

UNITED STATES  
DEPARTMENT OF LABOR  
MINE SAFETY AND HEALTH ADMINISTRATION

COAL MINE SAFETY AND HEALTH

REPORT OF INVESTIGATION

Underground Coal Mine

Fatal Rib Fall Accident

January 16, 2016

4 West Mine

Dana Mining Company, LLC  
Dilliner, Greene County, Pennsylvania  
I.D. Number 36-09326

Accident Investigators

Jeremy Stalnaker

Coal Mine Safety and Health Specialist, Roof Control

Walter George Taylor

Coal Mine Safety and Health Inspector

Walter Young

Coal Mine Safety and Health Specialist, Ventilation

Originating Office

Mine Safety and Health Administration

District 2

Paladin Professional Building

631 Excel Drive, Suite 100

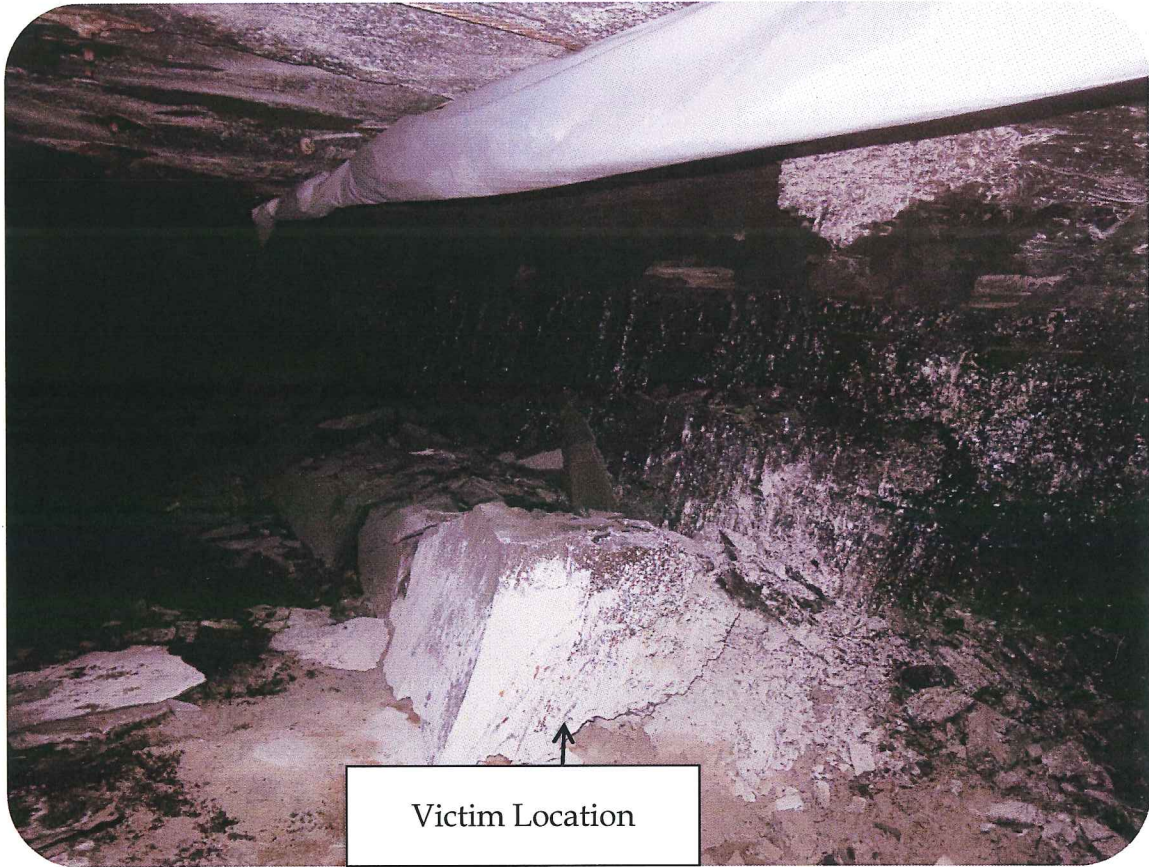
Mount Pleasant, Pennsylvania 15666

James Preece, District Manager (Acting)

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## OVERVIEW

On January 16, 2016, at approximately 5:50 p.m. a 31-year-old continuous mining machine operator with 13 years of experience was fatally injured when he was struck by a large section of the mine rib. The victim was operating a remote controlled continuous mining machine in the I Sub-Main section when a large portion of the right side rib fell pinning him to the mine floor, causing fatal crushing injuries.

The mine operator failed to adequately support or control the ribs to protect miners from the hazards of rib falls. Contributing to the accident was the failure of the operator to recognize and support deteriorating ribs in high stress areas.

## 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. The mine is 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:

Steve Polce.....	Senior Vice President
James Price.....	Superintendent
Gary Dixson.....	Safety Director
Ronald Bishoff.....	Mine Foreman

The Mine Safety and Health Administration (MSHA) completed a regular safety and health inspection (E01) at this mine on December 29, 2015. The Non-Fatal Days Lost (NFDL) injury incident rate for this mine during the period of January through December 2015 was 0.42, compared to a national rate of 3.11 for this type of mine.

## DESCRIPTION OF ACCIDENT

On Saturday, January 16, 2016, Jeremy Neice, Continuous Mining Machine Operator, and the section crew began their shift at 8:00 a.m. They entered the mine at the Marshall Portal and travelled underground to the I Sub-Main section arriving at approximately 8:40 a.m.

