UNITED STATES DEPARTMENT OF LABOR MINE SAFETY AND HEALTH ADMINASTRATION

REPORT OF INVESTIGATION

Facility (Coal)

Fatal Slip or Fall of Person Accident August 4, 2021

Marfork Coal Company - Marfork Environmental (S463) Whitesville, West Virginia

at

Marfork Processing Marfork Coal Company, LLC Whitesville, Raleigh County, West Virginia ID No. 46-08374

Accident Investigators

Franklin Stover Mine Safety and Health Inspector

Jamie Shufflebarger Mine Safety and Health Specialist

Originating Office
Mine Safety and Health Administration
Beckley District
1293 Airport Road
Beaver, West Virginia 25813
Larry Bailey, Acting District Manager

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OVERVIEW

On August 4, 2021, at 8:12 a.m., Jeffery Hudnall, a 60 year-old steam truck operator with 16 years of mining experience, was fatally injured while steam cleaning a front-end loader. Hudnall was standing on the front-end loader's right-side deck when he fell over nine feet to a concrete pad.

The accident occurred because the contractor did not ensure the miner wore fall protection where there was a danger of falling.

GENERAL INFORMATION

Marfork Coal Company, LLC owns and operates Marfork Processing and Marfork Coal Company - Marfork Environmental (Marfork Environmental). Marfork Environmental is located on the same property as Marfork Processing. Marfork Environmental operates one tenhour shift per day, five days per week, and performs work exclusively on Marfork Coal Company, LLC's properties. Marfork Environmental maintains roadways, ditch lines, impoundments, and other work as needed.

The principal management officials at Marfork Environmental at the time of the accident were:

Kenneth Williams Cameron Craft Michael Vaught Superintendent Foreman Safety Manager

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at Marfork Processing on July 13, 2021. The 2020 non-fatal days lost incident rate for Marfork Processing was 0.27, compared to the national average of 1.83 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On August 4, 2021, at 6:00 a.m., Hudnall arrived at the mine and met with Craft who assigned him a list of equipment that needed to be steam cleaned that day. The first piece of equipment on the list was a front-end loader. Based on interviews and video surveillance footage, Hudnall performed a pre-operational examination on the steam truck and filled the truck with fuel and water. While Hudnall was getting fuel and water, Ronald Maloskey, Greaser, moved the front-end loader to the Marfork Environmental maintenance yard steam pad. After returning to the maintenance yard, Hudnall positioned his steam truck beside the front-end loader where he met with Maloskey, who had started steam cleaning the front-end loader.

According to video surveillance footage provided by the Marfork Environmental, at 7:44 a.m., Maloskey started steam cleaning the loader at ground level while Hudnall observed. At 7:54 a.m. Hudnall took the steam cleaner wand from Maloskey and resumed steam cleaning on ground level. At 8:09 a.m., Hudnall climbed up the ladder to the right-side deck of the front-end loader and continued steam cleaning. At 8:12 a.m., Hudnall collapsed and fell through an opening in the front-end loader's deck, between a handrail and the closed cab, to a concrete pad over nine feet below. Maloskey was close by, turned around, saw Hudnall on the ground, and yelled for help. Robert Irvin, Sweeper Truck Operator, who also serves as an Emergency Medical Technician, and Scott Lambert, Mechanic, were close by when they heard Maloskey yelling. Irvin ran to the office and informed Craft that Hudnall had fallen off the front-end loader and instructed him to call 911. Irvin returned to the scene to assist Lambert in providing first aid to Hudnall. Craft instructed Hebert Brooks, Office Clerk, to call 911. Whitesville Ambulance arrived on scene at 8:25 a.m. and took over care of Hudnall. Hudnall was transported to Charleston Area Medical Center. On August 8, 2021, Paul Mellen, M.D., pronounced Hudnall dead at 4:00 p.m.

INVESTIGATION OF ACCIDENT

On August 4, 2021, at 8:46 a.m., Brooks called the Department of Labor National Contact Center (DOLNCC). At 9:01 a.m., the DOLNCC contacted Pamela Wilson, Secretary, who contacted Fred Wills, Supervisory Mine Safety and Health Inspector. Wills sent Jamie Shufflebarger, Mine Safety and Health Specialist, and Franklin Stover, Mine Safety and Health Inspector, to the mine. At 9:50 a.m., Stover arrived at the mine and issued an order under the provisions of Section 103(k) of the Mine Act to ensure the safety of the miners and preservation of evidence. Wills assigned Stover to be the lead accident investigator.

MSHA's accident investigation team, in conjunction with the West Virginia Office of Miners' Health Safety and Training, conducted an examination of the accident scene, interviewed miners and mine management, and reviewed conditions and work procedures relevant to the accident. See Appendix A for a list of persons who participated in the investigation.

DISCUSSION

Chargeability Review Committee

When a miner's death is not conclusively determined to be chargeable to the mining industry, MSHA submits the facts of the case, including background and supporting information, to the MSHA Chargeability Review Committee (Committee) for a decision. The Committee reviewed the autopsy report and MSHA's investigation and concluded that Hudnall's death resulted from the injuries sustained during the accident at the mine and therefore, his death is chargeable to the mining industry.

Location of the Accident

The accident occurred at the Marfork Environmental maintenance yard steam pad (see Appendices B and C).

Weather

At the time of the accident, the weather was clear. Investigators determined the weather did not contribute to the accident.

