CAI-2006-33

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

COAL MINE SAFETY AND HEALTH
REPORT OF INVESTIGATION

Underground Coal Mine

Fatal Powered Haulage Accident
May 24, 2006

Sycamore Mine No. 2
Wolf Run Mining Company
I.D. No. 46-09060

Accident Investigators

Jan B. Lyall
Coal Mine Safety and Health Inspector – Roof Control

Craig S. Aaron
Mining Engineer – Health

Jerry W. Vance
Mine Health and Safety Specialist (Training)

Originating Office
Mine Safety and Health Administration
District 3
604 Cheat Road
Morgantown, West Virginia 26508

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OVERVIEW

On Wednesday, May 24, 2006, at approximately 2:15 p.m., Todd Upton, a 34-year old Utility Man operating a scoop, was struck and fatally injured by two wooden planks that entered the deck of the scoop. The accident resulted from failure to follow an existing procedure for maintaining haulageways free of extraneous material and is lacking procedure or policy requiring physical protection for scoop operators.

GENERAL INFORMATION

The Sycamore Mine No. 2, I.D. No. 46-09060, is operated by Wolf Run Mining Company, a subsidiary of International Coal Group (ICG), LLC, and is located near Jarvisville, Harrison County, West Virginia. The mine is accessed by three drift openings, into the Pittsburgh No. 8 coal seam, which averages 65 inches in height. Coal is extracted by two advancing continuous miner sections and is transported from the working faces by shuttle cars to belt conveyors for transport to the surface. The mine employs 94 persons working two production shifts, and one maintenance shift, five days a week. The mine was placed in active status on July 5, 2005, and averages 1,200 tons of coal per day.

A regular safety and health inspection by the Mine Safety and Health Administration (MSHA) was ongoing at the time of the accident. The previous regular safety and health inspection of the mine was completed March 17, 2006. For the previous four quarters, the mine NFDL Rate was 19.3 compared to a national average of 5.02 for the same period.

The principal officers at this mine at the time of the accident:

Samuel R. Kitts……………...President
Randy Riddle………………..General Manager
Roger Spencer……………….Superintendent
George Rannenberg………….Safety Manager
Johnny Bishoff……………….Production Coordinator
Barry Redman………………..Mine Foreman

DESCRIPTION OF ACCIDENT

On Wednesday, May 24, 2006, the day shift started at 6:00 a.m. Upton was assigned by Johnny Bishoff, Production Coordinator, to get the Fairchild Scoop, Model Number 35C-WH, Company Number 7, and start picking up trash in the Number 3 entry. He proceeded to do so when the scoop he was operating had battery problems. Gary Campbell, Number 5 Scoop Operator, was instructed by Dwight Riegel, Outby Foreman, to pull the Number 7 scoop to 7 block, so the batteries could be changed. The scoop was moved to the battery charging station where the batteries were changed.

Upton traveled to the surface after changing the scoop batteries and emptied the trash from the scoop bucket. He was then assigned to deliver rock dust to the section dumping point of the Number 3 belt. Upton made three trips from the surface to this location, hauling two pallets of rock dust each trip. At approximately 1:50 p.m., Upton spoke with Riegel and stated this would be his final trip. Riegel instructed him to haul a load of trash consisting of empty wooden pallets and rock dust bags outside. During his final trip to the surface at approximately 2:00 p.m., Upton stopped and spoke with Chris Mayle, Contract Laborer, and Dave Broll, Utilityman, near the 26 block of Number 3 entry.

Mayle and Broll were in the process of putting away their tools. After putting their tools away, they started walking out the Number 3 entry toward the surface. They came upon the scoop at 12 block, and saw Upton's cap light shining. Both men yelled at Upton to see if Upton was having problems. When Upton did not respond, they ran toward the scoop and found Upton trapped against the inby side of the operator's compartment. They noticed two planks had entered the operator's compartment, pinning Upton. The opposite ends of the planks were buried approximately one foot in the mine floor. Another plank was lying across the two that had Upton pinned. Mayle ran to the mine telephone at Number 2 Belt Drive and notified the dispatcher of the accident. The dispatcher notified Steve Hively, Section Foreman, of the accident and he and his crew proceeded to the area to assist. Upon arrival, Hively prepared to administer first aid while the planks pinning Upton were being removed. Once the planks were removed from the deck, the victim was removed from the machine and first aid and CPR were administered.

