

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

COAL MINE SAFETY AND HEALTH

REPORT OF INVESTIGATION

Surface Coal Mine

Fatal Surface Haulage Accident
May 28, 2015

ST&T Leasing, Inc. (ZJD)
Pikeville, Kentucky

at

No. 11 Allen Branch Job
Apex Energy, Inc.
Phelps, Pike County, Kentucky
I.D. No. 15-19722

Accident Investigator

Todd Belcher
Coal Mine Safety and Health Inspector, Surface Specialist

Originating Office
Mine Safety and Health Administration
District 6
100 Fae Ramsey Lane
Pikeville, KY 41501
Jim W. Langley, Acting District Manager

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Photograph of Accident Scene



OVERVIEW

At approximately 11:55 a.m., on Thursday, May 28, 2015, Roy Mullins, a 45-year-old foreman for ST&T Leasing Inc., received fatal injuries when he was pinned between the rear of a road grader and the front of a loaded tractor-trailer truck. The tractor-trailer was transporting the base power module of the highwall mining machine to the mine site. The tractor-trailer was unable to ascend the steep incline without assistance. A road grader was driven to the tractor-trailer to provide assistance. The victim was positioned between the two machines connecting a chain when the grader rolled back, fatally crushing the victim. R. Mullins had approximately 27 years of total mining experience, one year and four months at this mine, and approximately 15 years with ST&T Leasing. Chris Mullins, an equipment operator for Apex Energy, was operating the road grader.

The accident occurred because the service brakes failed on the road grader. The haul road grade was too high for the tractor-trailer and adequate training was not given to miners and contractors regarding proper towing procedures.

GENERAL INFORMATION

Apex Energy Inc; is a privately owned and operated company and is a subsidiary of Cambrian Coal Corporation. Apex Energy has multiple active surface mining operations located in Eastern Kentucky and Southwest Virginia. Contour and highwall mining methods are utilized to extract coal from multiple coal seams that are commonly mined in eastern Kentucky.

ST&T Leasing Inc. is a privately owned company that provides trucks primarily for coal haulage. The trucks are also used to transport the highwall mining machine and accessories when the highwall mining machine is transported between Apex surface mine operations.

The No. 11 Allen Branch Job mine operates one, 10-hour shift per day, five days per week, and employs 18 miners. The mine produces approximately 300 tons of coal per day. The last regular safety and health inspection of the mine prior to the accident was completed on March 31, 2015. The non-fatal days lost (NFDL) injury incidence rate at this mine in 2014 was 6.89 compared to a national average of 1.00.

The principal officers of Apex Energy, Inc. at the time of the accident were:

James H. Booth.....	President
Ted McGinnins.....	Vice President
J. Mark Campbell.....	Vice President/Secretary

DESCRIPTION OF ACCIDENT

On Thursday, May 28, 2015, at approximately 5:00 a.m., four of the ST&T employees reported to work at the Big Creek Shop No. 1. R. Mullins, victim, and another truck driver, Doug Taylor, arrived at approximately 5:30 a.m. in trucks driven from off-site. All trucks departed the shop at approximately 6:00 a.m. and arrived at the Piney Branch Mine, located in Buchanan County, Virginia, at approximately 7:20 a.m. Their work assignment consisted of transporting the highwall mining machine from the Piney Branch surface mine to the Apex No.11 surface mine. The first truck was loaded with the cab reel and highwall miner cab. The next truck, driven by R. Mullins, was loaded with the base power module (BPM). These two trucks departed the mine site at approximately 10:30 a.m. and traveled to the Apex mine, arriving at approximately 11:30 a.m. Four other trucks departed at approximately 11:30 a.m. and arrived between 12:15 and 12:30 p.m. at the mine. The truck drivers and equipment they were hauling are listed below in order of departure from the Piney Branch Mine:

- 1) Michael Sammons, cab and reel
- 2) R. Mullins, base power module
- 3) John Boggs, super beam
- 4) Joseph Mullins, super beam
- 5) Darrell Smith, main frame
- 6) Doug Taylor, miner head

The first truck to arrive at the mine was driven by Sammons. He transported his load to the Elkhorn No. 2 seam level without any assistance. The next truck to arrive at the mine was driven by R. Mullins. While traveling up the haul road, the vehicle stalled in a left-hand curve just below the equipment parking lot. He contacted Everette Crawford, Mine Foreman for Apex Energy, via cell phone to ask for assistance. Crawford responded that he would send someone to help. Crawford then went to get C. Mullins (the brother of R. Mullins), who was operating an excavator to develop access for future mining at the Williamson coal seam level.

Crawford took C. Mullins to the equipment parking lot to get the grader. C. Mullins conducted a pre-operational examination on the grader and then drove the grader to assist R. Mullins. R. Mullins indicated to C. Mullins that he needed assistance due to the weight of the BPM shifting to the left side of the trailer, causing loss of traction. One end of a 10-foot chain was attached to the rear of the grader and the other end to the front of the Mack Granite truck. C. Mullins then towed R. Mullins's truck (approximately 150 feet) to a flat area near the equipment parking lot and unhooked the chain from the front of the truck. C. Mullins traveled ahead of R. Mullins up the slope to the next steep road incline, just below the Elkhorn No. 2 seam bench and waited.

