

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

COAL MINE SAFETY AND HEALTH

REPORT OF INVESTIGATION

Underground Coal Mine

Fatal Falling Materials Accident
June 27, 2015

4 West Mine
Dana Mining Company of Pennsylvania LLC
Dilliner, Greene County, Pennsylvania
Mine I.D. No. 36-09326

Accident Investigators

Walter R. Young
Coal Mine Safety and Health Inspector, Ventilation Specialist

Walter George Taylor
Coal Mine Safety and Health Inspector

Originating Office
Mine Safety and Health Administration
District 2
631 Excel Drive, Suite 100
Mount Pleasant, PA 15666
Gregory W. Fetty, District Manager (Acting)

TABLE OF CONTENTS

PHOTOGRAPH OF ACCIDENT SITE.....	ii
OVERVIEW	ii
GENERAL INFORMATION.....	1
DESCRIPTION OF ACCIDENT	1
INVESTIGATION OF ACCIDENT	2
DISCUSSION.....	3
ROOT CAUSE ANALYSIS.....	6
CONCLUSION.....	7
ENFORCEMENT ACTIONS.....	8
APPENDIX A – Persons Participating in the Investigation.....	10
APPENDIX B - Expanded View of the Accident Scene.....	12
APPENDIX C – Kennedy Manual Machine Door Installation Instructions	13
APPENDIX D – Airlock Door Sketches	15
APPENDIX E – Victim Information	17



Approximate location of victim positioned under this airlock door

OVERVIEW

On June 27, 2015, at approximately 11:45 p.m., a 55-year-old diesel scoop operator, was fatally injured when he opened both sets of airlock doors to pass through the area with a load of supplies. The scoop and supply cars were too long to fit in between the two sets of airlock doors. After passing through the area, he closed the outby set of airlock doors which became dislodged and fell onto the victim pinning him between the door and the mine floor.

The fatal accident occurred because management failed to ensure that all airlock doors were installed in accordance with the manufacturer's recommendations.

GENERAL INFORMATION

The 4 West Mine is an underground mine owned and operated by the Dana Mining Company of Pennsylvania LLC, located in Greene County, Pennsylvania. The mine is accessed by four drift openings into the 54 inch to 72 inch Sewickley (bituminous) coal seam. At the time of the accident, the mine was ventilated with two intake shafts and two exhausting mine fans. The mine produces 763,900 cubic feet of methane every 24 hours. The mine employs 392 miners, with day shift working from 8:00 a.m. to 8:00 p.m. and the afternoon shift working from 8:00 p.m. to 8:00 a.m. The mine currently has four continuous mining machine sections producing 9,000 tons per day. Coal is extracted by continuous mining machines and transported by shuttle cars or ram cars and conveyor belts to the surface. Materials, supplies, and miners are transported into the mine using rubber-tired diesel scoops and rubber-tired diesel or battery-powered personnel carriers.

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

James Price.....Superintendent
Gary Dixson..... Safety Director

Prior to the accident, the Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection (E01) of the 4 West Mine on March 31, 2015. At the time of the accident, an E01 inspection was ongoing. The Non-Fatal Days Lost (NFDL) injury incidence rate for this mine in 2014 was 1.03, compared to the National NFDL rate of 3.31 for mines of this type.

DESCRIPTION OF THE ACCIDENT

John W. (Bill) Kelly, Outby Diesel Scoop Operator, started his regular shift on Saturday, June 27, 2015, at 5:00 p.m. The outby diesel scoop operators begin their shift early to alleviate the congestion in the rubber tired haulage roads. At approximately 11:45 p.m., after delivering supplies throughout other areas of the mine, Kelly was making his first trip through the 10 Right area of the mine in the company number 2 diesel scoop attached to three supply wagons. He was delivering conveyor belt supplies to the F-7 Working Section and had arrived at the outby set of airlock doors in the number 4 entry that he needed to pass through. The common practice was to disconnect the third supply wagon to allow the diesel scoop and two supply wagons to fit between the two sets of airlock doors. Kelly, however, opened both sets of airlock doors located at the 63.5 and 64.5 crosscuts and then trammed the diesel scoop and supply wagons to a point where the last supply wagon was inby the inby set of airlock doors. Kelly then traveled on foot to close the outby set of airlock doors prior to closing the inby set of airlock doors. While closing the outby set of airlock doors, the set of airlock doors and frame fell on Kelly, pinning him to the mine floor.

Bill Alexander, Outby Diesel Scoop Operator, was unloading supplies in the 11 Mains section when he noticed the victim's cap lamp had not moved in some time. Alexander

traveled to the airlock doors and discovered Kelly under the airlock doors with his head partially exposed from under the top frame of the doors. Alexander could not detect any vital signs. Alexander made several attempts to free Kelly, but could not under the heavy weight of the doors and frame. Alexander then traveled approximately 1,000 feet to the 11 Mains Working Section and told Ben Wilt, Section Mechanic, to get the Emergency Medical Technician (EMT) from the section and send him to the victim's location. Wilt traveled to the working faces and told Jeremiah Adams, Roof Bolter Operator, an Emergency Medical Technician (EMT), that help was needed at the accident scene. J. Adams departed immediately and traveled to the accident scene.