Equipment Involved

The front-end loader involved in the accident was a Komatsu WA 600-6 Wheel Loader. The front-end loader's handrails are 39½ inches high with two chains across the opening where a ladder provided access from the ground to the cab. The height of the handrails decreased to 25½ inches as the handrails approached the cab of the front-end loader. There was an 18-inch opening between the handrails and the cab when the cab door was closed. The opening had a 1/8-inch cable 17 inches off the deck (see Appendix D). This opening is designed by the manufacturer to provide maintenance access. Investigators determined the handrails were original from the manufacturer and were not modified by the contractor. Investigators examined the front-end loader and found no defects that contributed to the accident.

The steam truck involved in the accident was an International 4300 Flatbed Truck equipped with a Hotsy Steam Cleaner, Model #128055. Investigators examined the steam truck and found no defects that contributed to the accident.

Fall Protection

Marfork Environmental's fall protection policy at the time of the accident required fall protection to be worn when there was a danger of falling. A fall hazard was created by the 18-inch opening and an absence of handrails or other guarding features for the entire length of the walking deck on the front-end loader. Fall protection was provided and available but was not used to perform the task. The contractor did not ensure Hudnall wore fall protection where there was a danger of falling. Investigators determined that this contributed to the accident.

Training and Experience

Hudnall had 16 years of mining experience and worked as a steam truck operator for 11 years, with seven years at Marfork Processing. Investigators reviewed training records and determined that Hudnall received all training in accordance with MSHA Part 48 training regulations, including task training on operating the steam truck.

Examinations

Craft conducted an onshift examination of the Marfork Environmental on the morning of August 4, 2021, with no hazards noted in the record book. Mr. Hudnall conducted a pre-operational examination on the steam truck and the only defect noted was an antifreeze leak. Investigators reviewed the contractor's examination records and determined that the examinations were adequate and did not contribute to the accident.

ROOT CAUSE ANALYSIS

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

<u>Root Cause</u>: The contractor did not ensure the miner wore fall protection where there was a danger of falling.

<u>Corrective Action</u>: The contractor developed and implemented a new written procedure and equipment modification to protect miners from falling. The mine operator trained miners on the procedure and modification which includes:

- A. Fall protection equipment, consisting of a full-body harness or full-body vest type harness with an anchored lanyard, must be worn when working in the following circumstances:
 - 1. Within six feet of a ledge or opening that lacks safety rail protection
 - 2. Working in precarious positions at any elevation, such as working while leaning, working inside an approved bucket, basket, man-lift, chute, bin, and all overhead hoist doorways or access points
 - 3. While performing work in an elevated position with exposure to falling five feet or greater
- B. The contractor installed an additional handrail that closed the gap between the factory handrail and cab. The company has performed the same modification on all other frontend loaders with a similar opening.

CONCLUSION

On August 4, 2021, at 8:12 a.m., Jeffery Hudnall, a 60 year-old steam truck operator with 16 years of mining experience, was fatally injured while steam cleaning a front-end loader. Hudnall was standing on the front-end loader's right-side deck when he fell over nine feet to a concrete pad.

The accident occurred because the contractor did not ensure the miner wore fall protection where there was a danger of falling.

Approved By:	
Larry Bailey	Date
Acting District Manager	

ENFORCEMENT ACTIONS

1. A 103(k) order was issued to Marfork Coal Company - Marfork Environmental.

A fatal accident occurred on August 4, 2021, at 8:12 a.m. This order is being issued under the authority of the Federal Mine Safety and Health Act of 1977, under Section 103(k) to ensure the safety of all persons at the mine and requires the operator to obtain the approval of an authorized representative of MSHA of any plan to recover any person in the mine or to recover the mine or affected area. This order prohibits any activity in the affected area. The operator is reminded of the obligation to preserve all evidence that would aid in investigating the cause or causes of the accident in accordance with 30 CFR 50.12.

2. A 104(a) citation was issued to Marfork Coal Company - Marfork Environmental for a violation of 30 CFR 77.1710(g).

A fatal accident occurred at this mine on August 4, 2021, when a miner fell over nine feet from the deck of a front-end loader to a concrete pad. The miner was standing on the front-end loader's right-side deck to steam clean it. The contractor did not ensure the miner wore fall protection where there was a danger of falling.

APPENDIX A – Persons Participating in the Investigation

Marfork Coal Company, LLC

Jason WhiteheadChief Operating OfficerCarl LucasVice President of OperationsSeth PortorSafety RepresentativeScott LambertMechanicRonald MaloskeyGreaserRobert IrvinSweeper Truck Operator

Marfork Coal Company - Marfork Environmental

Kenneth Williams

Cameron Craft

Josh Johnson

Hebert Brooks

Superintendent
Foreman

Equipment Operator

Office Clerk

West Virginia Office of Miners' Health Safety and Training

Eugene WhiteDirectorJohn KinderDeputy DirectorMcKennis BrowningInspector-at-LargeJeffery DavisElectrical InspectorSteven PharesAccident investigatorVictor ShinglerAccident Investigator

Mine Safety and Health Administration

Jamie ShufflebargerMine Safety and Health SpecialistFranklin StoverMine Safety and Health Inspector

APPENDIX B – Aerial View of Accident Scene



APPENDIX C – Accident Scene



APPENDIX D – Komatsu WA 600-6 Wheel Loader