Ray Durbin, Section Foreman, conducted an onshift examination. Richard Teets, Roof Bolting Machine Operator; Max Seibert, Roof Bolting Machine Operator; Thomas Keller, Ram Car Operator; Joseph Menear, Ram Car Operator; Lonnie Greenawalt, Ram Car Operator and Emergency Medical Technician (EMT), and Neice conducted pre-operational checks of their equipment. Jason Donaldson, Compliance Officer, assisted Neice with the pre-operational check of the dust control parameters on the continuous mining machine. The mine operator was conducting a respirable dust survey on this shift using a Continuous Personal Dust Monitor (CPDM). Mining began at 9:20 a.m., shortly after the examinations were completed.

Teets and Seibert bolted crosscut 21 between the No. 2 and No. 3 entries that was mined on the previous shift (See Appendix A). They bolted the No. 2 entry next and Neice



mined 27 feet in the No. 1 entry, completing an air connection between the No. 1 and No. 2 entries.

Neice finished mining in the No. 1 entry, trammed the continuous mining machine to the No. 6 entry and mined 27 feet. Teets and Seibert trammed the roof bolting machine to the No. 1 entry and discovered that the immediate roof had fallen. The fallen rock blocked access to the entry, and prevented the installation of roof bolts. They reported the condition to Durbin. Durbin decided to remove the rock using the continuous mining machine. Teets and Seibert installed a few roof bolts as supplemental support, outby in the No. 2 entry.

Neice mined the No. 6 entry, the No. 5 entry, the No. 5 to No. 4 crosscut, and the No. 4 entry. Beginning at 1:00 p.m., Durbin conducted a preshift examination of the section. Durbin observed and reported "spillage" at the section feeder and in the No's 3, 4, and 5 entries, but did not report any adverse roof or rib conditions. Durbin assigned persons to clean up the spillage. After Durbin finished his examination, Neice mined in the No. 3 to No. 4 crosscut and the No. 3 entry. After Neice finished mining the No. 3 entry, Durbin directed him to tram the continuous mining machine to the No. 1 entry to clean up the fallen rock. Following the clean-up of the No. 1 entry, Neice trammed the continuous mining machine to the No. 2 entry.

At approximately 5:20 p.m., Seibert and Teets began installing roof bolts in the No. 1 entry outby No. 20 crosscut. Durbin obtained an air quantity reading at the inby end of the ventilating curtain in the No. 2 entry. Neice then began mining the No. 2 entry. Neice mined the right side of the cut referred to as the "Run B" (See Appendix B) for a distance of approximately 27 feet. After finishing "Run B", Neice positioned the continuous mining machine to begin mining the "Run A" on the left side of the entry.

Neice had mined eighteen feet out of the "Run A" when Keller positioned his ram car behind the continuous mining machine to receive a load of coal. As Neice loaded the ram car, Keller heard a loud "bang." He observed the rib rolling away from the coal block, striking Neice from behind, and pinning him to the mine floor. Keller stated that Neice was standing along the right side rib, approximately 5 feet inby crosscut 21 when the accident occurred.

Keller exited his ram car and attempted to free Neice. He was unable to move the fallen material off of Neice and went to the No. 1 entry where he notified Seibert and Teets of the accident and requested their help. He traveled outby and notified Menear and Greenawalt. Donaldson and Durbin, who were located at the section power center, heard Keller call for help and proceeded to the face of the No. 2 entry.

Seibert and Teets proceeded to the accident scene and attempted to remove the rock by hand, but it was too heavy. Seibert went back to the roof bolting machine to get a slate bar for leverage. When Seibert returned to the site, he found that Durbin, Donaldson, Greenawalt, Keller and Menear had arrived. Greenawalt moved his ram car out of the way, thinking a scoop may be needed to free Neice. Greenawalt notified Jason Haskiell,

Scoop Operator, to get the first aid supplies. Seibert and Teets used the slate bar to lift the rock while Durbin pulled Neice free. Haskiell arrived with a backboard and cervical collar. Greenawalt detected a faint pulse and immediately began administering first aid. He then secured a cervical collar around Neice and placed him on the backboard.

Meanwhile, Donaldson proceeded to the section power center and called outside to report the accident to Kevin Rosenberger, Mine Clerk. Rosenberger called "911" at 5:54 p.m. Donaldson, then obtained a battery-powered personnel transport, and drove it toward the accident site.

Greenawalt, Teets, and Meneer were carrying the victim on a back board and met Donaldson just inby the section loading point. They transferred the victim onto the transport and travelled to the section power center to retrieve the medical oxygen bottle. The group then transported the victim approximately 9,000 feet to the Marshall Portal.

Cardiopulmonary Resuscitation (CPR) was performed and oxygen was administered in route and continued until arrival on the surface at 6:23 p.m. The ambulance crew from Southwest Emergency Medical Services (EMS) immediately assumed care and transported the victim to Ruby Memorial Hospital in Morgantown, West Virginia, where he was pronounced dead at 7:07 p.m. by Dr. Rosanna Sikora, attending physician.