When J. Adams arrived at the accident scene, he and Alexander extricated Kelly and began to perform cardiopulmonary resuscitation (CPR). Robert Adams, Section Foreman, told Thomas Gray, Roof Bolter Operator, to gather up the EMT supplies on the section and take them to the accident scene. An Automated External Defibrillator (AED) was placed on Kelly, which advised them not to shock. J. Adams and Alexander stopped a diesel personnel carrier that was passing by to transport Kelly. Gray and Alexander continued to perform CPR. Once Kelly was placed on a back board and secured on the diesel personnel carrier, they began traveling the 6,700 feet toward an escape elevator.

Mark Knotts, Shift Foremen and outside responsible person, heard someone on the mine pager calling in a very excited manner around 12:25 a.m. Knotts answered the pager and Alexander informed Knotts that there had been an accident. Knotts told John Tichnell, Production Coordinator, to call James Price, Superintendent, and notify him that there may be something serious going on in the mine. James Taylor, Outside/Tracking Person, called 911 at 12:44 am.

The victim arrived on the surface at approximately 1:15 am and was taken by EMS Southwest ambulance service to South West Regional Medical Center in Waynesburg, Pennsylvania where he was pronounced dead by Gregory P. Rohanna, Greene County Coroner, at 1:43 a.m. on June 28, 2015.

INVESTIGATION OF THE ACCIDENT

Price received the call from the mine at home at 12:38 a.m. and called the MSHA hotline at 12:40 a.m. Records show that the first call was received from the mine and it was disconnected accidentally at 12:40 a.m.

Price then contacted Thomas Bochna, Supervisory Coal Mine Safety and Health Inspector, Ruff Creek Field Office, informing him that a scoop operator had been found unresponsive. A 103(j) order was issued verbally by Bochna at 12:50 a.m. to Price to protect the safety of the miners and to preserve the accident scene. J. Taylor was able to complete the notification to the MSHA Call Center at 12:53 a.m. The MSHA Call Center notified Doug Sciotto, MSHA emergency contact person, at 1:02 a.m. Sciotto notified Bochna, who was previously aware of the accident and was arranging for an accident investigator to go to the mine. Bochna contacted Walter R. Young, Coal Mine Safety and

Health Inspector, and directed him to go to the mine. Young arrived at the mine at 2:35 a.m. and modified the 103(j) order to a 103(k) order.

The accident investigation was conducted in cooperation with the Pennsylvania Bureau of Deep Mine Safety and the mine operator. Informal interviews were conducted with miners that were present at the accident scene or involved in the recovery of the victim (see Appendix A). Investigators then traveled to the accident scene where they obtained information, measurements, and photographs during a physical examination of the accident scene.

An additional onsite investigation of the accident scene was conducted on Monday, June 29, 2015, with MSHA Technical Support personnel consisting of Michael Murawski, Civil Engineer, and Rodi Murad, Civil Engineer. Formal interviews were conducted on July 8, 2015, and July 10, 2015. MSHA received additional information that the agency needed to verify and conducted additional interviews on January 19, 2016.

DISCUSSION

Accident Scene

The accident occurred in the number 4 entry of the 10 Right area of the mine, between the number 63 and 65 crosscuts. The area had been examined at 9:28 p.m. on June 27, 2015, and had some standing water on the mine floor. The mine roof was adequately supported and the mine floor was solid. The crosscuts were on 90 foot centers and the mine was approximately 5.5 feet to 6 feet high.

Equipment

The diesel scoop was manufactured by Sandvik, model number 935NP, and serial number 4097. The diesel scoop is 33.5 feet long. The length of the three supply wagons is 21.5 feet, 23 feet, and 18 feet, for a total length of 96 feet, including the scoop.

The airlock doors were manufactured by Jack Kennedy Metal Products and Buildings Inc. Each set of airlock doors was approximately 14 feet wide and 5.5 feet high. The 14 foot lintel weighed 200 pounds, each of the 2 columns weighed 80 pounds, and each door weighed 310 pounds, for a total weight of 980 pounds. The airlock door sets were installed approximately 85 feet apart on June 22, 2015, by Jim Ridenour, Assistant Mine Foreman; Sid Martinez, and Ryan Wilson, Outby Construction Workers.

Accident Scenario

The investigation determined on the evening of the accident, Kelly opened both sets of airlock doors. He then drove the scoop and 3 attached wagons to a point where the back of the last supply wagon was 12 feet in by the inby set of airlock doors. This was done because the 96 foot train could not fit into the 85 foot length within the airlock. Kelly

then traveled by foot to the outby set of airlock doors. While closing the outby set of airlock doors, they fell on Kelly, pinning him to the mine floor (see Appendix B).

Each set of airlock doors would see an incremental increase or decrease in external pressure across each set of doors as they were being opened or closed when used and installed properly.

