CAI-2006-43

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

COAL MINE SAFETY AND HEALTH

REPORT OF INVESTIGATION

Underground Coal Mine

Fatal Machinery Accident
October 30, 2006

No. 65
Double Bonus Coal Company
Pineville, Wyoming County, West Virginia
MSHA I.D. No. 46-09020

Accident Investigator

James R. Humphrey
Coal Mine Safety and Health Inspector

Originating Office
Mine Safety and Health Administration
District 4
100 Bluestone Road
Mount Hope, West Virginia 25880
Robert G. Hardman, District Manager

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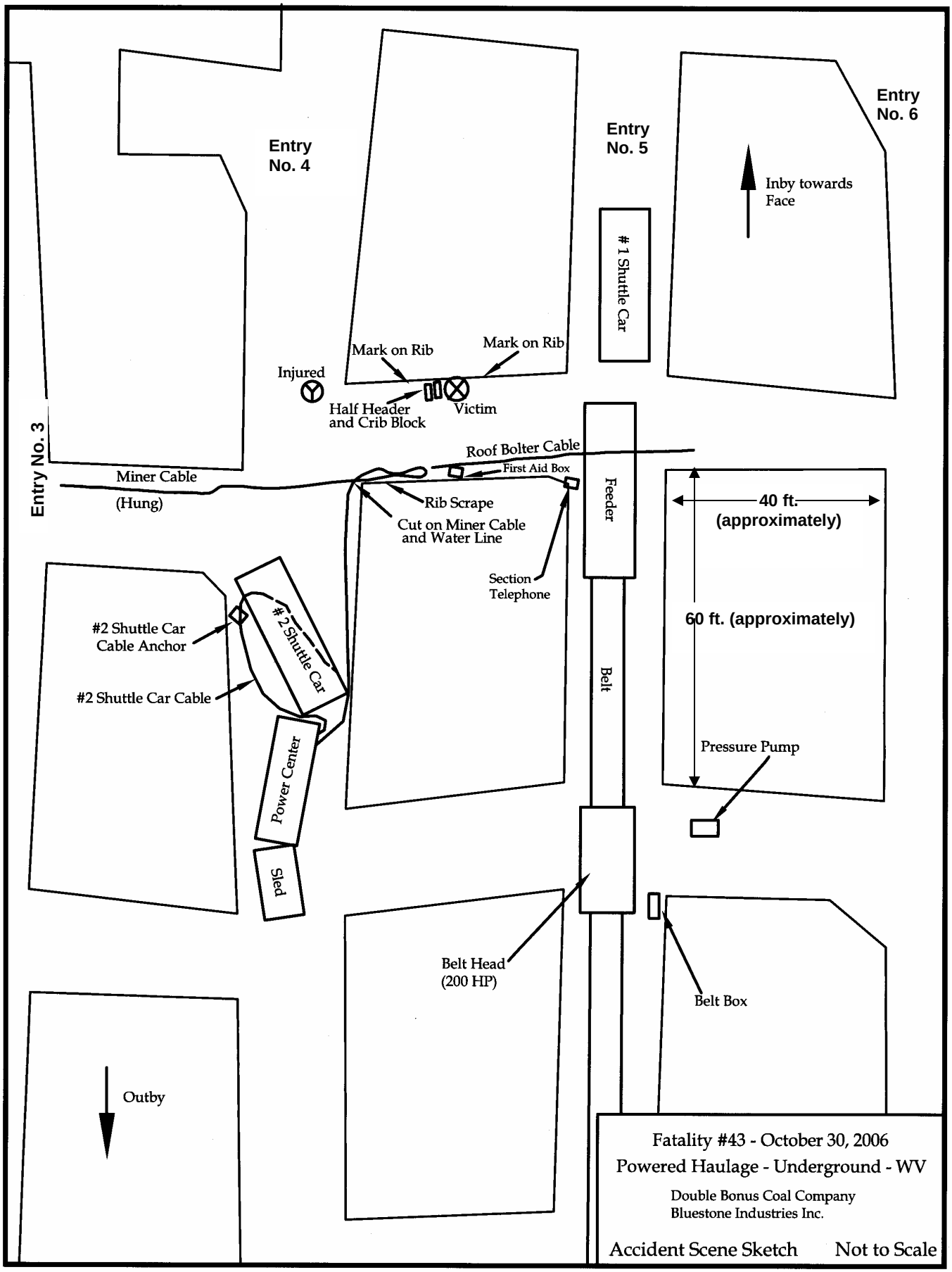
Entry No. 4
Entry No. 5
Entry No. 6
Inby towards Face
1 Shuttle Car
Mark on Rib
Mark on Rib
Injured
Half Header and Crib Block
Victim
Entry No. 3
Roof Bolter Cable
First Aid Box
Miner Cable
(Hung)
Rib Scrape
Cut on Miner Cable and Water Line
Feeder
40 ft. (approximately)
Section Telephone
#2 Shuttle Car Cable Anchor
#2 Shuttle Car
#2 Shuttle Car Cable
Belt
60 ft. (approximately)
Power Center
Pressure Pump
Sled
Belt Head (200 HP)
Belt Box
Outby
Fatality #43 - October 30, 2006
Powered Haulage - Underground - WV
Double Bonus Coal Company
Bluestone Industries Inc.
Accident Scene Sketch
Not to Scale