C. Mullins observed R. Mullins attempting to ascend the steep incline. R. Mullins was only able to ascend the steep incline approximately 207 feet before having to back down to a point near the bottom. R. Mullins's truck was positioned on approximately a 12% incline just above the level area. As C. Mullins was backing the grader down the slope, R. Mullins was standing beside the passenger side of his truck waiting to perform the hook-up for towing. After positioning the grader within a few feet of the front of the truck, C. Mullins lowered the grader blade and set the park brake. R. Mullins attempted to attach the chain to the tow hook of the truck, but the chain wouldn't reach. R. Mullins stepped back off to the side of the grader and motioned for C. Mullins to come back further. C. Mullins released the park brake and raised the grader blade up slightly to let the grader roll back in neutral while applying the service brake and the clutch brake (D-brake).

While C. Mullins held the grader stationary with both the service foot brake and clutch brake (D-brake) applied, R. Mullins stepped back in between the rear of the grader and the front of the truck to attach the chain. After about 4 or 5 seconds, the low air pressure alarm sounded and the grader rolled backward while C. Mullins applied both service brakes. After realizing the grader had made contact with the front of the truck, C. Mullins exited the left side of the grader and observed R. Mullins pinned between the grader and truck. C. Mullins re-entered the cab of the grader and pulled forward a couple of feet and set the park brake. The low air pressure alarm was still sounding while he pulled forward. C. Mullins returned to R. Mullins and checked for a pulse but got no response. C. Mullins then called Crawford for help. C. Mullins stayed with R. Mullins, while Crawford went to get Neal Anders, C. W. Augering Superintendent, for assistance. Crawford and Anders returned with the MET (Mine Emergency Technician's kit) but were unable to administer medical treatment due to the nature of the injury.

The first emergency responder from the Phelps Fire Department received a call at 12:02 p.m. and arrived at 12:21 p.m. The safety director for Apex Energy had called the mine office and instructed the secretary to call 911. Trans-Star ambulance service arrived at 12:35 p.m., and transported C. Mullins to Pikeville Medical Center for emotional trauma and distress related to the accident. Russell Roberts, Pike County Coroner, pronounced R. Mullins dead at the scene of the accident at 1:35 p.m.

INVESTIGATION OF ACCIDENT

Craig Spartman, Safety Director for Apex Energy, first notified the Call Center at 12:02 p.m., and later called the Phelps Field Office at approximately 12:10 p.m., to report the fatal accident. The MSHA District 6 Office was notified by the Call Center at 12:14 p.m. Silas Adkins, Pikeville Field Office Supervisor issued a verbal 103(j) order to Sam Billiter, Apex Energy Mine Manager, at 12:20 p.m.

MSHA personnel from the Phelps field office were immediately dispatched to the scene. The 103(j) order was modified to a 103(k) Order upon MSHA personnel arriving at the mine. The 103(k) was issued to ensure the safety of any person working at the mine. The investigation was conducted in cooperation with the Kentucky Division of Mine Safety. The Kentucky State Police came to the accident scene and conducted an independent investigation.

Photographs and relevant measurements were taken. A review of the training records was conducted. A mechanical evaluation of the Caterpillar 16G road grader involved in the accident was performed by an engineer from the MSHA Approval and Certification Center, Mechanical Engineering and Safety Division. Interviews were conducted with five employees of Apex Energy, Inc., three employees of ST&T Leasing, Inc., and one employee of CW Augering, Inc. Eight of the interviews were conducted on May 29, 2015, at the Pikeville, Kentucky Division of Mine Safety office. The remaining interview was conducted at the MSHA District 6 Office in Pikeville, Kentucky on June 8, 2015. A list of those who were interviewed can be found in Appendix A and those who participated in the investigation can be found in Appendix B.

DISCUSSION

ACCIDENT SCENE

The steep incline section of road the victim was attempting to ascend was approximately 594 feet in length, with an overall sustained grade of approximately 20%. This road was constructed of spoil material from the overburden that had been removed during previous surface mining. The road surface was firm and dry and was approximately 28 feet wide. The road provides access from the Lower Alma coal seam level to the Elkhorn No. 2 coal seam level, with an elevation change of approximately 120 feet. This was the last steep section of road just prior to reaching the level area on the Elkhorn No. 2 seam mine bench where the highwall miner was to be assembled. At the time of the accident, this road had been used for approximately one year for coal haulage and other general access use. A sketch of the accident scene and steep road incline is included in Appendix C Drawings 1 and 2.

The tractor-trailer driven by the victim was parked on an approximate 13% grade and the grader was parked on an approximate 22% grade. Tire tracks from the truck were observed at a distance of 207 feet up the steep incline from the bottom level area (Lower Alma). This location was at the steepest section of the road - approximately 25% grade. The rear of the grader was observed approximately 28 inches from the point where contact was made with the front bumper of the truck. The grader blade was down and had left a scrape mark from the initial ground contact point to the point of impact with the truck measuring 94 inches in length (see Appendix C Drawing 3).

The grader's park brake was set and the transmission was in neutral. Both the grader and the truck were scotched with chocks to block both pieces of equipment from movement after the accident occurred.