### **INVESTIGATION OF ACCIDENT**

At 6:10 p.m. on January 16, 2016, Jeremy Rice, Production Coordinator, notified the MSHA call center of the accident. A citation, which did not contribute to the accident, was issued for a violation of 30 CFR § 50.10 because the mine operator did not notify MSHA immediately, at once, without delay, and within 15 minutes. The call center notified Charles Clark, Roof Control Supervisor, of the accident at 6:28 p.m. Clark notified Thomas Bochna, Ruff Creek Field Office Supervisor. Bochna contacted the mine operator at 6:40 p.m. and learned that the accident was serious. Bochna reminded the operator of their responsibility to secure the accident site and to preserve evidence that may aid in the investigation. Bochna along with Walter Young, Coal Mine Safety and Health Inspector (CMI), Ventilation Specialist, and Jeremy Stalnaker, CMI, Roof Control Specialist, were dispatched to the mine.

Upon his arrival, CMI Young issued a 103(k) order to Gary Dixson, Safety Director, to ensure the safety of all persons involved, and preserve evidence that may aid in determining a cause or causes of the accident. Young and Bochna obtained preliminary statements from persons having knowledge of the facts and circumstances concerning the accident. Training records were requested and obtained from the mine operator. Stalnaker arrived at the mine site at 10:10 p.m. and was briefed by Bochna and Young.

Witness interviews were conducted in conjunction with Pennsylvania Bureau of Mine Safety and the mine operator, on January 16, 2016, at the 4 West Mine conference room. Statements were taken from miners who had knowledge of the facts and circumstances



relating to the accident. The investigation team then traveled underground to the accident site. Photographs of the site and measurements were collected for further evaluation.

Formal interviews were conducted on February 4, 2016, with miners having direct involvement with the accident. A list of the persons who participated in the investigation and those who were interviewed is contained in Appendix C.

## **DISCUSSION**

### **Accident Scene**

The accident occurred in the No. 2 entry of "I" Sub-Main Section, MMU 004-0 at permanent reference 23+56. The face of the No. 2 entry was being mined when the accident occurred. The face was extended beyond the last row of permanent supports for a distance of twenty-seven feet on the Run B and eighteen feet on the Run A. A three-way intersection was present at 23+40 which was created by a crosscut driven for a distance of forty-five feet, when measured from the center of the No. 2 entry toward the No. 3 entry.

The accident occurred along the right rib of the entry, approximately 5 feet in by the corner created by the crosscut. The coal seam height averages 5.5 feet at this location. However, the mining height was approximately 7 feet due to approximately 2 feet of shale being mined above the coal seam. It is sometimes necessary to mine the shale on advance to remove roof fractured by the multiple seam stress. This practice provides a solid surface for the roof bolters to install permanent support. The measured entry width was between 21 and 22 feet. The excessive entry width was a result of rib failure. Measurements taken at the roofline indicated the entry width was 18 feet prior to rib failure.

The right rib of the No. 2 entry, which failed during mining of Run A, was present in several pieces which extended past permanent roof support. The fallen rib material was measured and determined to be 29 feet long, approximately 3 feet high, down to a tapered point, and 2.5 feet thick at the thickest point, also tapering to a point. The portion of rib that struck Neice measured 3 feet high, 4.5 feet in length and 2.5 feet thick. It was comprised of 2 feet of rock and 1 foot of coal and weighed approximately 4,500 pounds.

The continuous mining machine was moved from its location prior to arrival of accident investigators to prevent it from being covered up by a roof fall since it was under unsupported roof.

### **Geologic Conditions on the I Sub-Main Section**

The immediate roof found in the I Sub-Main section is typical of the 4 West Mine with many clay veins and weak bedding layers. Significant horizontal stress is also present. Extensive mining has been conducted in the Pittsburgh seam an average of 78 feet below the Sewickley coal seams, in the area where the accident occurred.

Where remnant pillars were left in the Pittsburgh seam, large amounts of vertical stress is applied to the Sewickley seam resulting in adverse conditions including floor heave, crushing ribs, and cutter roof.

The I Sub-Main section is located above remnant pillars and gob areas in the Pittsburgh seam. A large remnant pillar is shown directly beneath the number 2 Entry between 19+80 inby to 23+40 including where the face of the entry was at the time of the accident (see Appendix A). The presence of the large remnant pillar, transferring stress to a concentrated area, caused the coal in the ribs of the No. 2 and No. 1 entries to slough under the stress. The sloughage of the coal removed the natural support to the rock above leaving an unsupported rock brow 24 inches in height. The remaining entries, No. 3 through No. 6, on the right side of the I Sub-Main section, are located above a gob area without remnant pillars and do not display the adverse conditions present in the No. 1 and No. 2 entry.

### **Roof Control Plan**

The last complete roof control plan was approved on June 30, 2015 and a six-month review of the plan was completed on November 16, 2015. This plan was developed and approved with guidance from Technical Support and utilizes both tensioned and passive bolts installed for permanent support. Areas of the mine are separated and listed as Mains, Submains, and Retreat Panels requiring a minimum support for each. Rib control minimum requirements were adopted within the June 30, 2015, plan and modeled after guidelines published in MSHA's Roof Control Handbook (PH13-V-4).

Rib control minimum standards, in effect at the time of the accident, can be found on page 16 item 33 of the currently approved roof control plan as follows.

*33. When overburden exceeds 700ft and mining height exceeds 7ft. the area from the feeder to the last open crosscut shall have additional rib support installed, in the form of ribs bolts, at intervals not to exceed 8 feet. All rib bolts will be a minimum of 36" in length.*

These provisions in the approved roof control plan did not require rib supports to be installed inby the last open crosscut.

