozak, Assistant Director of Longwalls for Murray Energy, and Garloch to discuss plans for the afternoon shift. Garloch then traveled underground to the 14-West Longwall where the mine's other longwall was being moved. His plans were to check on the longwall move and then travel to 12-East Longwall to assist with correcting the out-of-seam condition.

Kozak and Hennebert rode into the mine with the afternoon shift crew and arrived on the 12-East Longwall at approximately 4:30 p.m. Kozak was in charge of the blasting work on afternoon shift and he informed the crew of the plan to blast the coal between the panline and the face. The crew was moved outby the longwall face so the holes drilled by day shift could be loaded and blasted. The two blasts were made at approximately 5:30 p.m. Kozak examined the area and the crew returned to the face to shovel. A crack was observed in the face near the area of No.5 shield. While the crew shoveled the blasted material onto the panline, the face conveyor chain was loaded and ran multiple times to transport the material off the face.

The crew began drilling more holes for additional blasting. Two sets of five holes were drilled at an angle underneath the panline in the area between the No. 2 to No. 6 shields. The crew was moved outby the longwall face between 7:45 p.m. and 8:00 p.m., so the holes could be loaded and blasted. At this time, Garloch arrived on the 12-East Longwall. After the two blasts were made, Hennebert, Kozak, Garloch, and Richard Miller, Maintenance Foreman, went to examine the face area.

The area was examined by Kozak, determined to be safe, and the miners traveled back to the longwall face to continue work. Charles Neitzelt, Shearer Operator, and Hennebert jack hammered under the panline at the edge of the No. 3 and No. 4 shields to remove the coal. The remaining crew members shoveled the blasted material from the No. 2 to No. 6 shields onto the panline. Ken Torac, Loader Operator; Colby Yarbrough, Miner Bolter; and Chris Cox, Rib Bolter Operator, began installing roof bolts around the No. 7 shield and bolted toward the tailgate.

At approximately 8:55 p.m., shortly after running shoveled material off the face conveyor chain, a piece of coal and rock fell from the face between the No. 4 and No. 6 shield, striking Garloch, Hennebert, Neitzelt, and Josh Roth, Shuttle Car Operator. The material was approximately 10 feet long, five feet wide, and up to two feet thick. Roth, who was standing at the edge of the No. 5 and No. 6 shield, was struck in the left shoulder and knocked to the ground. A piece of the material pinned his leg, but it was quickly removed by crew members standing nearby. Neitzelt and Hennebert were knocked to the ground and pinned by the fallen material. Coworkers freed Neitzelt and Hennebert when Kozak and John Beattie, Faceman, noticed that Garloch was under the rock.

Kozak, Beattie, and other crew members attempted to lift the rock off of Garloch, but were unsuccessful. Beattie checked for a pulse, but none was detected. While they continued to free Garloch, other crew members ran outby to retrieve first-aid materials and additional tools to help lift the rock. The crew members returned to the face with jacks, crib blocks and cap boards. The rock was raised up with the jacks and blocked, freeing the victim.

The victim was placed on a backboard and transported to the Mac-8 emergency ride located in the last open crosscut at crosscut #29. Matt Remke, Longwall Shield Operator/Emergency Medical Technician (EMT), and Beattie placed the Automated External Defibrillator (AED) on Garloch's chest, but no heart rhythms were detected. The victim was transferred to a rail-mounted mantrip and transported to the Cameron Portal elevator. The mantrip was met by Chad Lucas, EMT, who administered Cardiopulmonary Resuscitation (CPR) to the victim while on the elevator. The victim was transported from the mine site by Cameron Emergency Medical Services (EMS). Dr. Katherine Langley, M.D. with West Virginia University Hospital (WVUH) Medcom, pronounced the victim dead at 9:45 p.m., while in transport to Reynolds Memorial Hospital in Glen Dale, West Virginia.