The grader is equipped with a ripper attachment that is mounted to the rear of the grader (see Appendix C Drawing 3). It measures 9 feet 10 inches wide from outside to outside. It has seven available receiver holders for ripper teeth to be installed. It was only equipped with two ripper teeth. The tooth on the right side was turned down and the one on the left side was turned up. The one on the right side was barely touching the ground and would not have provided any stopping force as evidenced by no scrape marks on the ground. The third ripper tooth receiver from the left side made contact with the victim. The right side portion of the truck's front bumper was pushed back into the right front truck tire from the force of impact from the grader.

The end of the chain to be connected to the truck was piled near the hook on the right side of the truck's front bumper, indicating the victim most likely was in the process of attempting to secure the chain on the hook under the front bumper of the truck. The other end of the chain was fastened to the second receiver holder over from the left side end of the ripper attachment (see Appendix C Drawing 4). It was apparent that the victim was in a crouched or squatted position due to the vertical height of the contact point made between the rear of the grader and the front truck bumper. The victim would not have been visible to the grader operator while in this position, due to the blind spots at the rear of the grader.

The steep road grade where the grader was positioned while the victim attempted to connect the chain, the short length of the chain, the inability of the grader operator to make constant visual contact with the victim, and the failure of the service brakes all contributed to this accident.

The front of the tractor-trailer was approximately 70 feet from being positioned on the level ground that was located behind the truck. The front of the grader was positioned further up the slope and was about 115 feet from being on level ground at the bottom of the slope. The total distance from the bottom of the road slope to the top, at the Elkhorn 2 seam level, is 594 feet.

MECHANICAL EVALUATION OF EQUIPMENT

Equipment Information

The equipment involved in the accident was a Caterpillar road grader, model 16G, and the serial number is 93U02040. The gross vehicle weight (GVW) was approximately 60,100 pounds. The hour reading was 13,002.1 hours and it was manufactured in 1981. The grader is approximately 38 feet long (with ripper attachment), and approximately

10 feet wide. The grader weighs approximately 64,800 pounds including the ripper attachment with a full tank of fuel.

The tractor driven by the victim was a 2005 Mack Granite. The serial number is 1M1AG11Y65M033398. The low-boy trailer being pulled by the tractor was a Pitts Trailer. The serial number is 5JYLB35229P090308. The GVWR was 86,400 pounds and it was manufactured in November of 2008.

A base power module for the highwall miner, weighing 40,000 pounds was being transported on the trailer. Neither the GVWR of the tractor or trailer were exceeded in transporting the base power module. A mechanical evaluation of the tractor-trailer was not considered necessary because it was not determined to be a contributing factor in the accident.

Road Grader Operator's Compartment

The service brake and accelerator pedal could be moved without difficulty by hand. During later tests with the grader running, no defects with the accelerator's foot control or hand operated governor control of the engine's speed were observed. The positions of the operator's controls were observed after the accident. The transmission lever was in neutral and the park brake lever was in the applied "ON" position when the machine was viewed during the investigation. The operator's compartment of the grader was free of debris that could have interfered with the operation of the grader. The hour meter, engine temperature meter, two brake air pressure gauges and the engine oil pressure gage were mounted on the engine cover located outside and to the rear of the operator's compartment. To view the gauges, the operator would have to turn around and look through the cab's rear window. Dirt on the rear window and on the glass covers of the gauges, made reading the gauges difficult. Visibility to the rear of the grader was limited by the engine cover. The transmission lever was in neutral and the park brake lever was in the applied "ON" position when the machine was viewed during the investigation. The grader had been moved forward up the grade after the accident.

Road Grader Brake System

The grader was equipped with a service brake and a park brake. The service brake consisted of air applied, wet disk brakes at each of the four rear wheel spindle housings. There were no brakes on the front axle.

The service brakes consist of two independent air circuits divided between the left and right side rear wheels. The failure of one circuit would not affect the operation of the other circuit. An air tank with separate reservoirs for the left and right side circuits supplied air to the dual circuit service brake valve. The service brake valve was activated by a foot pedal in the operator's compartment.

Examination of the service brake system identified a large air leak in a brake system component in the left side tandem housing (chain box). The tandem housing was not disassembled to locate the source of the leak.

It was determined that at engine high idle, the air compressor could keep up with the leak and maintain air pressure to both the left and right side service brake systems but at low engine idle or with the engine off, the left side air reservoir pressure quickly (within approximately 20 seconds) dropped to 0 psi with the service brakes applied. The right side air reservoir pressure also dropped when the service brake was applied. Its air loss rate was approximately 16 psi/min. Considering an acceptable maximum 2 psi/min. air loss rate for on-highway trucks, this leakage rate is also excessive and would require maintenance.

The park brake consisted of a wet disk brake in the transmission housing. The park brake was spring-applied and air pressure released. A check valve in the park brake air supply line prevented the park brake from automatic application due to loss of air pressure in the system. Manually applying the park brake caused the transmission to shift to neutral. The park brake could be used as an emergency brake. The park brake was activated by a hand lever located to the left of the operator and adjacent to the transmission gear shift lever. Examination of the park brake system did not identify any defects.

WORKPLACE EXAMINATION

Title 30 CFR § 77.1713(a) requires examinations by a certified person of each working area of the mine at least once during each shift.