### **Examinations**

The mine operator is required to designate a certified person to conduct preshift examinations within 3 hours preceding each 8 hour interval in which any person is scheduled to work in an underground area. This person must record all violations, dangers, and hazardous conditions that are present during his examination. The mine works 2 twelve-hour shifts. The operator's established 8-hour intervals to conduct preshift examinations are between 5:00 a.m. and 8:00 a.m., between 1:00 p.m. and 4:00 p.m., and between 9:00 p.m. and 12:00 a.m. A review of the 6 pre-shift examinations



conducted prior to the fatality indicate that no hazardous conditions or violations other than “spillage” were reported or recorded. When the investigation team arrived in the section after the accident they discovered excessive entry widths beginning outby the face of the No. 2 entry and continuing a distance of approximately 300 feet.

The pre-shift examination of I Sub-Main (MMU 004) conducted by foreman Durbin between 1300 hours and 1355 hours on January 16, 2016, failed to identify hazardous conditions present at the time of examination. The number 2 entry of the I Sub-Main presented a condition hazardous to miners in the form of rock brows, averaging 24 inches in height, created by sloughage of the coal pillars below the rock. This condition was present from the crosscut at 23+40, just outby the face where the accident occurred for a distance of approximately 360 feet. Although standing support (cribs and posts) had been installed from 360 feet outby the face to 270 feet outby the face, several supports were dislodged and ineffective. Those dislodged supports should have been reported on the examination. The deteriorating conditions that existed prior to the accident indicated additional rib support was needed and would be needed as No. 2 entry advanced above the remnant pillar. Also unreported on the examination was an ongoing violation of the ventilation plan for extending entries without completing crosscuts. The deteriorating conditions that existed prior to the accident showed rib support was needed to protect miners from hazards relating to falls of mine ribs inby the crosscut at 23+40.

Standing support installed in one area to reduce the width had been dislodged by mobile equipment and not replaced. A citation (non-contributory) was issued for a violation of 30 C.F.R. § 75.220(a)(1) for this condition.

### **Rib Control Past Practices**

The Fletcher Roof Ranger II-15 Roof Bolter (RR-II) is used throughout the mine on development sections. The RR-II does not have a designed capability to install bolts horizontally (rib bolts). Mine management retrofitted a drill pot attachment using the roof bolting machine’s hydraulic system and drill mast swing function as a feed to install rib support (see Appendix D) from the outby end of the machine.

### **Training and Experience**

Neice had 13 years of total mining experience and 10 years of experience as a continuous mining machine operator. He held miner’s certificates in Virginia, West Virginia, Pennsylvania, and Kentucky and was employed at this mine for 18 days. Training on the Approved Roof Control and Approved Ventilation Plan was documented on December 30, 2015. No training deficiencies were found.

The victim had received new task training but it was not properly recorded on the 5000-23 form that was on file. A citation, that did not contribute to the accident, was issued for a violation of 30 CFR 48.9(a) because of an improperly completed training record.

## ROOT CAUSE ANALYSIS

A root cause analysis was conducted to identify the causes of the accident that were correctable through reasonable management controls. Listed below are root causes identified during the analysis and the corresponding corrective actions implemented to prevent a reoccurrence of the accident.

1. Root Cause: The mine operator failed to adequately support or otherwise control the mine ribs.

Corrective Action: The approved roof control plan was revised to identify remnant pillar areas in the underlying mine that could contribute to poor rib conditions. The revised plan requires rib support to be installed in-cycle in these areas inby the last open crosscut.

2. Root Cause: Hazardous mining conditions were not identified during pre-shift examinations.


Corrective Action: Hazardous mining conditions were corrected and mine examiners were retrained to properly evaluate and identify hazards along with corrective actions.



## CONCLUSION

The mine operator failed to identify and effectively control adverse rib conditions present on a working section. A continuous mining machine operator received fatal crushing injuries when the mine rib rolled away from the coal block and pinned him to the mine floor. Deteriorating conditions existed prior to the accident indicating rib support was needed to protect miners from hazards relating to falls of mine ribs.

Approved By:



James Preece  
District Manager (Acting)

Date 6.1.2016

## ENFORCEMENT ACTIONS

1. 103(k) Order, number 9073750, was issued to 4 West Mine, to ensure the safety of the miners until the investigation could be completed.

The mine has experienced a fatal accident on the I-Section (004-0 MMU), in the Number 2 entry, inby 21 crosscut, where a miner operator was reportedly struck with a piece of coal rib. This order is being issued to assure the safety of all persons in the mine, until further examination or investigation is made to determine if the area is safe from further deterioration or other hazards. Only those persons selected from company officials, the miner's representatives, state officials, and other persons deemed appropriate by MSHA to have information relevant to the investigation, and safely secure the scene may remain in the affected area. This order is also being issued to prevent the destruction of any evidence which would aid in the investigation and determine the cause or causes of the accident. It prohibits all activity inby the loading point on the I-working section until MSHA has determined that it is safe to resume normal mining operations in the area. This order applies to all persons engaged in the rescue and recovery operation and other persons on-site.