This sudden increase in external airflow pressure caused the outby set of airlock doors to become dislodged due to not being properly installed per manufacturer's recommendations.

It was evident the doors had not been installed correctly. There was mine sealant on the top of the two outside support columns and 5 out of the 6 T-handle set screws were not installed in the lintels and columns. Without the required T handle set screws, the air lock doors would not be adequately secured. This condition was compounded by the improper use of the airlock system. The roof cleat was missing from the top of the left column (looking outby) of the outby set of airlock doors. When the set of inby airlock doors at the number 64.5 crosscut was inspected, similar conditions were found.

There was one T-handle set screw present in the left side of the airlock lintel (looking outby) at the outby set of airlock doors, and there was one T-handle set screw present in the left side of the airlock column (looking outby) at the inby set of airlock doors. Both T-handle set screws were not tightened.

The manufacturer's installation instructions require that a hydraulic jack be used to tighten the columns between the mine floor and roof to secure the frame in place. Afterwards, all T-handle set screws are to be secured very tight to anchor the airlock doors in place. See the manufacturer's installation instructions in Appendix C and airlock door sketches in Appendix D.

The following evidence supports MSHA's conclusion:

- Interviews by persons at the accident scene during the recovery process revealed they saw the inby set of airlock doors open at the number 64.5 crosscut.
- The diesel scoop and the attached supply wagons were never moved prior to the investigation.
- The investigation and interviews show that the airlock doors were not installed according to the manufacturer's installation instructions.
- No new damage from mobile equipment striking the airlock doors or evidence that persons were pushing the airlock doors with equipment to operate them was observed at the accident site.
- Interviews and a training audit shows persons were not trained in the proper procedure for installation of these airlock doors.
- Buildup of material in the threaded holes for the T-handle set screws and the sealant around the tops of the columns indicate that these doors were not secured to the mine

roof and ribs during installation. The doors that fell had old sealant remaining on them from at least one previous installation.

Training and Experience

Kelly had 34 years of mining experience. He had 3 years and 40 weeks of experience at his regular job duties as an outby diesel scoop operator. Airlock doors were not commonly used throughout this mine, but they had been used in the past to access construction areas located in separate air courses. No specific task training forms were filled out for traveling through airlock doors, but all persons interviewed who were classified as outby diesel scoop operators showed that they had knowledge of how to correctly use and operate the airlock doors.

As previously stated, the airlock doors were installed by Ridenour, Martinez, and Wilson. The mine operator did not properly task train these miners in the correct installation procedures.

ROOT CAUSE ANALYSIS

The accident investigation team conducted an analysis to identify the underlying cause or causes of the accident that were correctable through reasonable management controls. During the analysis, the team identified root causes that, if eliminated, would have either prevented the accident or mitigated its consequences.

Listed below are root causes identified during the analysis and the corresponding corrective actions implemented to prevent a recurrence of the accident:

1. Root Cause: The mine operator's programs, policies, and procedures were not sufficient to ensure that the airlock doors were secured to the mine roof and ribs per manufacturer's recommendations.

Corrective Action: The mine operator developed a policy requiring all persons to install all types of ventilation controls used at the mine, including airlock doors, in accordance with manufacturer's instructions. This included initial training, supervised instruction, and documentation of completion of training.

2. Root Cause: The mine operator failed to instruct miners assigned to a new task in the safety and health aspects and safe work procedures for the task of brattice man/mason (including the building of airlock doors).

Corrective Action: The mine operator trained brattice men/masons in how to build all types of ventilation controls, including airlock doors, in accordance with manufacturer's instructions. This included initial training, supervised instruction, and documentation of completion of training.

3. Root Cause: The airlock doors did not function correctly because both sets were open at the same time.

Corrective Action: The mine operator retrained all miners in the proper use and operation of airlock doors.

CONCLUSION

An outby scoop operator received fatal crushing injuries when a set of airlock doors fell and pinned him to the mine floor. Because the mine operator did not train miners to install the airlock doors properly, the doors were not installed correctly. In addition, the victim did not use the airlock correctly because he opened both sets of doors at the same time. The accident occurred when he was closing the outby set of airlock doors causing the doors to fall on him.

Approved By:

Gregory W. Fetty
Gregory W. Fetty
District Manager (Acting)

02/19/2016
Date

ENFORCEMENT ACTIONS

1. 103(j) Order, number 7033807, was issued to 4 West Mine, to ensure the safety of the miners until the investigation could be completed.

An accident occurred at this operation on 06/27/2015 at approximately 23:45 hours. As rescue and recovery work is necessary, this order is being issued, under Section 103(j) of the Federal Mine Safety and Health Act of 1977, to assure the safety of all persons at this operation. This order is also being issued to prevent the destruction of any evidence which would assist in investigating the cause or causes of the accident. It prohibits all activity in the number 4 entry of 10 Right Area between 63 and 65 crosscut except to the extent necessary to rescue an individual or prevent or eliminate an imminent danger until MSHA has determined that it is safe to resume normal mining operations in this area. This order applies to all persons engaged in the rescue and recovery operation and any other persons on-site. This order was initially issued orally to James Price, Mine Superintendent at 00:50 hours on 6/28/2015 by Coal Mine Safety and Health Supervisor, Thomas Bochna and has now been reduced to writing. Young modified the 103(j) order to a 103(k) order upon his arrival at the mine site.