Examinations of the work areas for Apex Energy Inc. were performed by Everette Crawford, a certified person. The record for the workplace examination on the date of the accident conducted at 6:05 a.m., stated that “all work areas appear safe”.

PRE-OPERATIONAL EXAMINATION

Title 30 CFR § 77.1606(a) requires that mobile loading and haulage equipment shall be inspected by a competent person before such equipment is placed in operation. Equipment defects affecting safety shall be recorded and reported to the mine operator. A pre-operational examination form was filled out by C. Mullins on the Caterpillar 16G grader, dated May 28, 2015, according to the copy of the form in the cab of the grader. This form indicated the foot (service) brake required repair. However, after interviewing C. Mullins, he indicated that he did not fill out the pre-operational examination form before the accident. According to C. Mullins, he never informed anyone of the service brake defect nor had he given a copy of the pre-operational examination form to anyone before the accident. He said he first realized the brake

defect when the grader suddenly rolled backward while he was maintaining constant pressure on the foot pedal at the time of the accident. He said he then filled out the form in the pre-operational examination book of forms and marked that the foot brake was defective.

Title 30 CFR § 77.1606(c) requires that equipment defects affecting safety shall be corrected before the equipment is used. The grader was put into service on May 28, 2015. The equipment operator's pre-shift safety checklist book was retrieved from the cab of the grader. The pink copies left in the book date back to February 26, 2015, when the grader was located at the Piney Branch Mine site. The first entry in the book for Allen Branch, dated March 17, 2015, listed the grader door required repair. A total of eight separate pre-operational examinations were listed in the book between March 17, 2015 and May 28, 2015. None of these records indicated any defects with the service brake. Additionally, there was no indication that the defective service brake was ever reported to MSHA. The results of the investigation, interviews and mechanical evaluation could not determine whether the air leaks in the braking system existed immediately prior to or occurred during operation at the time the accident occurred.

TRAINING

Training records for both R. Mullins and C. Mullins were reviewed by Bruce Linville, Training Specialist, Educational Field and Small Mine Services. His findings are included as follows:

A review of the training records for ST&T Leasing Inc. revealed that R. Mullins (victim) had received appropriate Part 48 training. R. Mullins received annual training on July 26, 2014 and hazard training on January 1, 2015. Records were not provided verifying task training for the Mack Granite truck he was driving at the time of the accident. According to statements from his co-workers, R. Mullins had operated trucks for the contractor for the past several years. Since he had operated the truck in the past, the record retention requirement of two years is not applicable.

A review of the training records for C. Mullins indicated he received the appropriate Part 48 training. He received task training on January 16, 2012, for the grader he was operating at the time of the accident. He also received annual refresher training on February 7, 2015. According to statements by his co-workers, he had operated the grader periodically in each of the last 3 years, dating back to the time of the task training on file.

ROOT CAUSE ANALYSIS

The accident investigation team conducted an analysis to determine the most basic causes of the accident. Listed below are the root causes they identified during the analysis and the corresponding corrective actions implemented to prevent a recurrence of the accident.

1. Root Cause: The mine operator failed to establish policies and procedures to ensure access roads are designed and maintained to allow mobile equipment operators to travel the roadways without being towed.

Corrective Actions: The mine operator revised the ground control plan to state that the mine operator will use best efforts to design and maintain access/haul roads to allow equipment operators to travel the roadways without assistance. Mine employees and the trucking contractor, used to transport the highwall miner were trained in the ground control plan revision. The road where the accident occurred has been eliminated from use. An alternate road with a lesser grade has been established to provide access to the Elkhorn 2 seam coal level.

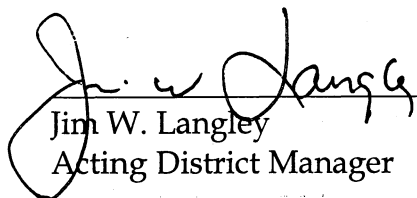
2. Root Cause: The policies and procedures of the mine operator were inadequate to ensure that proper towing procedures and equipment were in place when towing became necessary.

Corrective Actions: The mine operator developed policies and procedures to be followed when towing becomes necessary. These procedures were incorporated into the mine operator's ground control plan, training plan, and safety program of instruction. All mine employees were task trained in the elements of these plans.

CONCLUSION

The accident occurred when the service brake failed on the Caterpillar 16G road grader. The road was not properly designed to have a grade that could be travelled by the tractor-trailer carrying the base power module. Additionally, the mine operator failed to adequately train all mine employees in proper towing procedures.

Approved by:


Jim W. Langley
Acting District Manager

12-07-2015
Date

ENFORCEMENT ACTIONS

1. A 103(j) Order No. 8302959 was issued on May 28, 2015, to Apex Energy, Inc. to assure the safety of all persons at the mine. The 103(j) order was later modified to a 103(k) order once MSHA arrived at the mine.

Condition or practice: A fatal mining accident has occurred at this mine site, at approximately 11:55 am, when a miner was caught between the front end of a Mack tractor-trailer low boy, serial number 1M1AG1Y65M033398, and a Cat 16G grader, serial number 930U2040, while attempting to connect a chain between the two machines, in preparation for towing. A verbal 103(j) order was issued to Sam Billiter, mine manager, at 12:20 p.m. by Silas Adkins, Field Office Supervisor. The entire mining operation is to cease work and all equipment is to be shut down while the cause of the accident is determined.