2. A 104(d)(2) S&S Order, number 7030882, was issued to 4 West Mine, citing 30 CFR § 75.360(b)(11)(i).

A pre-shift examination conducted by an agent of the operator, between the time of 1300 hours and 1355 hours on January 16, 2016, for the I Sub-Main section, (MMU 004) failed to identify hazardous conditions. The number 2 entry of the I Sub-Main section had adverse rib conditions beginning at the No. 17 crosscut at 19+80, inby to 21 crosscut at 23+40. The coal sloughing from the ribs created a rock brow measuring 24 inches in height. The rock brow failed and rolled away from the roof line at various locations between 23+40 and 19+80 leaving an entry width in excess of 21.5 feet. A portion of the mine rib fell and struck a continuous mining machine operator working 5 feet inby the intersection at 23+40, causing fatal crushing injuries. The rock brows are being created by a large remnant pillar below the No. 2 entry as shown on mine maps. The mine operator is aware of the detrimental effects of remnant pillars by the use of numerical modeling programs combined with the past history of mining over remnant pillars. Supplemental support in the form of posts and cribs were installed from 19+80 to 20+70. The supports were dislodged in various locations. The examination also failed to identify violations of the approved ventilation plan (review B9). While mining faces or rooms, the approved plan states that entries inby rib of the crosscut to be turned before the crosscut is holed through. Entry No. 5 was mined for approximately 81 feet past the inby ribline of the No. 20 crosscut turned from entry 4 to entry 5. These conditions were obvious and extensive. This is an unwarrantable failure to comply with a mandatory standard.

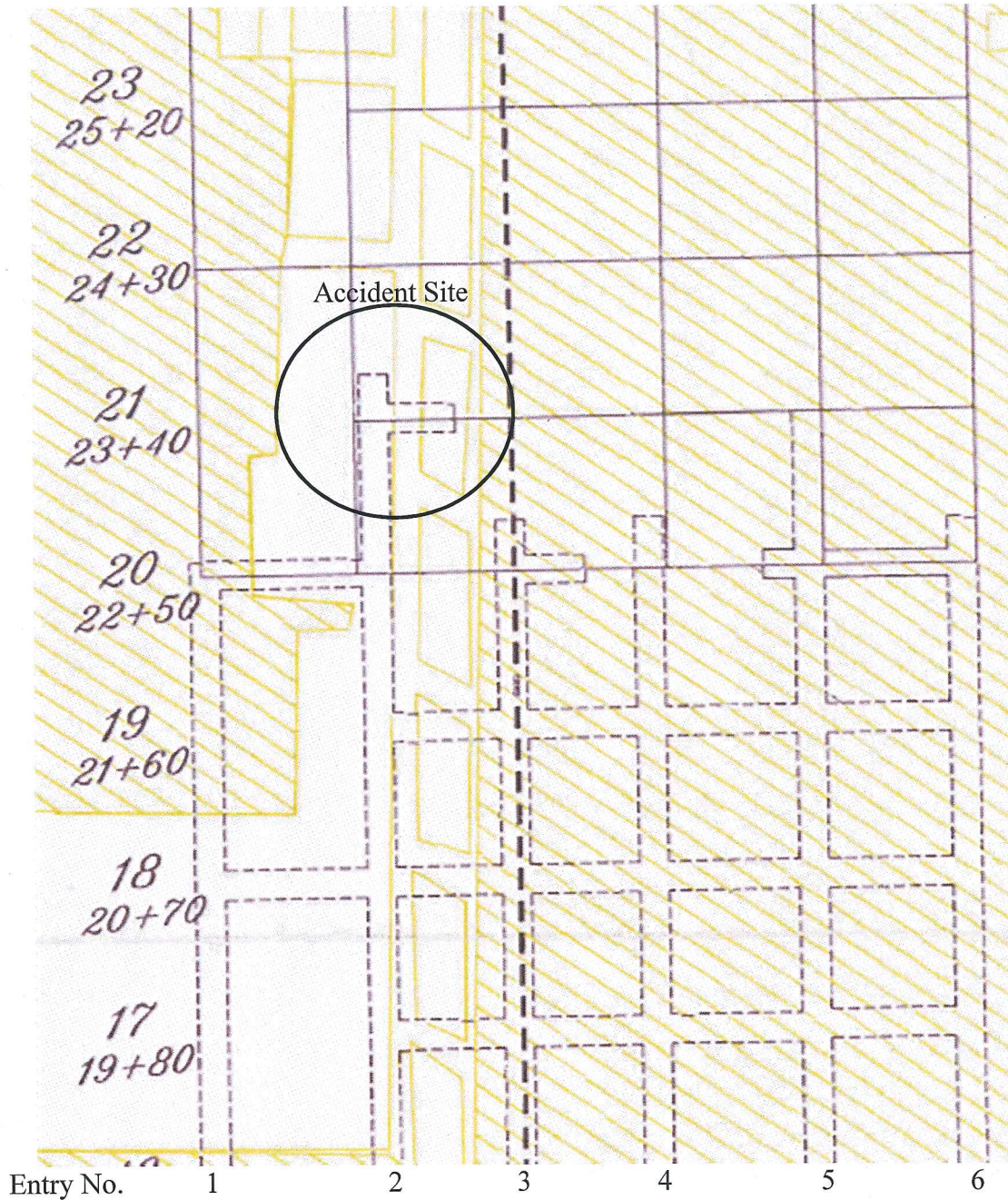


3. A 104(d)(2) S&S Order, number 7030883, was issued to 4 West Mine, citing 30 CFR § 75.202(a).

The operator failed to support or otherwise control the mine ribs located on the I Sub-Main section (MMU 004) number 2 entry inby the intersection at 23+40. A portion of the mine rib fell measuring 29 feet long, 3 feet high averaging 2.5 feet thick. The rib roll struck a continuous mining machine operator working 5 feet inby the intersection at 23+40, causing fatal crushing injuries. This violation is an unwarrantable failure to comply with a mandatory standard.