2. A 104(d)(1) S&S Citation, number 7033810, was issued to 4 West Mine, citing 30 CFR § 48.7(c).

The operator failed to train employees Jim Ridenour, Sid Martinez, and Ryan Wilson assigned to a new task in the safety and health aspects and safe work procedures for the task of brattice man/mason (includes building airlock doors) at the 4 West Mine. After interviews with persons on 7/10/2015 and further review, it was determined that they were not trained by the operator or had ever seen the airlock door manufacturer's installation instructions. This was a contributing factor in a fatal accident which occurred on June 27, 2015.

This citation will not be terminated until these persons who install ventilation controls, including airlock doors have been given the proper training.

3. A 104(d)(1) S&S Order, number 7033811, was issued to 4 West Mine, citing 30 CFR § 75.333(d)(2).

The operator failed to install both pairs of airlock doors located in the 10 right area of the mine, in the number 4 entry at the numbers 63.5 and 64.5 crosscuts to be of sufficient strength to serve their intended purpose of maintaining separation and permitting travel between or within air courses or entries. A fatal accident investigation which was conducted on 6/28/2015 revealed that these airlock doors were not installed according to the manufacturers installation instructions. A jack was not used to tighten the columns to the mine roof and 5 out of 6 T-handle set screws were missing in both sets of doors. The one T-handle set screw that was in place in both sets of the door frames was not tight. Page 6, items 1-9 of the

manufacturers installation instructions states that, a jack will be used to tighten the columns into the mine roof so that it cannot move or be dislodged and to tighten T-handle set screws very tight with a wrench or hammer. This was a contributing factor in a fatal accident which occurred on June 27, 2015. One set of these airlock doors and the frame weigh 980 pounds.

4. A 104(a) S&S Citation, number 7033809, was issued to 4 West Mine, citing 30 CFR § 75.333(d)(3).

The operator failed to properly operate the doors, other than personnel doors used in lieu of permanent stoppings or to control ventilation within an air course located in the number 4 entry of the 10 right area of the mine at the numbers 63.5 and 64.5 crosscuts. The airlock doors installed at these locations were both opened at the same time on 6/27/2015 by a scoop operator on the afternoon shift to permit the company number 2 diesel scoop and 3 supply wagons to travel from the number 63 crosscut to the number 65 crosscut. These doors are to be installed in pairs to form an airlock. When an airlock is used, one side shall remain closed. When not in use, both sides shall be closed.

This was a contributing factor in a fatal accident which occurred on June 27, 2015.

Appendix A
Persons Participating in the Investigation

Mine Operator

<u>Name</u>	<u>Title</u>
Jeremiah Adams	Roof Bolter-11 Left Working Section
Robert Adams *	11 Mains Section Foreman
Bill Alexander *	Outby Diesel Scoop Operator
Thomas Gray *	Roof Bolter-11 Left Working Section
Chris Hoh *	Mine Examiner
Mark Knotts *	Shift Foreman
Ryan Wilson *	Outby Construction Worker
Sid Martinez *	Outby Construction Worker
Jim Ridenour *	Assistant Mine Foreman
John Roush *	Outby Diesel Scoop Operator
Larry Fisher *	Outby Diesel Scoop Operator
Ron Bishoff *	Mine Foreman
Gary Dixson.....	Safety Director
Don Firm.....	Safety Department
Steve Golden.....	Maintenance Foreman
Kevin Hatfield.....	Mine Engineer
Robert Maxwell.....	Safety Department
Steve Police.....	Senior V.P. of Underground Operations
James Price.....	Superintendent
Mark Riley.....	Safety Department
Steve Simms.....	Maintenance Supervisor
Brad Summers *	Construction Foreman
Myron Galloway *	Outby Construction Foreman
Jake McCleary *	Special Project Foreman