2. A 104(a) Citation No. 8300772 was issued for a violation of 30 CFR 77.1605(b) for failure to maintain adequate brakes on the Caterpillar 16G road grader.

Condition or practice: The company has failed to maintain adequate brakes on the Caterpillar 16G Road Grader, unit #207, serial number 93U02040. On May 28, 2015, a fatal accident occurred when the truck driver was attempting to make a connection with a chain between the tractor/trailer and the grader in order to tow the truck up a steep incline. The grader operator was holding the service/foot brake when the grader suddenly lost air and rolled back down the slope fatally crushing the victim between the rear of the grader and the front truck bumper. Technical support has conducted a mechanical evaluation of the road grader and found the braking system had air leaks on both the left and right sides. After numerous tests were conducted to determine the rate of air loss and ability to regenerate air for the air brake system, it was determined that the grader should have not been in service at the time the accident occurred.

3. A 104(a) citation No. 8300774 was issued for a violation of 30 CFR 48.27(a) for failure to insure adequate training was given to mine employees for proper towing procedures.

The company has failed to insure that adequate task training was given to mine employees for proper towing procedures. On May 28, 2015, a fatal accident occurred when the victim was attempting to make a connection with a chain to a tractor for towing up a steep incline.

4. A 104(a) citation No. 8300776 was issued for a violation of 30 CFR 48.23(a) for failure to insure adequate training was given to mine employees for proper towing procedures.

The contract trucking company has failed to insure that adequate task training was given to the contract trucking company employees for proper towing procedures. On Thursday, May 28, 2015, a fatal accident occurred when the victim was attempting to make a connection with a chain to a tractor for towing up a steep incline.

Appendix A

List of Persons Interviewed

ST&T Leasing, Inc.

Jay Kennedy Bingham.....	Truck Driver
Michael Andrew Sammons.....	Truck Driver
Darrell Austin Smith.....	Truck Driver

Apex Energy, Inc.

Bud Allen Coleman.....	Equipment Operator
Everette Stewart Crawford.....	Foreman
Junior Lee Hurley.....	Equipment Operator
Jared Moore.....	Mechanic
Chris Mullins.....	Equipment Operator

CW Augering, Inc.

William Neal Anders.....	Superintendent
Billy Shelton (attended).....	Miners Representative
Sam Billiter (attended).....	Miners Representative

APPENDIX B

List of Persons Participating in the Investigation

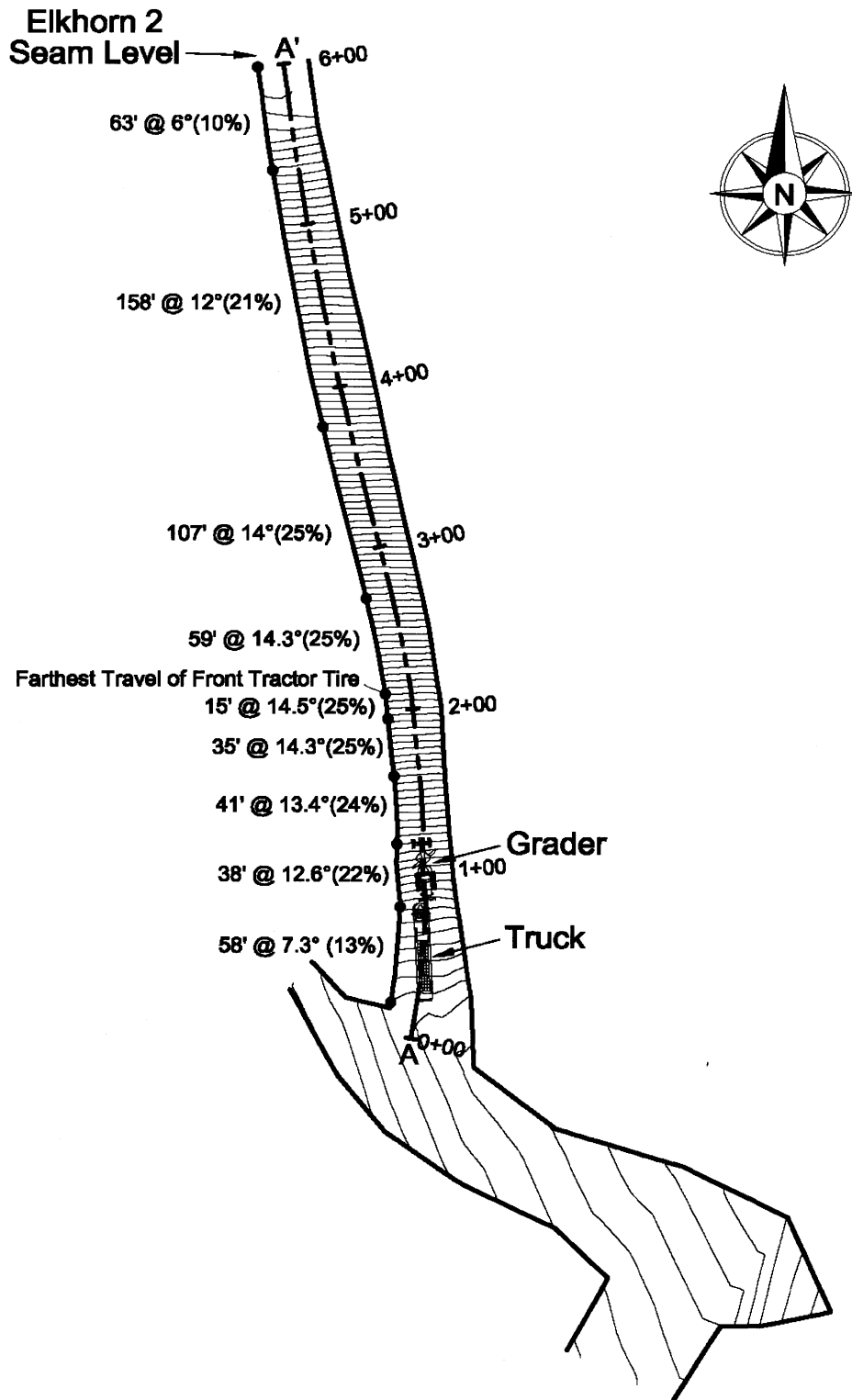
Kentucky Office of Mine Safety and Licensing