While persons underground were freeing the victim, George Rannenberg, Safety Director, and members of the second shift crew gathered additional first aid equipment and traveled to the accident scene via mantrip. After Rannenberg arrived at the accident scene, the victim was moved onto the mantrip and transported to the surface. CPR was continued on the ride to the surface until they met Jim Lacy, Afternoon Shift Foreman, who was carrying an Automatic External Defibrillator (AED). The AED was positioned on the victim, treatment was administered without success and CPR was continued.

When the victim arrived on the surface, Harrison County EMS with assistance of Health Net, continued emergency care. Tim Sergent, Paramedic, Harrison County EMS, through radio communication, with Dr. Roger Tilletson, MD, of Ruby Memorial Hospital in Morgantown WV, pronounced Upton dead at 3:25 p.m.

INVESTIGATION OF ACCIDENT

On Wednesday, May 24, 2006, at 2:40 p.m., Greg Fetty, Staff Assistant, Mine Safety and Health Administration, District 3 Office, received a telephone call from Eric Sherer, of MSHA Headquarters, informing him of a serious accident that occurred at the Sycamore Mine No. 2. Sherer stated he acquired this information during a telephone conversation with the Dispatcher at the mine. Fetty called the mine at approximately 2:45 p.m. and issued a 103(k) Order to Randy Riddle, General Manager of the mine, assuring the health and safety of the miners and securing the accident scene.

An investigation was initiated by Jan B. Lyall and Craig S. Aaron, Coal Mine Safety and Health Inspectors and Jerry W. Vance, Mine Health and Safety Specialist (Training). This investigation was conducted by MSHA, WVMHST, and ICG representatives. Formal interviews were conducted of 12 persons who had knowledge of the accident at the ICG Buckhannon Office. An inspection of the accident scene and operational checks on the Fairchild 35C-WH scoop were also conducted. Photographs, measurements, mapping, and testimony were obtained during the investigation.

DISCUSSION

Mining Equipment

Fairchild 35C-WH Scoop

The machine involved in the accident was a rubber tired, battery powered, Fairchild Scoop, Model 35C-WH, Company Number 7, Serial Number T339-351, with MSHA approval Schedule 2G-3599-2. The scoop was equipped with a bucket front end attachment which could be raised and lowered by the scoop's hydraulic system. The scoop is used to bring supplies into the mine.

Operational tests on the scoop during the investigation revealed no defects or deficiencies pertaining to tramming, steering, braking, hydraulic system, emergency de-energization device, lights, etc. The operator's compartment was located near the center of the machine on the right side, and was provided with an approved canopy. A protective metal grid enclosure was provided around ¾ of the operator's compartment. There was an opening measuring 18 ¼ inches wide by 28 inches in height, allowing an operator to enter the compartment. This model scoop was not provided with a door in its original configuration.

Examinations

During the shift, two examinations had been conducted by a certified person. A preshift and an on-shift were conducted of the roadway and belts. No hazardous conditions were reported.

Communications

There were no witnesses to the accident.

Training

Training records were reviewed, and the records indicate that Mr. Upton received West Virginia Apprentice Miners Certificate on February 14, 2005, Newly Employed Inexperienced Miner Training on October 24, 2005 and was issued a West Virginia Underground Miners Certificate on December 16, 2005. He also received task training on the following equipment:

October 31, 2005------------Fork Lift and Scoop (meaning Fairchild 35C)
March 3, 2006---------------488 S&S Scoop
March 6, 2006---------------Gunnite Machine
March 27, 2006--------------488 Long Airdox Scoop

Accident Scene

The roadway, at the accident site, was rolling and slightly damp, defined by two deeply rutted tracks. Roadway height was 52 inches and the width was 17 1/2 feet in the accident area. The immediate roof above the scoop had three dislodged roof bolts with plates missing.

Just inby 12 Block, on the right side next to the rib were two crib blocks and two planks. In the belt side cross-cut at 12 Block, there were 10 planks lying on the ground. The planks were 3inches thick by nine inches wide by 12 feet long.