*** Persons Interviewed**

State Agency

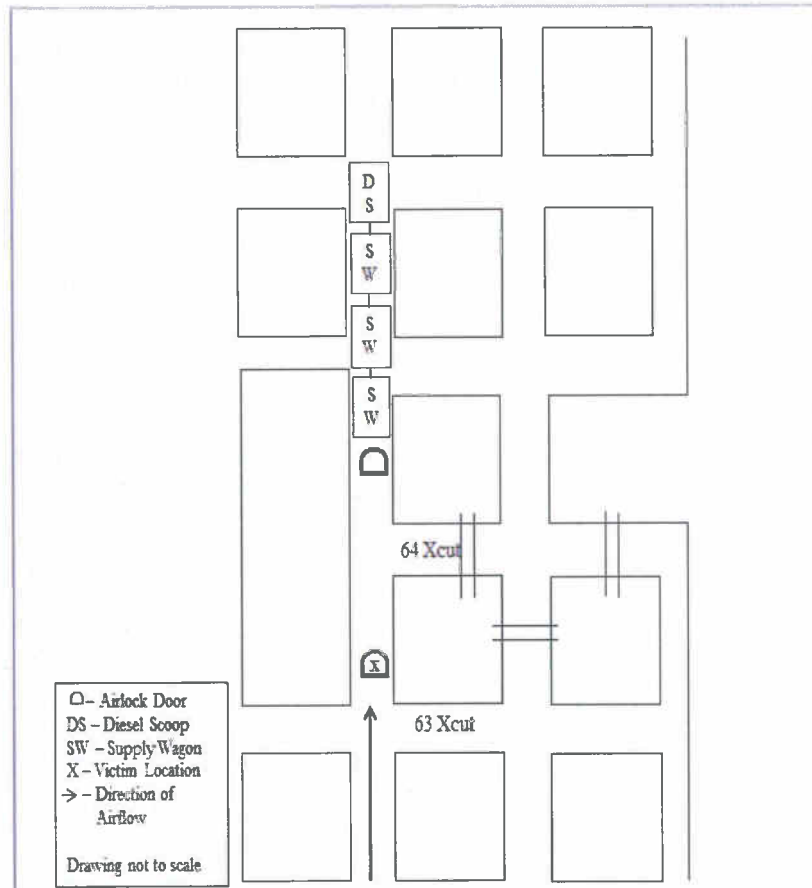
<u>Name</u>	<u>Title</u>
Colvin Carson.....	Supervisory Pennsylvania State Inspector
Bill Gardner.....	Supervisory Pennsylvania State Inspector
John High.....	Pennsylvania State Inspector
Jeff Kerch.....	Pennsylvania State Electrical Inspector
Vince Little.....	Pennsylvania State Electrical Inspector

Appendix A Cont'd

Mine Safety and Health Administration

<u>Name</u>	<u>Title</u>
Thomas Bochna.....	Supervisory Coal Mine Safety and Health Inspector
Anthony Guley.....	Assistant District Manager Technical
Rodi Murad, E.I.T.	Civil Engineer, Tech Support
Michael Murawski, P.E.	Civil Engineer, Tech Support
Walter Young.....	Coal Mine Safety and Health Inspector
Walter George Taylor.....	Coal Mine Safety and Health Inspector

Appendix B Expanded View of the Accident Scene

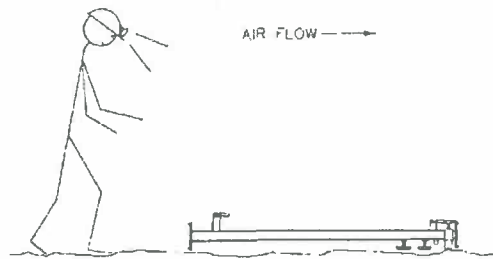


Appendix C
Kennedy Manual Machine Door Installation Instructions (Pages 5 & 6 only)

KENNEDY MANUAL MACHINE DOOR
 INSTALLATION INSTRUCTIONS

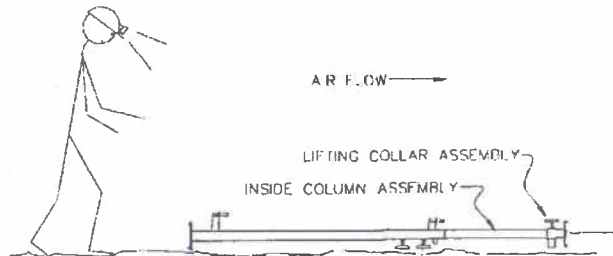
1

LAY COLUMNS ALONG ENTRY WITH T-HANDLE SCREWS DOWN & HINGE PINS POINTING IN DIRECTION OF AIR FLOW AS SHOWN. NOTE THAT FROM THE POINT OF VIEW OF "MICKEY MINER", THE COLUMN WITH GREEN HINGE PINS IS ON HIS RIGHT & THE COLUMN WITH RED HINGE PINS IS ON HIS LEFT. WITH THE COLUMNS IN THIS POSITION, THE STOPPING CHANNELS SHOULD BE FACING THE RIB ON EACH SIDE.



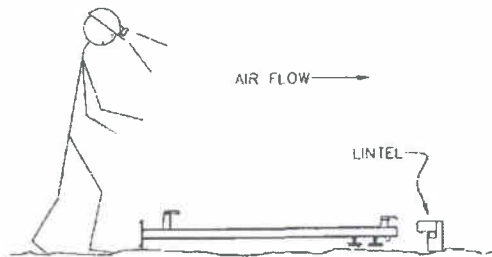
2

LOOSEN BOTTOM TWO T-HANDLE SET SCREWS & SLIDE INSIDE COLUMN ASSEMBLIES WITH LIFTING COLLAR ASSEMBLY OUT OF OUTSIDE COLUMNS. KEEP INSIDE COLUMN ASSEMBLY NEAR AS YOU WILL NEED TO USE IT LATER INSTALLATION STEPS.



