FAI-6313886-1

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Underground
(Coal)

Fatal Powered Haulage Accident
November 23, 2020

American Eagle Mine
Panther Creek Mining, LLC
Cabin Creek, Kanawha County, West Virginia
ID No. 46-05437

Accident Investigator

Joshua A. McNeely
Mine Safety and Health Inspector

Originating Office
Mine Safety and Health Administration
East Region - Beckley District
1293 Airport Road
Beckley, West Virginia 25813
David Scott Mandeville, District Manager

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OVERVIEW

On November 23, 2020, at approximately 11:15 a.m., Taylor Halstead, a 20-year-old miner with approximately 14 months of mining experience, died when the scoop he was operating ran over a four-inch diameter, seventeen-foot long polymer pipe laying in the roadway. When the scoop tire ran over the polymer pipe, the end of the pipe entered the operator's compartment and struck the victim.

The accident occurred because mine management: 1) did not assure that the miner was properly task trained to operate the scoop, 2) did not remove extraneous material from the mine roadways and, 3) did not conduct adequate preshift examinations to assure all extraneous material was removed from the roadways.

GENERAL INFORMATION

Panther Creek Mining, LLC, owns and operates the American Eagle Mine in Cabin Creek, Kanawha County, West Virginia. The underground mine employs 154 miners and operates three eight-hour shifts, five days per week. Coal is mined and transported to the surface by a belt conveyor through the Dawes slope.

The principal officers for American Eagle Mine at the time of the accident were:

Charles Bearse	Chief Operating Officer
Jesse Parrish	Chief Executive Officer
Bob Bennett	Chief Communications Officer

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on September 24, 2020. At the time of the accident, a regular

safety and health inspection (E01) was in progress. The 2019 non-fatal days lost (NFDL) incident rate for the American Eagle Mine was 3.84, compared to the national average of 3.10 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On November 23, 2020, Halstead started his shift at 7:00 a.m. He traveled from the Coal Fork Portal to the Dawes slope where he assisted several miners in removing accumulations and spillage on the Dawes slope. At approximately 11:00 a.m., Jeffery Edwards, Foreman, directed Halstead and Casey Burkhamer, Laborer, to retrieve belt conveyor structure located at the end of the Dawes slope track. They needed the structure to make repairs on the slope belt conveyor. Halstead, Edwards and Burkhamer traveled to the No. 537 battery scoop charging area to get a scoop to assist with moving the structure. Edwards directed Halstead to operate the scoop. Edwards and Burkhamer traveled to the end of the track where the belt conveyor structure was loaded on rail cars. They waited at the end of the track approximately 10 minutes for Halstead to arrive with the scoop before becoming concerned, at which point they went looking for him. Edwards and Burkhamer found Halstead approximately one crosscut away, pinned in the scoop by a piece of polymer pipe. The polymer pipe had been laying in the track entry roadway. Halstead was traveling towards the rail cars with the battery end of the scoop leading. As the scoop traveled over the polymer pipe, the weight of the scoop raised it, and it entered the operator's compartment and struck Halstead (see Appendix A).

Edwards radioed for help and Burkhamer checked Halstead's pulse, but could not detect one. Edwards and Burkhamer could not remove the polymer pipe. Jason Dooley, Chief Electrician, and Eric Adkins, Mine Examiner, responded to Edwards's call for help. When they arrived at the accident scene, Dooley located a grinder and cut the polymer pipe to free Halstead. Several miners assisted in removing Halstead from the scoop and placing him on a backboard. Burkhamer started cardiopulmonary resuscitation. The Kanawha County Emergency Ambulance Authority (KCEAA) arrived at the mine at 12:18 p.m. Miners transported Halstead to the surface at 12:45 p.m. and KCEAA transported him to Charleston Area Medical Center General Hospital. Dr. Allen Mock, Continuing Medical Education - Office of the Chief Medical Examiner Main, pronounced Halstead's death at 1:44 p.m.

INVESTIGATION OF THE ACCIDENT

On November 23, 2020, at 11:27 a.m., Phillip Martin, Dispatcher, called the Department of Labor's National Contact Center (DOLNCC) to report a possible fatal accident. The DOLNCC contacted Dave Morris, Assistant District Manager. Morris contacted Joshua A. McNeely, Mine Safety and Health Inspector, and instructed McNeely to travel to the mine.

