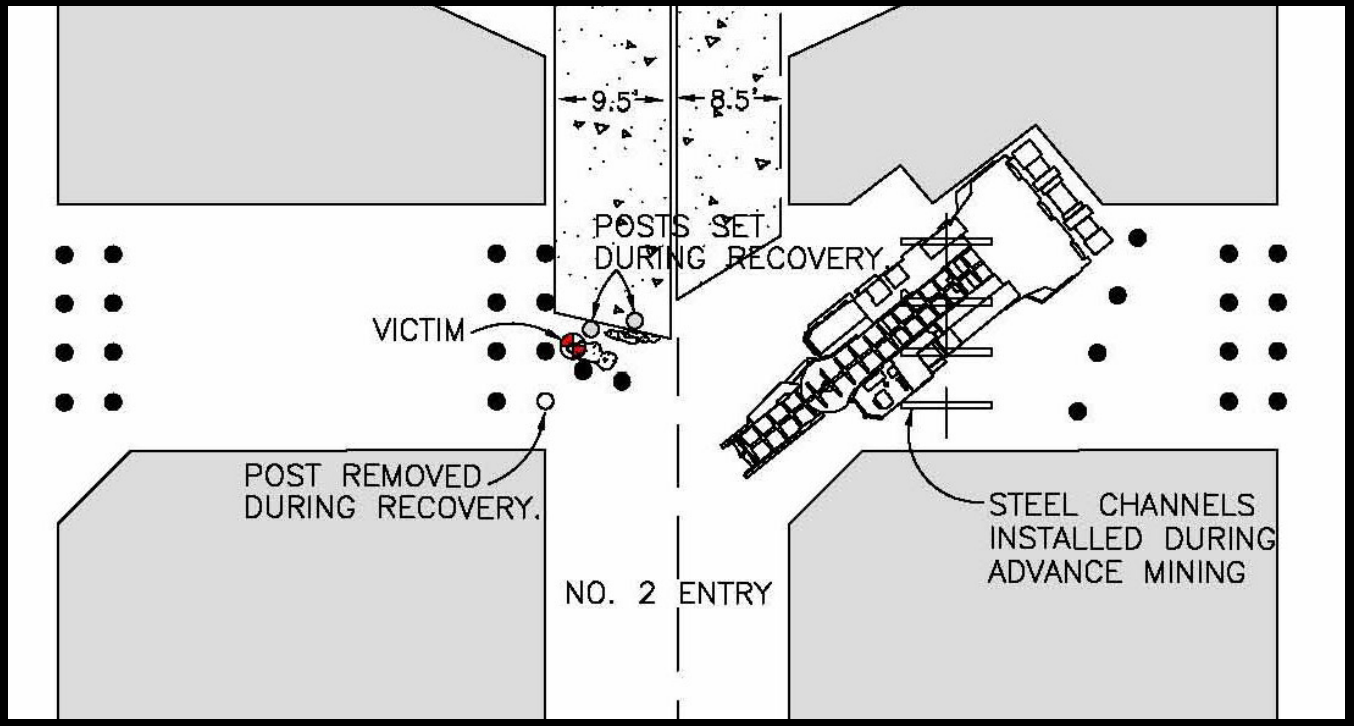
*This presentation is for illustrative and **general** educational purposes only and is not intended to substitute for the official MSHA Investigation Report analysis nor is it intended to provide the sole foundation, if any, for any related enforcement actions.*