Tim Fugate	Accident Investigator
Greg Goins.....	Accident Investigator
Glen Mace.....	Inspector
Randy Chapman.....	Inspector

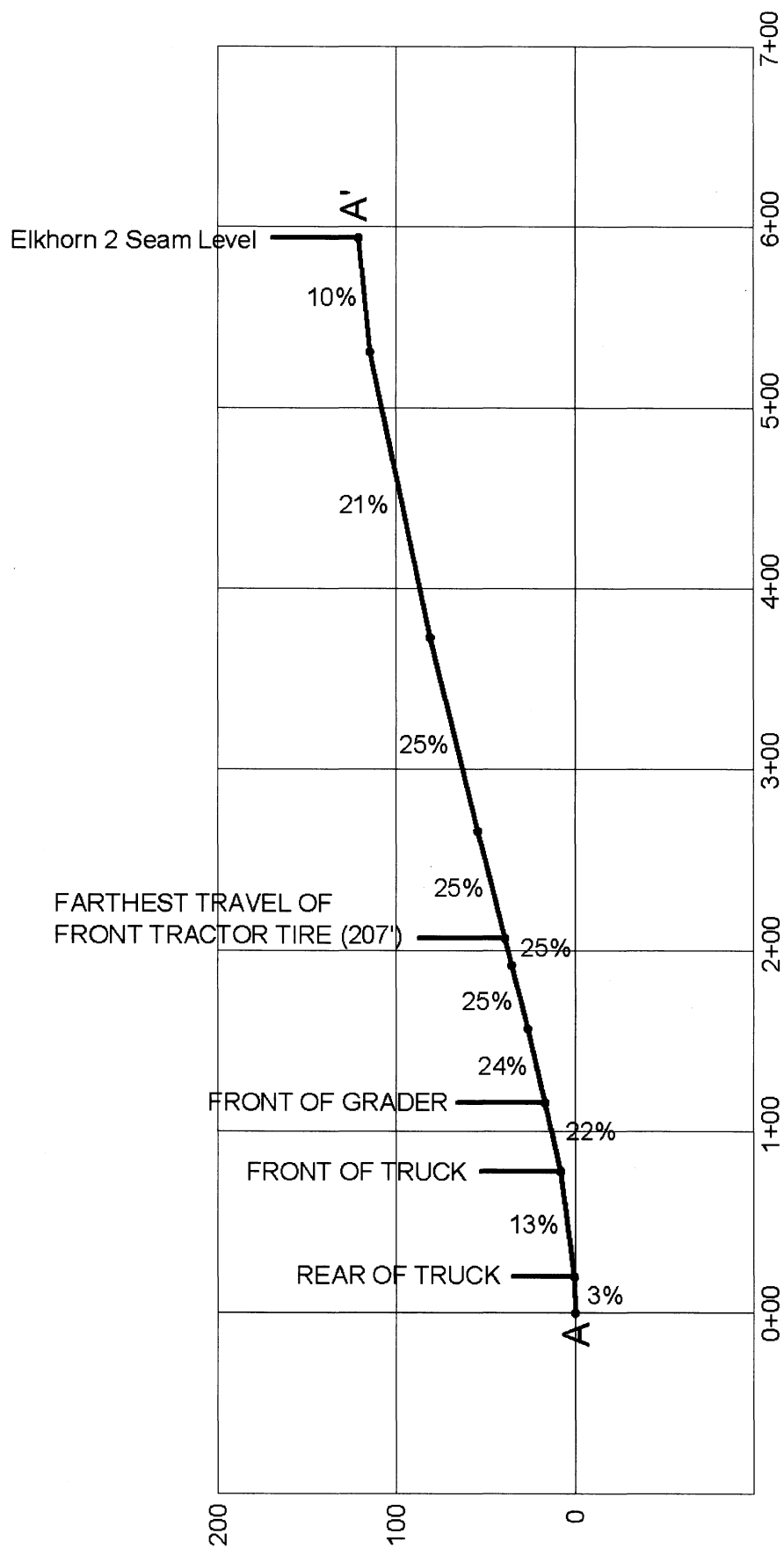
Mine Safety and Health Administration

Mike Sergent.....	Assistant District Manager
Silas Adkins.....	Supervisory Coal Mine Inspector
Robert Bellamy.....	Supervisory Roof Control/Impoundments
Alan Howell.....	Supervisory Special Investigations
John Godsey.....	Staff Assistant/Accident Investigator Coordinator
Bruce Linville.....	Training Specialist, Educational Field Services
Chalmer Williamson.....	Training Specialist
Jim Angel.....	Mechanical Engineer
Todd Belcher.....	Surface Specialist/Lead Investigator
Wanda McComas.....	Surface Specialist
Melvin Wolford.....	Surface Specialist
Gregory Hall.....	Civil Engineer
Larry Wolford.....	Coal Mine Inspector