INVESTIGATION OF THE ACCIDENT

Richard Marcavitch, Director of Safety, notified the MSHA Call Center at 9:11 p.m., on Sunday, March 8, 2015, and reported a rib roll had occurred on the 12-East Longwall and one miner was trapped under a rock. Chad Currence, Bridgeport Field Office Supervisor, received notification of the accident from the call center at 9:19 p.m. Currence contacted the mine and issued a verbal 103(j) order at 9:30 p.m., to ensure the safety and health of the miners and to preserve the accident scene. Nicholas Blevins, Mining Engineer - Roof Control, and Michael Kelley, Supervisory Coal Mine Safety and Health Specialist - Roof Control, were immediately dispatched to the mine by Michael

Stark, Staff Assistant. The 103(j) order was modified to a 103(k) order upon arrival at the mine.

The accident investigation was conducted by MSHA personnel in conjunction with the West Virginia Office of Miner's Health, Safety, and Training (WVMHS&T), Ohio Valley Resources, Inc., and the United Mine Workers of America (UMWA). The investigation was initiated on the day of the accident. Upon arrival to the mine, the accident investigation team was briefed of the circumstances of the accident. Prior to going underground, preliminary discussions were conducted with the afternoon shift miners assigned to work on the 12-East Longwall. The investigation team travelled to the accident scene to make observations, take measurements, and take photographs. Following the initial underground investigation, the 103(k) order was modified to allow the mine operator to survey and map the accident scene (See Appendix A).

On Monday, March 9, 2015, Eric Case, Coal Mine Safety and Health Inspector, arrived at the mine on day shift to continue the investigation along with Carlos Mosley, District Manager and Stark. Additional photographs and measurements were taken and additional relevant documents obtained.

On Tuesday, March 10, 2015, the miners assigned to work on the 12-East Longwall on the day shift prior to the accident were interviewed (See Appendix B).

On Tuesday, March 17, 2015, and Wednesday, March 18, 2015, formal interviews were conducted at the Murray Energy Training Center located near Moundsville, West Virginia. Representatives of the victim's family were present during the interviews (See Appendix C).

DISCUSSION

12-East Longwall

The accident occurred on the 12-East Longwall face at the No. 4 shield, approximately 12 feet from the headgate end of the face. The longwall equipment mines the coal block between the 12-East headgate section and the 11-East tailgate section. The longwall panel is approximately 1,400 feet wide and 6,800 feet long. At the time of the accident, the headgate had retreated to survey station (spad) No. 29+48 and the tailgate had retreated to spad No. 29+10. The last open crosscut was located at the No. 29 block, between the No. 2 and No. 3 entries.

The 12-East Longwall headgate overburden thickness was 1,008 feet at the time of the accident. An Analysis of Longwall Pillar Stability (ALPS) determined the pillar stability factor in the area. The analysis showed the loading in the headgate area had a stability factor of 2.83. The pillar design parameters present near the accident location were used in the analysis. The National Institute of Occupational Safety and Health (NIOSH) recommended pillar stability factor for retreat longwall mining is 1.30. The pillar design was adequate for handling the overburden weight and exceeded the recommended stability factor.

Face Condition

The out-of-seam face was approximately seven feet high prior to the drilling and blasting process. Throughout the day shift and afternoon shift, the face height increased from seven feet to approximately 12 feet, due to the removal of the material in front of and under the pan line. The face strata from the mine floor to the roof was approximately four feet of coal, one foot of rock binder, two feet of coal, and five feet of laminated shale at the time of the accident.

The increased face height caused the heavier shale rock (approximately 170 lbs/ft^2) to put pressure on the weaker, unconfined coal face (approximately 80 lbs/ft^2). The pressure caused the coal face to slough off during afternoon shift. As the shift progressed, the movement in the shale strata created a crack in the face at the No. 5 shield. The crack grew larger, forming a separation that could only be seen from the tailgate side looking towards the headgate. The rock fell from the face from the same area where the crack was seen. MSHA Investigators however, cannot definitively say that the crack caused the fall. The material that fell from the face measured approximately 12 feet long, 5 feet wide, and up to 2 feet thick. The piece broke and the material that struck the victim measured approximately 10 feet long, 5 feet wide, and up to 2 feet thick.