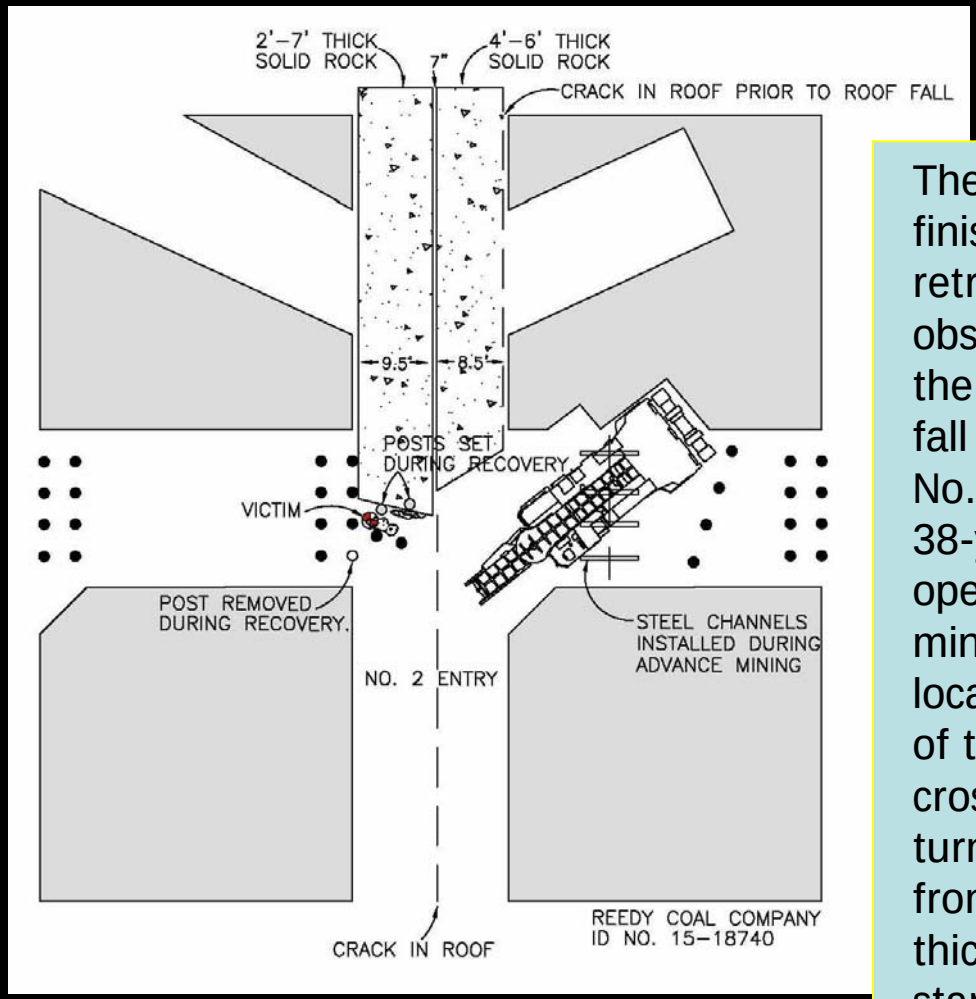
GENERAL INFORMATION

Coal Mine Fatal Accident 2004-15



Operator:	Reedy Coal Company, Inc.
Mine:	Mine No. 25
Accident Date:	August 2, 2004
Classification:	Fall of Roof
Location:	District 7, Knott County, KY
Mine Type:	Underground
Employment:	64

ACCIDENT DESCRIPTION



The section crew had just finished setting timbers for retreat mining and were observing the roof during the final push out, when a fall of roof occurred in the No. 2 entry. The victim, a 38-year old roof bolter operator with 14 years of mining experience, was located in the intersection of the No. 2 entry, at crosscut No. 20, inby the turn posts. The fall ranged from 0-60 inches in thickness, 18 feet wide, and started at the center of the No. 2 entry intersection and extended inby for an undetermined distance.

CONCLUSION

The accident occurred as a result of hazardous roof conditions on the working section not being corrected. An elongated crack, parallel with the right rib, extended into the No. 2 entry intersection. A hillseam was present in the right crosscut running parallel with the No. 2 entry. The parallel joints, combined with the extraction of coal, allowed the roof fall to initiate inby the pillar line and to propagate outby to the No. 2 entry intersection at crosscut 20. The contributing factors were: Failure to follow the approved roof control plan; the victims position was prohibited by the provisions of the approved roof control plan. The day shift mine foreman failed to alert the oncoming shift of the hazardous condition by not recording hazardous conditions found.

ROOT CAUSE ANALYSIS

Causal Factor: The victim was in an unsafe location in the No. 2 entry intersection inby the continuous mining machine.

Corrective Actions: Mining practices and procedures should be reviewed to ensure that during retreat mining no one is allowed inby the continuous mining machine. The mine operator should reinstruct all affected personnel in the approved roof control plan and ensure compliance with its provisions.

ROOT CAUSE ANALYSIS

Causal Factor: A review of examinations for hazardous roof conditions conducted during the day shift, prior to the accident, on the 001 mechanized mining unit (MMU) indicated that observed hazardous conditions were not recorded in the approved record book. In interviews the foreman acknowledged observing the crack radiating down the right rib but failed to record this condition. Identification of these conditions during the examination should have been recorded in the approved record book in order to alert the oncoming shift foreman to hazardous conditions. The record could have prompted corrective actions by mine management.

Corrective Actions: The certified persons making the examinations should properly identify, make the appropriate corrections, and record all hazardous conditions. Mine management should develop and follow procedures to identify and correct any and all hazardous conditions and to notify all persons affected by the condition.

ENFORCEMENT ACTIONS

104(a) Citation was issued for a violation of 30 CFR 75.220(a)(1).

An investigation of the fatal roof fall accident that occurred on August 2, 2004, determined that the approved Roof Control Plan, dated April 7, 2004, was not being complied with in the No. 2 entry on the 001 Mechanized Mining Unit (MMU). The victim was found inby the continuous mining machine while the continuous mining machine was mining. The approved plan required that all personnel be located in a safe location outby the continuous mining machine when the continuous mining machine is mining.

ENFORCEMENT ACTIONS

104(a) Citation was issued for a violation of 30 CFR 75.360(f).

An investigation of the fatal fall of roof accident that occurred on August 2, 2004, determined that the day shift foreman who conducted the pre-shift examination failed to properly record the results of his examination of the 001 Mechanized Mining Unit (MMU). The foreman stated that hazardous conditions were found and that a decision was made to back out the continuous mining machine and approach the pillar block from another position. The pre-shift record book did not contain any entries identifying the hazardous conditions.

BEST PRACTICES

- Ensure that the provisions of the approved Roof Control Plan are understood and followed by all miners.
- Ensure that miners are not needlessly positioned near the pillar line or inby turn posts.
- Be alert for changing roof conditions and install additional roof supports where necessary.
- Apply additional safety procedures or precautions in areas where geological changes and anomalies in strata, such as cracks, are observed.
- Conduct a thorough examination of the roof, face, and ribs immediately before any work is performed and thereafter as conditions warrant.