ROOT CAUSE ANALYSIS

A root cause analysis was conducted. The following root causes were identified:

Root Cause: Procedures, rules, policies required by safeguard No. 7098604, issued November 14, 2005, require that off track haulage roadways be maintained free of extraneous materials which could be contacted by the mobile equipment and cause injury to the equipment operators or bystanders or cause the equipment operator to lose control of the equipment.

Corrective Action: Mine management has reinstructed all persons on the existing safeguard that is in effect.

Root Cause: No procedures, rules, or policies were in place to ensure mobile equipment operators are protected from extraneous materials in off track haulage roadways that could enter the operator’s compartment. The scoop was not provided with doors or other effective means to prevent extraneous materials prom entering the operator’s compartment.

Corrective Action: Mine management has installed doors on the operator’s compartment of the Fairchild 35C-WH scoops.

CONCLUSION

The accident resulted from failure to follow an existing procedure for maintaining haulageways free of extraneous material and a lacking procedure or policy requiring physical protection for scoop operators.

______________________________ ______________________________

Kevin G. Stricklin Date
District Manager

ENFORCEMENT ACTIONS

A 103(k) Order, No. 6602165, was issued to Sycamore Mine No. 2, to ensure the safety of all persons until an investigation was completed and the equipment and the area deemed safe.

A 104(a) Citation, No. 6602167, was issued to Sycamore Mine No. 2:

The operator failed to maintain the off-track haulage roadway free of extraneous material as required by safeguard number 7098604 issued on November 14, 2005. On Wednesday, May 24, 2006, at approximately 02:15 p.m., in the number 12 block of the number 3 roadway, a fatal accident occurred when three wooden planks, approximately 3 inches by 9 inches by 12 feet entered the deck of a Fairchild 35C-WH scoop. These two planks were pinned under another plank that was lodged underneath the scoop. The investigation also revealed that two other planks and a crib block were located on the right rib behind the scoop.

A 314(b) Safeguard, No. 6602168, was issued to Sycamore Mine No. 2:

On Wednesday, May 24, 2006, at approximately 2:15 p.m., three planks, from the roadway, measuring 3 inches by 9 inches by 12 feet, entered the operator's compartment of the Fairchild 35C-WH Scoop, causing multi crushing injuries to the victim. The accident occurred in the number 3 entry, at 12 block.

This is a notice to establish a safeguard requiring that all Fairchild 35C-WH scoops be equipped and maintained with a door.

APPENDIX A
PERSONS PARTICIPATING IN THE INVESTIGATION

International Coal Group, LLC

Samuel R. Kitts……………………Vice-President
Tim A. Martin……………………..Corporate Director Health and Safety
H. Ty Coleman…………………….Manager of Safety
Greg L. Nester……………………..Safety Director
Dennise Smith-Kastick, ESQ……..Attorney with Spilman, Thomas & Battle
Mark E. Heath…………………….Attorney with Spilman, Thomas & Battle

Wolf Run Mining Company

Randy Riddle……………………..General Manager
Roger Spencer…………………….Superintendent
Johnny Bishoff…………………..Production Coordinator
George Rannenberg……………..Safety Manager
Dwight Riegel…………………..Outby Foreman
Steve Hively…………………….Section Foreman
Bill Hoover……………………….Maintenance Superintendent
Fred Jamison……………………Outby Mine Examiner
David Broll……………………..Utility/Scoop Operator
Gary Campbell…………………Utility/Scoop Operator
Roy Payne, Jr.……………..……Continuous Miner Operator
Johnny Wilfong………………...Section Mechanic
Everett Kalbaugh……………….Utility/Scoop Operator
William Short………..………Shuttle Car Operator
Mark Ross……………………...Outby Foreman

Mine Temp, LLC

Christopher J. Mayle……………Contract Laborer

Alpha Engineering Services, INC.