Appendix C
Drawing 1

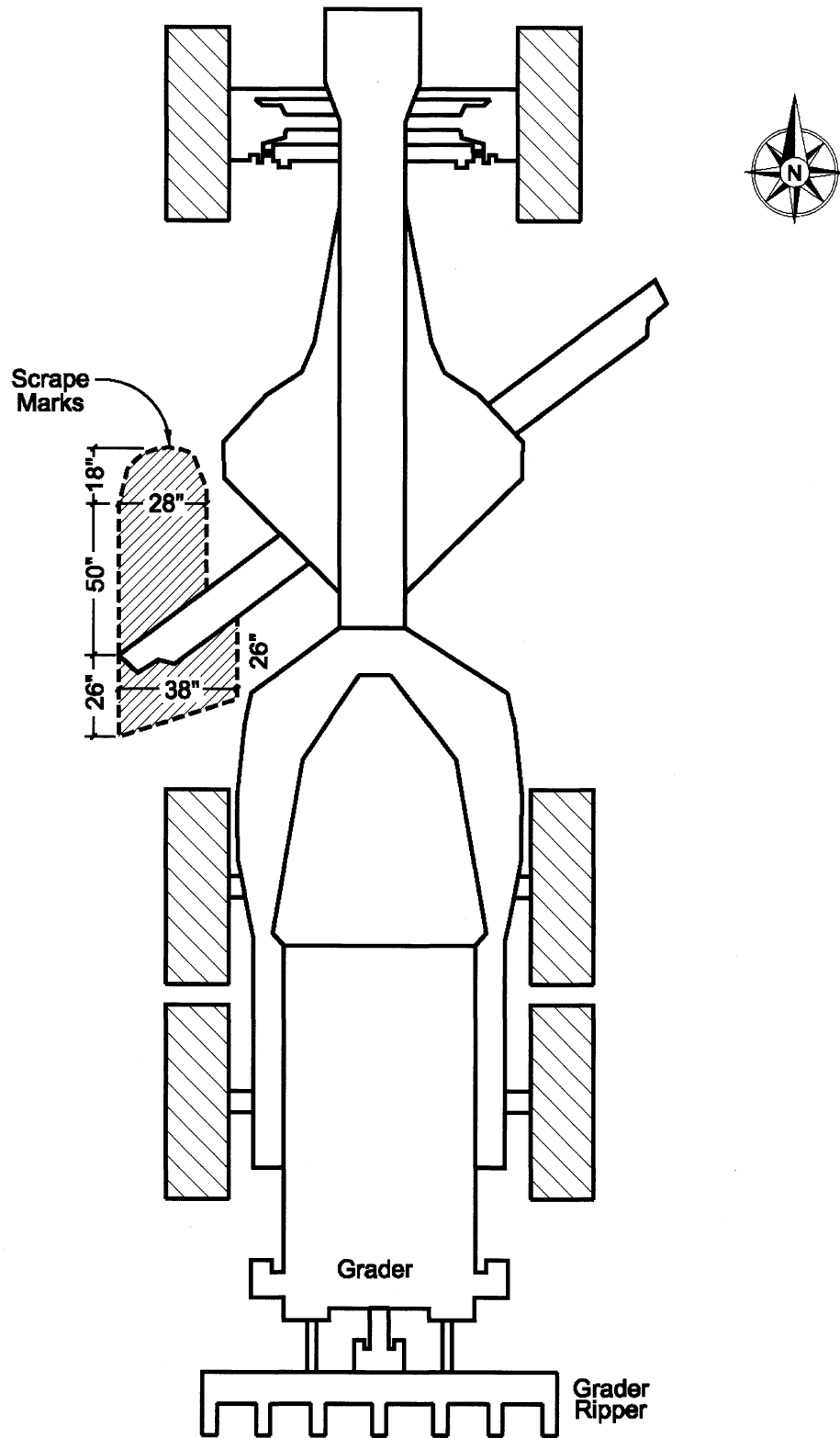


Plan View Sketch
(Not to Scale)