Roof Control Plan

The last fully revised and consolidated roof control plan for this mine was approved by MSHA on March 28, 2013, with nine revisions since that time. This mine has rib bolting procedures that are to be used during continuous mining machine development. Rib bolting is also required when mining trenches for belt or overcast installations when the height exceeds 10 feet.

The roof control plan had requirements when work is performed between the panline and the longwall face. The face conveyor breaker must be placed in the lock out

position and the rib or face shall be tested and any loose material shall be secured or pulled down before performing such work. Where the distance between the shield tips and face exceeds five feet, temporary supports shall be installed in the work area. The distance from the tip of the shield to the face was in excess of five feet where Garloch was working when the accident occurred. The roof from No. 8 shield to the headgate had been fully bolted. However, no face supports were installed where Garloch was working.

Mining Method

Longwall mining is dependent on maintaining the longwall face in the center of the gate entries as it is retreated out of the panel. Uneven retreat of the face ends can cause the longwall mining machine to shift off the gate center. When the longwall shifts too far to one end or the other, the shearer does not have clearance to properly cut out the solid coal block. This will leave stumps of coal in the roof and floor. The headgate or tailgate panline will begin to ride up on the coal stump and the shearer cannot properly clean the cuttings from in front of the panline. This condition will worsen and create an out-of-seam condition, if not recognized and corrected.

The 12 East Longwall production records for the 10 days preceding the accident were reviewed to determine the mining practices and rates of retreat. Mine management normally operates the 12 East Longwall face with the tailgate face location retreated 15 feet further out of the panel than the headgate face location. The midnight shift crew normally mined extra cuts off the tailgate end to maintain this differential from February 26th until March 3rd. The extra cuts were not taken on March 3, 2015, and by the end of the shift the tailgate end was only 4 feet outby the headgate. No extra cuts off the tailgate end were taken over the next several shifts and by the end of midnight shift on March 5, 2015, the headgate end was 24 feet outby the tailgate end. This differential caused the longwall face to shift toward the tailgate entry.

The operator directed extra cuts to be mined off the tailgate end to shift the longwall face back toward the headgate and additional clean up passes were made with the shearer to remove more material from in front of the panline. These actions were unsuccessful. On Day Shift, March 6, 2015, management noticed that the headgate end panline were climbing up and creating an out-of-seam condition.

The afternoon shift crew continued to take cuts off the tailgate end, but the condition worsened and by the end of the shift, the panline had climbed an additional four feet and the shearer was cutting approximately five feet of rock. The No. 2 shield became fouled and would no longer pull in due to the elevated panline so management decided

to halt production and take other measures to correct the condition. The tailgate end of the longwall face was retreated 38 feet outby the headgate at this time.

Examinations

The mine operator is required to conduct examinations of work areas for hazardous conditions and violations of mandatory health and safety standards. The mine operator is required to conduct additional examinations following blasting work to identify misfires, methane, or other hazardous conditions. Near the beginning of afternoon shift, a crack appeared in front of the No.5 shield. As the shift progressed, the crack reportedly grew larger. Two additional examinations were made as a result of blasting on afternoon shift. These examinations did not identify the crack. During the investigation, the crack was not visible in the face. Therefore, investigators were not able to determine if the crack contributed to the fatal accident. A non-contributory violation was issued for 30 CFR 75.1326 because of these examinations.

Training and Experience

Garloch had 12 years and 48 weeks of total mining experience; all at this mine. A review of the training records showed Garloch was provided annual refresher training on April 2, 2014. The records also indicate Garloch was task trained for operating the longwall.

ROOT CAUSE ANALYSIS

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

Listed below are the factors identified during the analysis and the corrective actions that were implemented to prevent a similar reoccurrence.