James Jackson, Mine Safety and Health Inspector, was working on an ongoing E01 inspection elsewhere at the mine when the accident occurred. Jackson issued a Section 103(k) order to secure the accident scene and assure the safety of miners. At 2:00 p.m., McNeely arrived at the mine. MSHA and the West Virginia Office of Miners Health Safety and Training (WVOMHST) conducted an investigation with the participation of mine management and miners. See Appendix B for a list of persons participating in the investigation.

DISCUSSION

Accident Scene

The accident occurred at an area referred to as the slope bottom, which is located underground on the Dawes side of the mine. Halstead was operating the scoop in a roadway, which contained a belt conveyor and track for track-mounted haulage equipment. The scoop was traveling, battery first, toward rail cars containing belt structure. The belt conveyor was on the side opposite the scoop operator's deck.

Equipment Involved

The scoop involved in the accident was rebuilt in 2009 by C.A.I. Industries. The scoop was originally manufactured as a model 488 scoop by S&S. This is an older scoop that was not equipped with a door to the operator's compartment. There is no supporting evidence that the scoop had ever been retrofitted with a door.

Safeguard Notice for Extraneous Material in Roadways

On August 7, 2017, a safeguard notice was issued at this mine for extraneous material in roadways on working sections. The safeguard stated that this material posed a hazard to mobile equipment operators. On November 7, 2017, this safeguard was modified to include all roadways in the mine. Before the accident, inspectors issued nine citations for violations of this safeguard. The standards, policies, and administrative controls in use at the mine were inadequate to assure that extraneous material was not stored or otherwise deposited in roadways and travelways. Investigators found an abundance of extraneous material in the roadways and crosscuts adjacent to the track entry. The mine operator removed 48 rail cars worth of extraneous material from the mine. These roadways are traveled by scoops and large rubber-tired mobile equipment. Investigators issued four additional citations.

Testing, Observations and Conclusions

Personnel from MSHA, WVOMHST, and mine management evaluated the operation of the scoop controls. Investigators did not find any deficiencies on the scoop that contributed to the accident.

Examinations

The operator did not conduct an adequate pre-shift examination of the area where the accident occurred on November 23, 2020. The pre-shift examination did not identify hazards relating to extraneous material, including the polymer pipe, along the track in the area of the accident.

Training and Experience

Taylor Halstead had approximately 14 months of mining experience. He did not receive task training to operate a scoop as required by 30 CFR § 48.7(a), which would have included the health and safety aspects of newly assigned tasks. Task training would have included instruction

in examining roadways and travelways for hazards. Halstead had previously worked at the American Eagle Mine until May 2020. Halstead was called back to work on November 3, 2020, and received experienced miner training.

ROOT CAUSE ANALYSIS

The accident investigation team conducted an analysis to identify the underlying causes of the accident. The team identified the following root causes, and the mine operator implemented the corresponding corrective actions to prevent a recurrence.

1. Root Cause: The mine operator did not assure that the miner was properly trained prior to directing him to operate a piece of mobile equipment (scoop).

   Corrective Action: The mine operator will assure that miners are adequately task trained in accordance with the training plan. The mine operator also developed written policies and procedures to assure that each new miner completes three hours of specialized training regarding extraneous material in roadways, including training on all safeguards and citations received regarding extraneous materials, prior to working or operating equipment underground. The mine operator revised the training plan to require this additional training.

2. Root Cause: The mine operator did not remove extraneous material from roadways. Also, mine management did not conduct adequate examinations to assure all extraneous material was removed from roadways.

   Corrective Action: The mine operator provided three hours of training to all miners in identifying and correcting hazards, including the removal of extraneous material from mine roadways. After this training, the mine operator removed extraneous material from the mine's roadways. The mine operator also provided three hours of training for all examiners and management personnel regarding safeguards and citations issued for inadequate examinations. Mine examiners and management will assure that extraneous material is removed from roadways.

CONCLUSION

On November 23, 2020, at approximately 11:15 a.m., Taylor Halstead, a 20-year-old miner with approximately fourteen months of mining experience, died when the scoop he was operating ran over a four-inch diameter, seventeen-foot long polymer pipe laying in the roadway. When the scoop tire ran over the polymer pipe, the end of the pipe entered the operator's compartment and struck the victim.