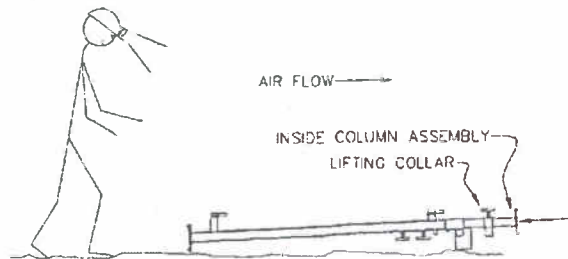
3

POSITION LINTEL ACROSS ENTRY WITH LINTEL PIPES TOWARD TOP OF ENTRY AS SHOWN.



4

SLIDE INSIDE COLUMN ASSEMBLY THROUGH LINTEL PIPE & BACK INTO OUTSIDE COLUMN ASSEMBLY. MAKE SURE LIFTING COLLAR ASSEMBLY STAYS BETWEEN LINTEL PIPE & TOP CLEAT ON INSIDE COLUMN ASSEMBLY. NOTE THAT FACE OF PROPERLY INSTALLED LINTEL IS FLUSH WITH TOP SIDE OF COLUMN PIPE. THIS COMPLETES THE DOOR FRAME ASSEMBLY & YOU ARE NOW READY TO ELEVATE THE FRAME INTO THE VERTICAL POSITION.



JACK KENNEDY METAL PRODUCTS & BUILDINGS, INC.
 P.O. BOX 138
 TAYLORVILLE, IL 62568
 (217) 287-7231

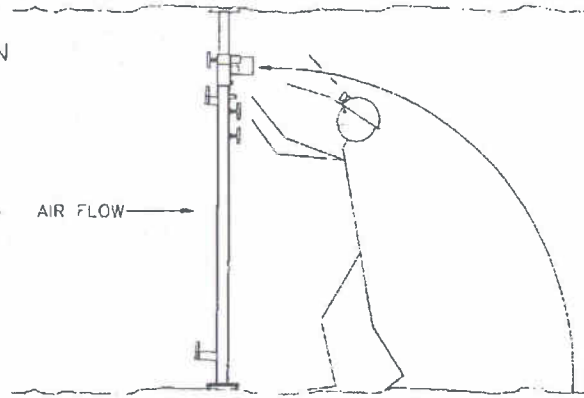
Appendix C Cont'd.

KENNEDY MANUAL MACHINE DOOR INSTALLATION INSTRUCTIONS

5

TIP DOOR FRAME ASSEMBLY UP TO THE VERTICAL POSITION AS SHOWN. LOOSEN ALL THREE T-HANDLE SET SCREWS ON THE COLUMN & EXTEND THE INSIDE COLUMN ASSEMBLY TO THE ROOF. TIGHTEN THE TWO T-HANDLE SET SCREWS ON THE OUTSIDE COLUMN PIPE.

USE EXTREME CAUTION AS THE DOOR IS NOT SECURED & COULD FALL; PROCEED TO STEP 6.



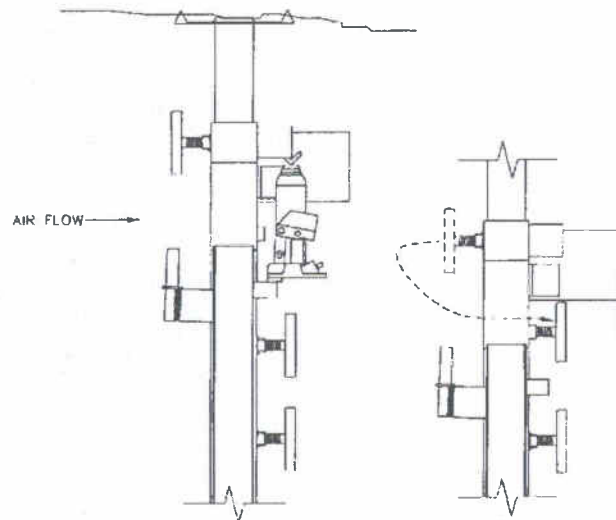
6

HYDRAULIC COLUMN JACKING INSTRUCTIONS:

1. INSTALL JACK AS SHOWN
2. TIGHTEN SET SCREW IN LIFTING COLLAR ASSEMBLY HAND TIGHT.
3. JACK INSIDE COLUMN TIGHTLY AGAINST ROOF SO IT CANNOT MOVE OR BE DISLODGED, & MAKE SURE COLUMN IS PLUMB AND LINTEL IS LEVEL.
4. IF MORE THAN ONE JACK STROKE IS NEEDED, TIGHTEN COLUMN SET SCREWS.
5. LOOSEN LIFTING COLLAR ASSEMBLY SET SCREW & LOWER JACK & LIFTING ASSEMBLY.
6. REPEAT STEPS 2 THROUGH 5 AS NEEDED TO INSURE TIGHT INSTALLATION SO IT CANNOT MOVE OR BE DISLODGED.
7. TIGHTEN T-HANDLE SET SCREWS **VERY TIGHT** WITH WRENCH OR HAMMER.
8. REMOVE JACK ASSEMBLY.
9. REMOVE T-HANDLE SET SCREW FROM LIFTING COLLAR ASSEMBLY & INSTALL IT IN LINTEL PIPE WELD NUT & TIGHTEN SECURELY.