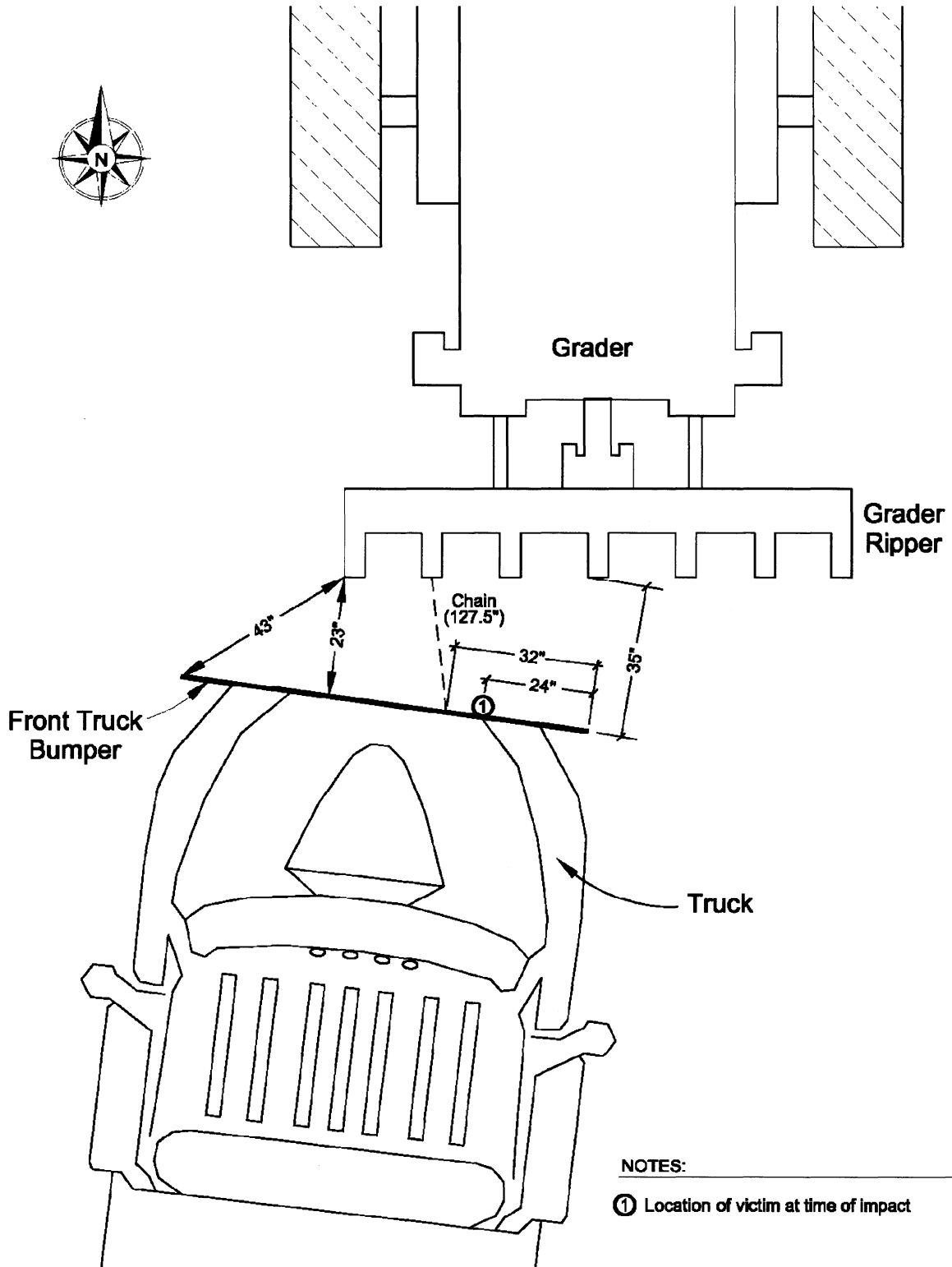


SECTION A - A' PROFILE OF ACCESS ROAD (Not to Scale)

Drawing 3



Drawing 4



Enlargement Sketch
(Not to scale)

APPENDIX D
Photographs





APPENDIX E

Victim Information

Accident Investigation Data - Victim Information

Event Number: 6 3 8 1 8 3 8

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																			
Roy L. Mullins			M		45		01 Fatal																			
5. Date (MM/DD/YY) and Time (24 Hr.) Of Death																										
a. Date: 05/28/2015 b. Time: 11:55																										
6. Date and Time Started:																										
a. Date: 05/28/2015 b. Time: 5:00																										
7. Regular Job Title:				8. Work Activity when Injured:				9. Was this work activity part of regular job?																		
049 Contract Truck Shop Foreman				098 connecting tractor to a grader				Yes No <input checked="" type="checkbox"/> X																		
10. Experience			Years			Weeks			Days			b. Regular			Years			Weeks			Days					
a. This			15			7			4			b. Regular			15			7			4					
Work Activity			Mining			1			16			0			d. Total			Years			Weeks			Days		
c. This			1			16			0			Mining			27			0			0					
11. What Directly Inflicted Injury or Illness?																										
076 Crushed between tractor and road grader																										
12. Nature of Injury or Illness:																										
170 fatal crushing injury																										
13. Training Deficiencies:																										
Hazard New/Newly-Employed Experienced Miner: Annual Task:																										
14. Company of Employment: (If different from production operator)																										
ST&T Leasing, Inc. Independent Contractor ID: (if applicable) ZJD																										
15. On-site Emergency Medical Treatment:																										
Not Applicable First-Aid: CPR: EMT: Medical Professional: None: <input checked="" type="checkbox"/> X																										
16. Part 50 Document Control Number: (form 7000-1)																										
17. Union Affiliation of Victim: 9999 None (No Union Affiliation)																										