The accident occurred because mine management: 1) did not assure that the miner was properly task trained to operate the scoop, 2) did not remove extraneous material from the mine roadways and, 3) did not conduct adequate preshift examinations to assure all extraneous material was removed from the roadways.

Approved By:

_____ _____

District Manager Date

ENFORCEMENT ACTIONS

1. A 103(k) Order No. 9248283 was issued to Panther Creek Mining, LLC on November 23, 2020:

   A fatal accident occurred at this operation on November 23, 2020, when a miner who was operating a scoop received injuries from a polymer pipe that entered the operator's deck. This order is issued to assure the safety of all persons at this operation. It prohibits all activity in the entire mine until MSHA has determined that it is safe to resume normal mining operations. The mine operator shall obtain prior approval from an authorized representative for all actions to recover and or restore operations to the mine.

2. A 104(d)(1) Order No. 9248300 was issued to Panther Creek Mining, LLC for a violation of 30 CFR §75.360(a)(1).

   The operator did not perform an adequate preshift examination. A fatal accident occurred on November 23, 2020, when a 20-year-old miner with approximately 14 months of mining experience, died when he was struck by a piece of polymer pipe while he was operating a scoop. As the scoop traveled over the pipe, the pipe raised up and entered the operator's compartment striking the operator. This section of pipe should have been identified during examinations and removed from the roadway. Before the accident, the mine operator was cited nine times for not complying with Safeguard No. 9113730 that was issued on 8/7/2017 because extraneous material was being allowed to exist in travelways. This violation is an unwarrantable failure to comply with a mandatory standard.

3. A 104(d)(1) Order No. 9248299 was issued to Panther Creek Mining, LLC for a violation of 30 CFR §75.1403

   The mine operator did not comply with an existing notice to provide safeguard in affect at the mine. A fatal accident occurred on November 23, 2020, when a 20-year-old miner with approximately 14 months of mining experience, died when he was struck by a piece of polymer pipe while he was operating a scoop. As the scoop traveled over the polymer pipe, the weight of the scoop raised it and it entered the operator's compartment and struck the operator. MSHA issued Safeguard Notice 9113730 on August 7, 2017, which requires that roadways be maintained free of extraneous material which may cause injury when being run over. MSHA modified the safeguard on November 7, 2017, to include removal of extraneous material from all travelways underground. Before the accident, MSHA cited the safeguard nine times. This is an unwarrantable failure to comply with a mandatory standard.

4. A 104(d)(1) Order No. 9248298 was issued to Panther Creek Mining, LLC for a violation of 30 CFR § 48.7(a)

   A fatal accident occurred on November 23, 2020, when a 20-year-old miner with approximately 14 months of mining experience, died when he was struck by a piece of polymer pipe laying in the travelway while he was operating a scoop. The scoop operator was taking the scoop to the end of the track to retrieve conveyor structure. As the scoop

traveled over the polymer pipe, the weight of the scoop raised it and it entered the operator's compartment and struck the operator. The scoop operator had not received task training from mine management on operation of the scoop covering the health and safety aspects and safe operating procedures for work tasks, equipment, and machinery as required by the 30 CFR. This violation is an unwarrantable failure to comply with a mandatory standard.

Appendix A – Photo of Scoop

Appendix B
Persons Participating in the Investigation

American Eagle Mine

Jamie Wiant	General Manager
Jamie Adkins	Superintendent
Rick Estepp	Safety Manager
Jason Dooley	Chief Electrician
Joe Grounds	Production Manager
Jeffery Edwards	Foreman
Adam Childers	Equipment Operator
Phillip Martin	Dispatcher
Richard Ooten	Maintenance
Eric Adkins	Mine Examiner
Rodney O'Dell	Mine Examiner
Robert Riffe	Mine Examiner
Ethan Shrewsbury	Mine Examiner
James Sisk	Mine Examiner
Scott Petry	Continuous Mining Machine Operator
Casey Burkhamer	Laborer

West Virginia Office of Miners Health Safety and Training

Eugene White	Director
John Kinder	Deputy Director
McKennis Browning	Inspector-at-Large
Charles Mole	District Inspector
Jeff Davis	Electrical Inspector

Mine Safety and Health Administration

Andrew Goad	Mine Safety and Health Inspector
James Jackson	Mine Safety and Health Inspector
Joshua A. McNeely	Mine Safety and Health Inspector