REPEAT STEPS 1 THROUGH 9 FOR THE OPPOSITE COLUMN.

NOTE: IF T-HANDLE SET SCREW IS LEFT IN LIFTING COLLAR ASSEMBLY, IT WILL INTERFERE WITH DOOR MOVEMENT.



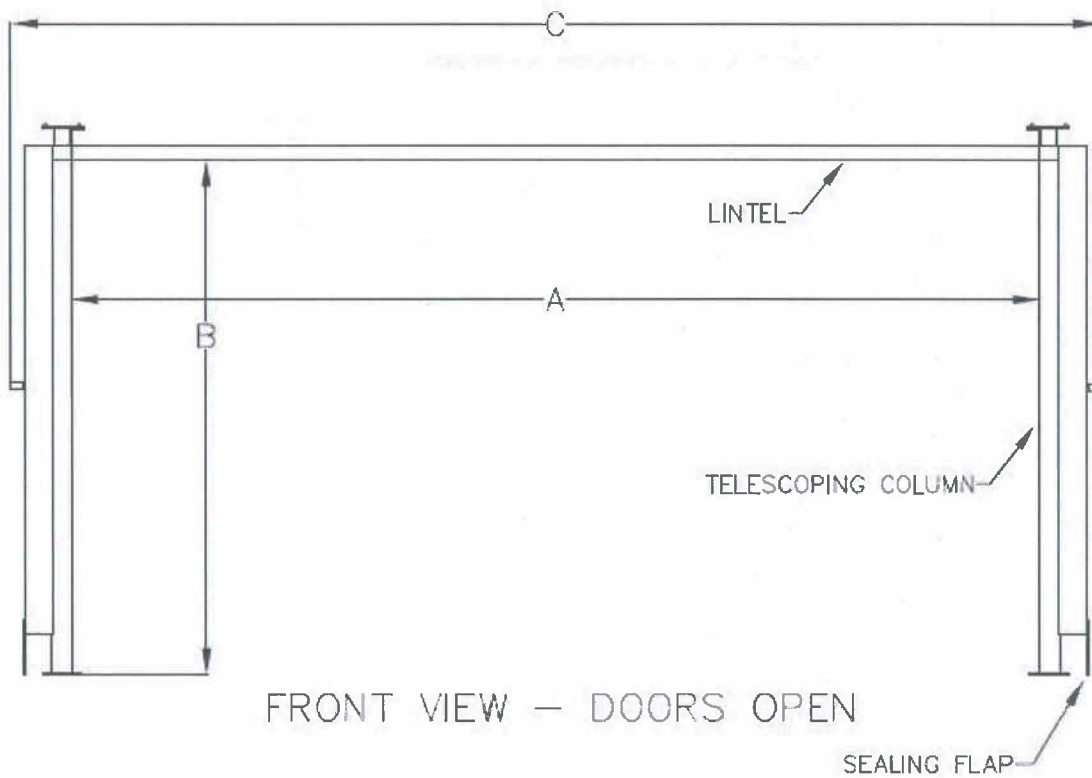
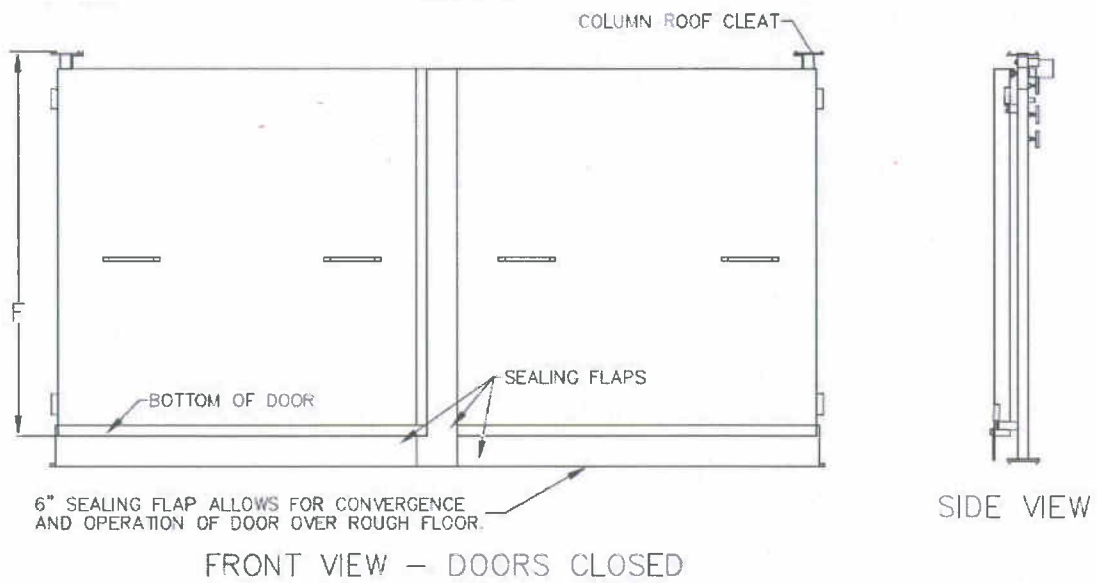
NOTE: TWO ROOF BOLT HOLES ARE PROVIDED IN THE UPPER LINTEL. BOLT TO ROOF IF NECESSARY TO INSURE ABSOLUTE STABILITY.