Root Cause: The mine operator failed to adequately support the roof, face, and ribs of areas where miners work or travel.

Corrective Action: The mine operator revised the roof control plan to address out-of-seam conditions. The revision stipulates the procedures and equipment needed to protect the miners from fall of roof, face, and ribs. The affected miners were trained in the revised roof control plan. The revised safety precautions will be reviewed with all miners prior to working in the affected area.

Root Cause: The mine operator did not have effective policies, programs, procedures, or training programs in place to ensure that proper actions are taken to limit or prevent the longwall from shifting off of proper alignment and mining off-center.

Corrective Action: The mine operator established a training program for all miners that work on the longwall. The training program outlines the procedures or actions that should be taken to limit or prevent the longwall from mining out-of-seam. All affected miners were trained in the new procedures.

Root Cause: The mine operator did not have effective policies, programs, procedures, or controls in place to protect miners from a fall of the longwall face while miners are positioned on the panline or between the panline and the longwall face.

Corrective Action: The mine operator revised the roof control plan. The revision stipulates the procedures and equipment needed to protect the miners from fall of roof and face if miners are required to be on the face side of the panline for any reason. The affected miners were trained in the revised roof control plan. The revised safety precautions will be reviewed with all miners prior to working in the affected area.

CONCLUSION

The accident occurred because the mine operator failed to adequately support the roof, face, and ribs of areas where miners work or travel. The mine operator did not have procedures or controls in place to protect miners from a fall of the longwall face or ribs while miners are positioned on the panline or between the panline and the longwall face. Additionally, the mine operator did not have effective policies, procedures, or training programs, in place to ensure miners are taking proper actions that would limit or prevent the longwall from mining out-of-seam.

Carlos Mosley

Carlos T. Mosley
District Manager

Date: 7/20/15

ENFORCEMENT ACTION

1. A 103(J) Order, Number 9082777, was issued to McElroy Coal Company at approximately 9:30 p.m., subsequently modified to a 103(K) Order at 12:28 a.m., to ensure the safety of all persons at the operation and to prevent the destruction of any evidence which would assist in investigating the cause or causes of the accident until an investigation was completed and the area deemed safe.

2. A 104(a) citation was issued to McElroy Coal Company for violation of 30 CFR § 75.202(a). The mine operator failed to adequately support or otherwise control the longwall face on the 12-East Section to protect miners from hazards related to falls of face. On March 8, 2015, a fall of face accident occurred resulting in fatal injuries to one miner. The victim and other miners were working between the panline and the longwall face near the headgate area removing previously blasted material from the mine floor when the accident occurred. The removal of the material resulted in a face height of 12 feet in the area where the accident occurred. The piece of material that fell from the face and struck the victim measured approximately 10 feet long, up to 5 feet wide, and up to 2 feet thick.

   Standard 75.202(a) was cited 82 times in two years at mine 4601437 (82 to the operator, 0 to a contractor).