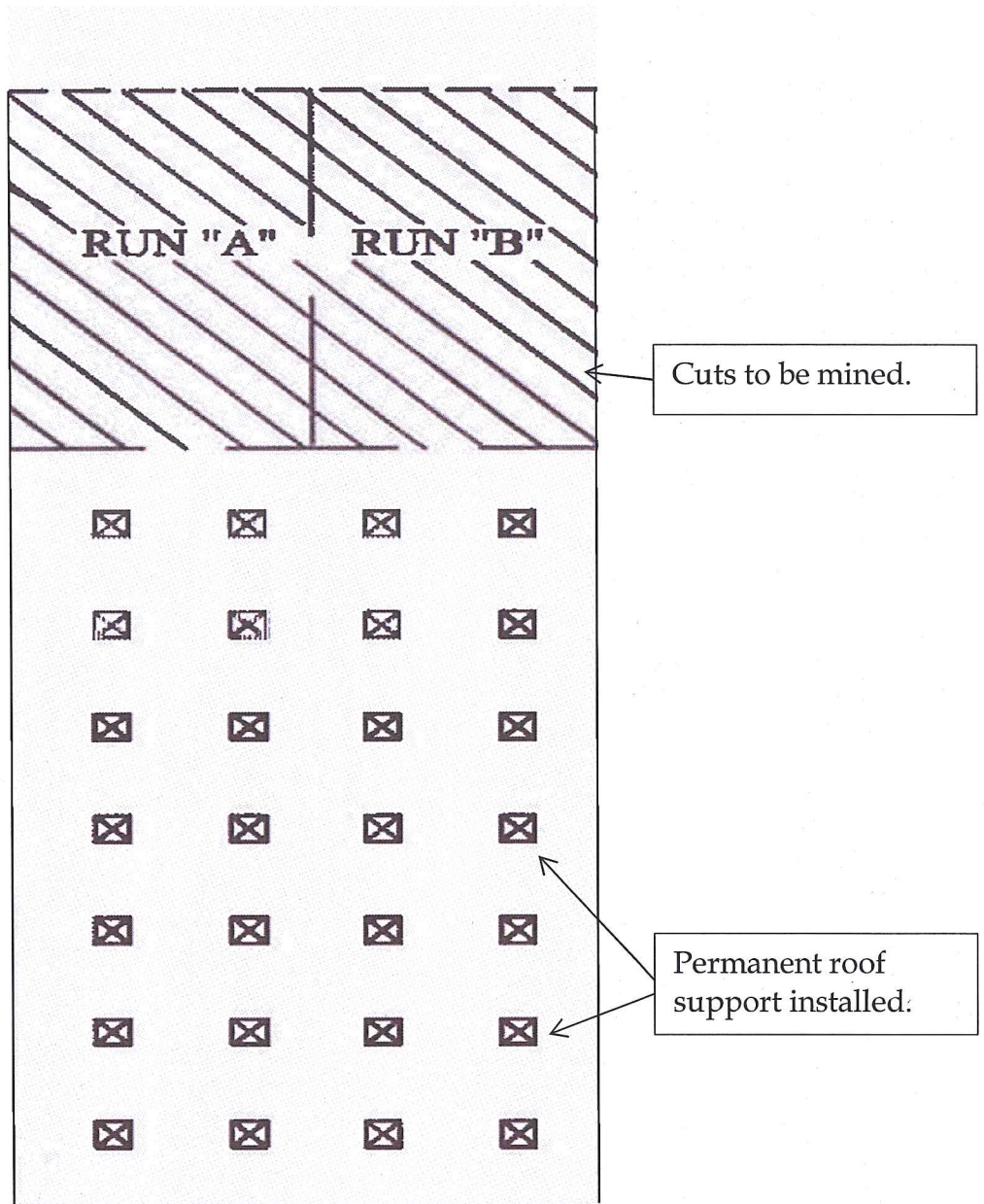
Standard 75.202(a) was cited 15 times in two years at mine 3609326 (15 to the operator, 0 to a contractor).

Appendix A  
Expanded View of the Accident Scene





**Appendix B**  
**Excerpt from the Approved Roof Control Plan**



**Appendix C**  
**Persons Participating in the Accident Investigation**

**Dana Mining Company**

<u>Name</u>	<u>Title</u>
Steve Polce.....	Senior Vice President
James Price.....	Superintendent
Gary Dixon.....	Safety Director
Ronald Bishoff.....	Mine Foreman
Roger Summerfield.....	Production Coordinator
Jeremy Rice.....	Production Coordinator
Kevin Hatfield.....	Mine Engineer
J. Henry Moore.....	Company Attorney
Christopher Pence.....	Company Attorney
Eric Silkwood.....	Personal Attorney (J. Rice)
Patrick Dennison.....	Personal Attorney (R. Durbin)
Ray Durbin*.....	Section Foremen
Joseph Menear*.....	Ram Car Operator
Lonnie Greenawalt*.....	Ram Car Operator, EMT
Thomas Keller*.....	Ram Car Operator
Robert McVeigh*.....	Roof Bolting Machine Operator
Zack Lukane*.....	Roof Bolting Machine Operator
Rick Williams*.....	Roof Bolting Machine Operator
Brady Fox*.....	Roof Bolting Machine Operator
Max Seibert*.....	Roof Bolting Machine Operator
Richard Teets*.....	Roof Bolting Machine Operator
Jason Haskiell*.....	Section Scoop Operator
Mark Thorn*.....	Outby Scoop Operator
Jason Donaldson*.....	Compliance Officer