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P.O. BOX 138
TAYLORVILLE, IL 62568
(217) 287-7231

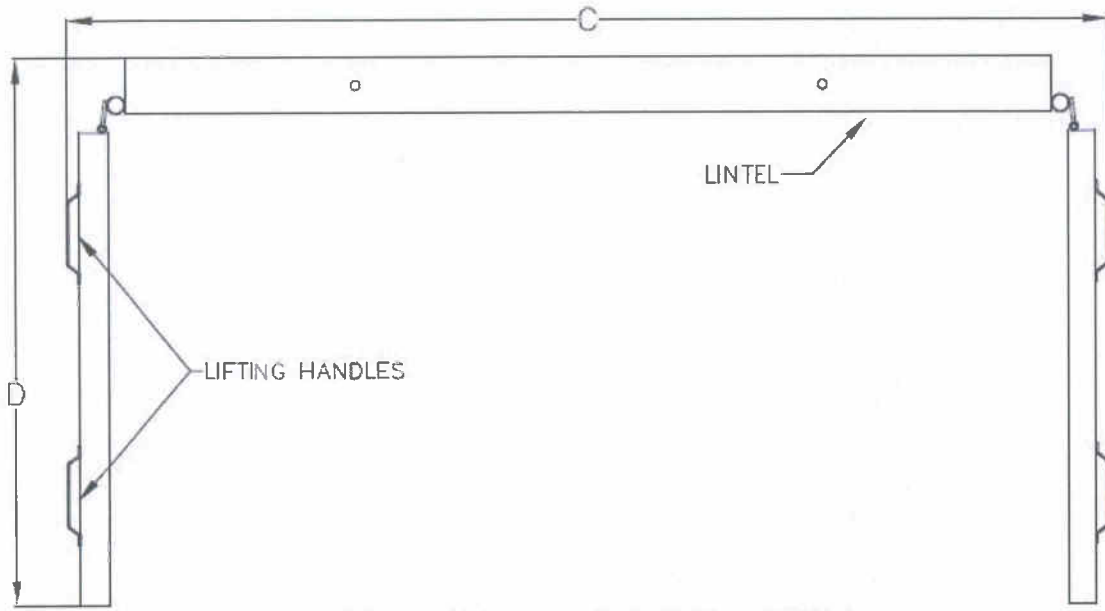
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Appendix D Airlock Door Sketches



Appendix D Continued



TOP VIEW — DOORS OPEN

Appendix E Victim Information

Accident Investigation Data - Victim Information

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



Event Number: 6 2 2 5 4 0 1

Victim Information: 1																							
1. Name of Injured/Ill Employee: <i>John W. Kelly</i>				2. Sex: <i>M</i>		3. Victim's Age: <i>55</i>		4. Degree of Injury: <i>01 Fatal</i>															
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death: <i>a. Date: 06/27/2015 b. Time: 23:45</i>								6. Date and Time Started: <i>a. Date: 06/27/2015 b. Time: 17:00</i>															
7. Regular Job Title: <i>028 Outby Scoop Operator</i>						8. Work Activity when Injured: <i>090 Closing airlock doors</i>						9. Was this work activity part of regular job? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>											
10. Experience																							
a. This				b. Regular				c. This				d. Total											
Work Activity	Years	Weeks	Days	Job Title	Years	Weeks	Days	Mine:	Years	Weeks	Days	Mining	Years	Weeks	Days								
<i>3</i>	<i>40</i>	<i>0</i>	<i>0</i>	<i>3</i>	<i>40</i>	<i>0</i>	<i>0</i>	<i>10</i>	<i>10</i>	<i>4</i>	<i>34</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>								
11. What Directly Inflicted Injury or Illness?: <i>012 Airlock doors and the frame work</i>								12. Nature of Injury or Illness: <i>170 Crushing</i>															
13. Training Deficiencies:																							
Hazard:				New/Newly-Employed Experienced Miner:				Annual:				Task:											
14. Company of Employment: (if different from production operator) <i>Operator</i>																							
Independent Contractor ID: (if applicable)																							
15. On-site Emergency Medical Treatment:																							
Not Applicable: <input type="checkbox"/>				First-Aid: <input checked="" type="checkbox"/>				CPR: <input checked="" type="checkbox"/>				EMT: <input checked="" type="checkbox"/>				Medical Professional: <input type="checkbox"/>				None: <input type="checkbox"/>			
16. Part 50 Document Control Number: (form 7000-1)								17. Union Affiliation of Victim: <i>9999 None (No Union Affiliation)</i>															