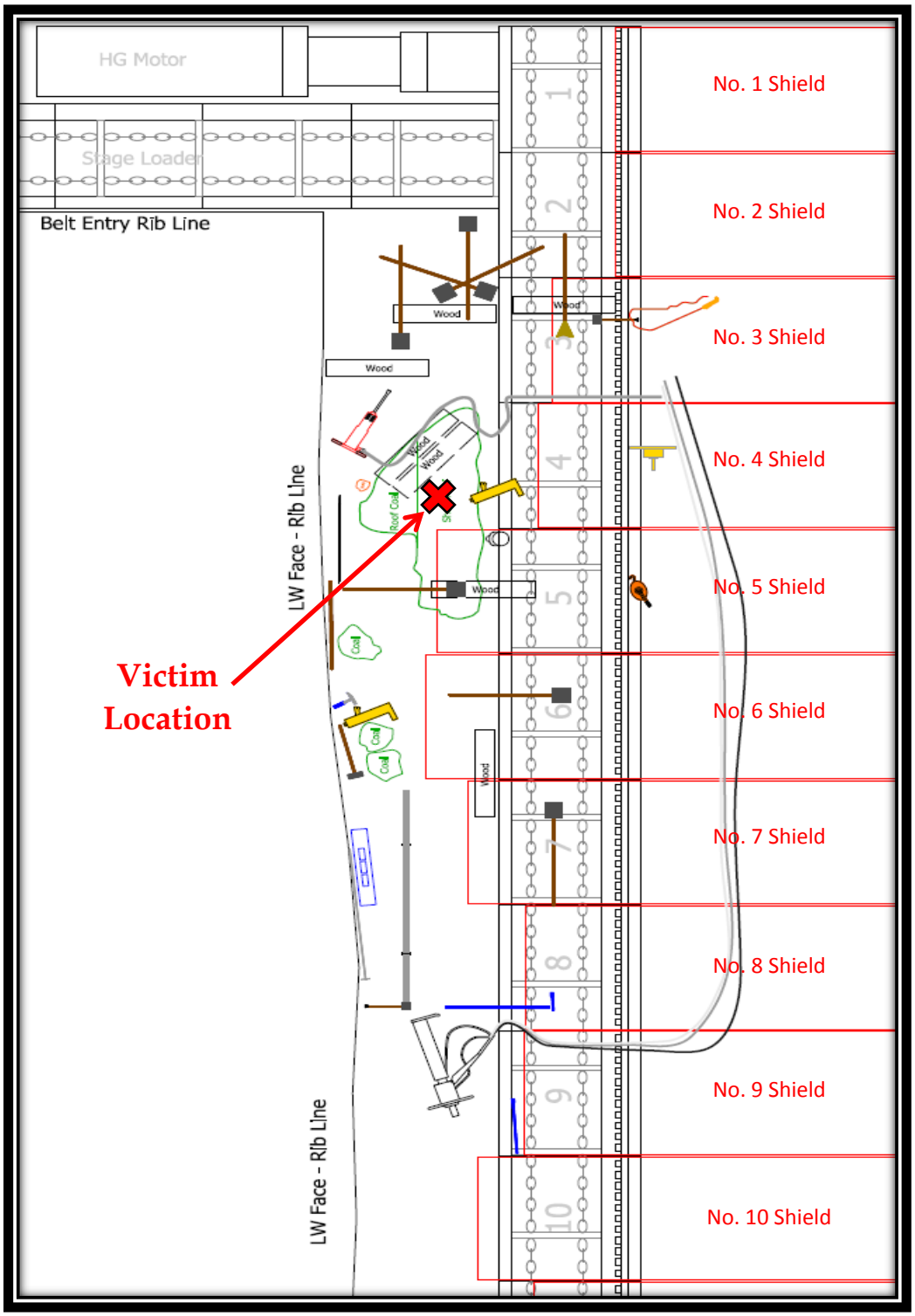
3. A 104(a) citation was issued to McElroy Coal Company for violation of 30 CFR § 75.203(a). On March 8, 2015, a fatal accident occurred on the 12-East Longwall Section due to a faulty pillar recovery mining method that created an out of seam condition and forced miners to work between the panline and the longwall face. On March 6, 2015, the mine operator noticed the headgate end of the longwall beginning to ride up on the coal seam. The cut sequence leading up to the accident caused the longwall face to shift off center, and push the stageloader against the coal pillar being mined. This prevented the shearer from making a full cutout at the headgate end, which left a coal stump in the mine floor. As the longwall continued to retreat, the shields and panline continued to elevate as a result of riding on top of the remaining stumps. By March 7, 2015, the longwall shearer was cutting approximately 5 feet of rock above the coal seam and the No. 2 shield became fouled and would no longer pull in. The operator then halted production to begin correcting the condition to allow the longwall to progress back down into the coal seam. During this process, three miners received lost time injuries and

one miner was fatally injured when a piece of material fell from the longwall face pinning him to the mine floor.