Persons Interviewed \*

**Pennsylvania Bureau of Mine Safety**

<u>Name</u>	<u>Title</u>
Colvin C. Carson.....	Bureau of Mine Safety Director
William Gardner.....	Supervisory Mine Inspector
Jeffery Kerch.....	Chief Program Manager Electrical
Thomas McKnight.....	Chief Mining Engineer Consultant
Gary Smith.....	Mining Engineer Consultant
Richard Wagner.....	Mining Engineer Consultant
Jonathan Tjac.....	Mining Engineer Consultant
John High.....	Underground Mine Inspector



**Appendix C Cont'd**  
**Persons Participating in the Accident Investigation**

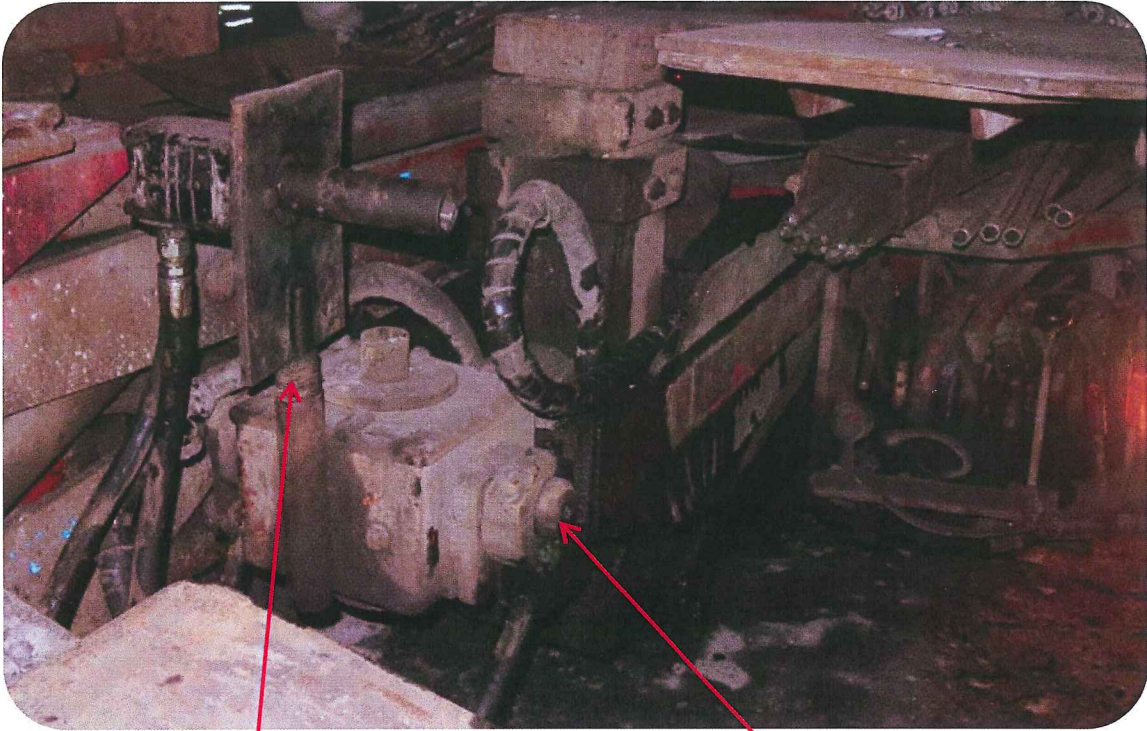
**Pennsylvania Bureau of Mine Safety**

<u>Name</u>	<u>Title</u>
Matthew Kessler.....	PA DMS Attorney
Mary Marthe Truschel.....	PA DMS Attorney

**Mine Safety and Health Administration**

<u>Name</u>	<u>Title</u>
Jeremy Stalnaker.....	Coal Mine Safety and Health Specialist, Roof Control
Walter Young.....	Coal Mine Safety and Health Specialist, Ventilation
Walter George Taylor.....	Coal Mine Safety and Health Inspector
Michael Gauna, PE.....	Mining Engineer, Technical Support
Christopher Mark, Phd, PE.....	Mining Engineer, Technical Support
William Gray.....	Mining Engineer, Technical Support
Randall Caramellino.....	Supervisory Coal Mine Safety and Health Inspector (Staff Assistant)
Charles W. Clark.....	Supervisory Coal Mine Safety and Health Inspector (Roof Control/Impoundments)
Thomas Bochna.....	Supervisory Coal Mine Safety and Health Inspector
Ronald Tolliver.....	Coal Mine Safety and Health Specialist, Roof Control