Mike Gosnell……………………...Contract Surveyor
Travis Hartsog…………………….Contract Surveyor
David Prelaz……………………....Contract Surveyor

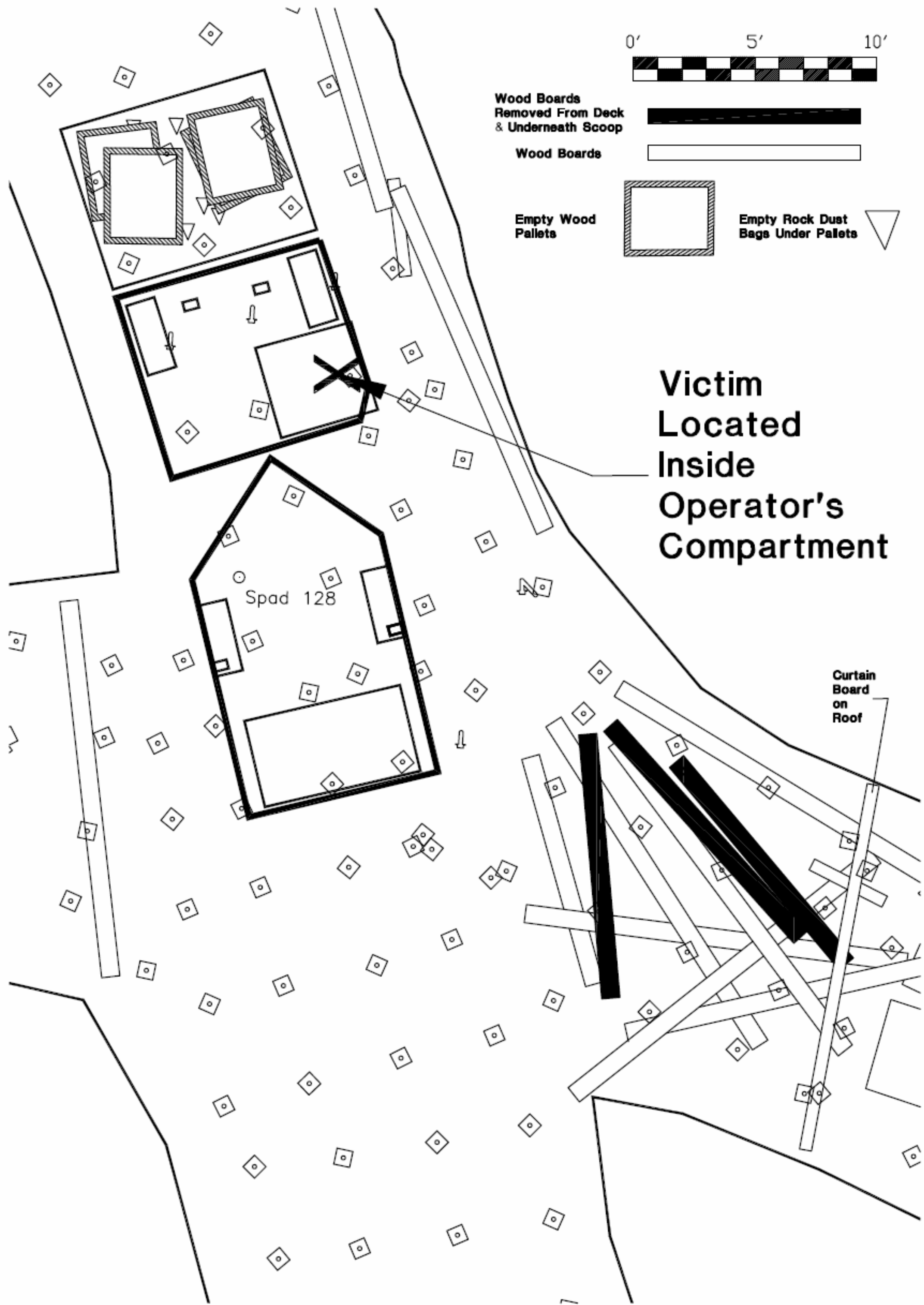
West Virginia Miners Health Safety & Training

Jim Dean…………………………..Director
Terry Farley……………………….Administrator
Brian Mills………………………...Inspector at Large
Jeff Bennett………………………..District Inspector
John Scott…………………….......Electrical Inspector
Bennie Comer……………………..Electrical Inspector

Mine Safety and Health Administration

Jan B. Lyall………………………..Coal Mine Safety and Health Inspector-Roof Control
Jerry W. Vance…………………….Educational Field Services
Craig S. Aaron……………………..Mining Engineer, Health Specialist
Frank Thomas……………………...Coal Mine Safety and Health Inspector-Electrical

APPENDIX B
Accident Site



APPENDIX C
Mine Map