Standard 75.203 (a) was cited 3 times in two years at mine 4601437 (3 to the operator, 0 to a contractor).

APPENDIX A

Drawing of the Accident Scene



APPENDIX B

Person Participating in the Accident Investigation

Mine Safety and Health Administration (MSHA)

Nicholas Blevins	Mining Engineer – Roof Control
Eric Case	CMS&H Inspector
Michael Kelley	Supervisory CMS&H Specialist - Roof Control
Michael Stark	Staff Assistant
Scott Chiccarello	Training Specialist – Educational Field Services

West Virginia Office of Miner's Health Safety and Training (WVMHS&T)

Ed Peddicord	Inspector at Large
John Meadows	Assistant Inspector at Large
Bill Coen	District Inspector
Jeff Bennett	District Inspector – Roof Control
Colin Simmons	District Inspector

McElroy Coal Company

Allen McGilton	Corporate Safety
Ron Van Horne	Corporate Safety
Greg Green	Corporate Safety
Drew Dally	Manager of Safety
Richard Marcavitch	Director of Safety
Ryan Carmen	Safety Director
Scott Martin	Safety Inspector
Cody Nett	Murray Energy Legal
Gary Broadbent	Murray Energy Legal

United Mine Workers of America (UMWA)

Ron Bowersox	International Representative
Levi Allen	President, Local 1638
Tom McGary	Safety Committeeman Chairman, Local 1638
Ryan Sparks	Safety Committeeman, Local 1638

APPENDIX C

Formal Interview List

Tuesday, March 17, 2015

Charles Neitzelt.....Shearer Operator
Josh Roth .....Shuttle Car Operator
Nick Shanks .....Assistant Longwall Coordinator – East Side
Brian Hennebert .....Longwall Production Foreman
Mike Rettinger .....Longwall Utility Man
Jason Drake .....Shearer Operator
Mike Carp.....Rib Bolter Operator
Mike Kozak .....Assistant Director of Longwalls for Murray Energy
Charles Kirby .....Longwall Mechanic
Dan Hepburn.....Shuttle Car Operator

Wednesday, March 18, 2015

Ron Koontz .....Director of Longwalls for Murray Energy
John Beattie .....Faceman
Tom Updegraff.....Longwall Headgate Operator
Matt Remke.....Longwall Shield Operator / EMT
Richard Miller.....Longwall Maintenance Foreman
Ken Torac .....Loader Operator
Eric Koontz.....General Superintendent
Colby Yarbrough.....Miner Bolter
Eric Lipinski.....Superintendent
Matt Jarrett.....Longwall Coordinator – East Side
Nick Vuchenich.....Longwall Production Foreman

APPENDIX D

Victim Information

Accident Investigation Data - Victim Information

Event Number: 6 2 6 8 4 1 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:
John M. Garloch	M	45	01 Fatal

5. Date(MM/DD/YY) and Time(24 Hr.) Of Death:	6. Date and Time Started:
a. Date: 03/08/2015 b.Time: 21:45	a. Date: 03/08/2015 b.Time: 16:00

7. Regular Job Title:	8. Work Activity when Injured:	9. Was this work activity part of regular job?
049 Supervisory/management/foreman/boss	011 Clean up	Yes	No X

10. Experience	Years	Weeks	Days		Years	Weeks	Days		Years	Weeks	Days		Years	Weeks	Days
a. This Work Activity:	0	36	0	b. Regular Job Title:	0	36	0	c: This Mine:	12	48	0	d. Total Mining:	12	48	0

11. What Directly Inflicted Injury or Illness?	12. Nature of Injury or Illness:
122 Side or rib	170 Crushing

13. Training Deficiencies:
Hazard: | New/Newly-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: X | EMT: X | Medical Professional: X | None: |

16. Part 50 Document Control Number: (form 7000-1) 220150770028
17. Union Affiliation of Victim: 9999 None (No Union Affiliation)