**Appendix D**  
**Roof Ranger II**  
**(Horizontal Drill Pot Attached)**

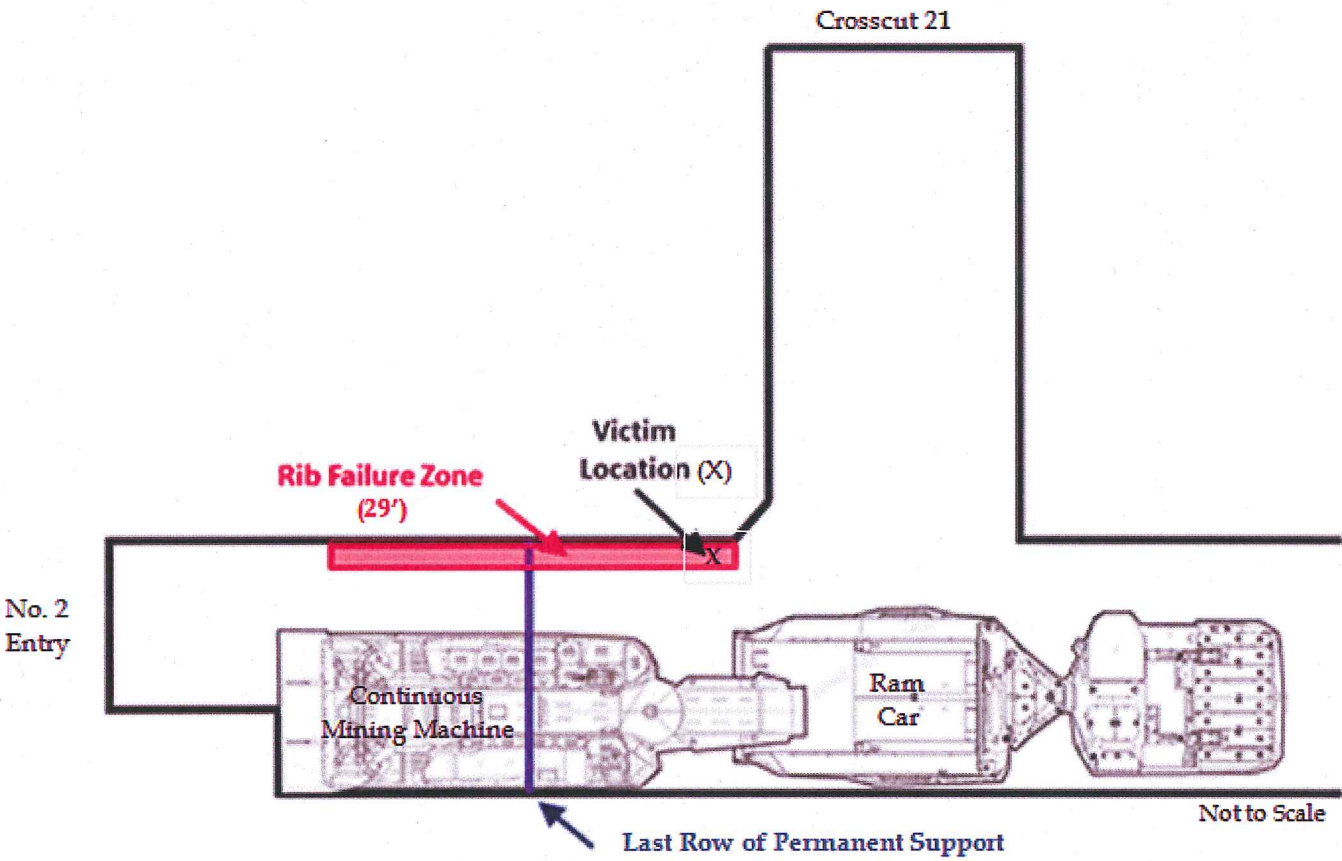


Horizontal Drill Pot Installed on  
the Mast of Fletcher Bolter

Vertical Drill Pot



Appendix E  
Drawing of Accident Scene



## Appendix F Victim Information

### Accident Investigation Data - Victim Information

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



Event Number: 

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Victim Information: 1

1. Name of Injured/Ill Employee: <i>Jeremy Neice</i>		2. Sex: <i>M</i>	3. Victim's Age: <i>31</i>	4. Degree of Injury: <i>01 Fatal</i>						
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death: <i>a. Date: 01/16/2016 b. Time: 17:55</i>				6. Date and Time Started: <i>a. Date: 01/16/2016 b. Time: 8:00</i>						
7. Regular Job Title: <i>036 Continuous miner operator</i>		8. Work Activity when Injured: <i>049 Operating continuous miner</i>			9. Was this work activity part of regular job? <table style="margin-left: auto; margin-right: auto;"><tr><td>Yes</td><td><input checked="" type="checkbox"/></td><td>No</td><td><input type="checkbox"/></td></tr></table>		Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>							
10. Experience		b. Regular		c. This		d. Total				
a. This	Years	Weeks	Days	Years	Weeks	Days	Years			
Work Activity:	<i>10</i>	<i>0</i>	<i>0</i>	Job Title:	<i>10</i>	<i>0</i>	<i>0</i>			
				Mine:	<i>0</i>	<i>2</i>	<i>2</i>			
11. What Directly Inflicted Injury or Illness? <i>122 Rib Roll</i>				12. Nature of Injury or Illness: <i>170 Fatal Crushing Injuries</i>						
13. Training Deficiencies:		New/Newly-Employed Experienced Miner:		Annual:		Task:				
Hazard:										
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:		First-Aid:		CPR:		EMT: <input checked="" type="checkbox"/>				
						Medical Professional: <input checked="" 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>						