OVERVIEW

At approximately 7:05 a.m. on Monday, October 30, 2006, Brett Gibson, a 31-year-old shuttle car operator with 2 years of underground mining experience was fatally injured when he was crushed between a shuttle car and the coal rib. The accident occurred when the victim and a section mechanic were attempting to free-up a sticking tram pedal on the #2 shuttle car. Both miners were positioned between the shuttle car and the inby solid coal rib of the #4 to #5 crosscut. The shuttle car was energized, the park brake was not set and the controls were set to fast tram. The shuttle car trammed and struck both miners. The section mechanic received life- threatening injuries when he was rolled along the solid coal rib.

GENERAL INFORMATION

The Double Bonus Coal Company, No. 65 mine, is located near Pineville, in Wyoming County, West Virginia. Double Bonus Coal Company is a subsidiary of Bluestone Mining Corporation. The mine began operation on August 20, 2004 and operates in the Firecreek bituminous coal seam which averages 55 inches in height. Miners enter the mine through drift portals via battery-powered, rubber-tired, self-propelled personnel carriers.

The mine employs 40 persons, operates 2 continuous mining units and utilizes the room and pillar method of mining. Approximately 4,000 tons of raw coal is produced daily on two 10-hour production shifts per day, 5 days a week. The mine liberates 61,893 cubic feet of methane in a 24–hour period.

The principal officers for Double Bonus Coal Company are:

Kenneth C. Lambert……President
Dale Lusk……..Mine Foreman
Troy Hill……....Section Foreman
Charles (Dusty) Williams……...Chief Electrician

The last regular MSHA inspection of this operation was completed on September 11, 2006. The mine's Non Fatal Days Lost (NFDL) incidence rate was 2.58, compared to the national average of 4.94 for mines of the same type.

DESCRIPTION OF ACCIDENT

On Monday, October 30, 2006, at approximately 5:00 a.m., the section crew, under the direction of Troy Hill, section foreman, entered the mine via battery-powered, rubber-tired, self-propelled personnel carriers to the mechanized mining unit (MMU) 003 section to begin the regularly scheduled production shift. The setup crew from the previous shift was still installing a conveyor belt drive and 90 feet of conveyor belt outby the active section when the day shift crew arrived.

After arriving on the section, Hill directed the preparation of the section for production and the completion of the belt move. At approximately 6:50 a.m., the conveyor belt work was completed and the section was ready to begin production activities. Brett Gibson shuttle car operator, trammed the #2 shuttle car, serial number ET17404, from the section dumping point in the #5 entry, to the continuous mining machine which was located in the face of the #3 entry. Chris Mullens, continuous mining machine operator, observed Gibson tramming the shuttle car around the intersection just outby the continuous mining machine and noticed that the tram control was sticking on the shuttle car. When Gibson pulled the shuttle car beneath the continuous mining machine conveyor boom for loading, Mullens told Gibson that he needed to get that fixed (referring to the tram pedal sticking). Gibson asked Mullens if he had any WD-40 (penetrating oil) on the continuous mining machine. Mullens replied, "No." Gibson asked, "Have you seen Lane?" Mullens again replied, "No." Gibson told Mullens to load the shuttle car. The shuttle car was loaded and Gibson trammed the shuttle car back to the section dumping point (feeder) and the shuttle car was dumped.

Gibson, walked outby along the conveyor belt, and told Hill the tram control was sticking on the #2 shuttle car. Hill instructed Gibson to walk outby along the belt toward the conveyor belt drives and tell Charles (Dusty) Williams, Chief Electrician, who had just arrived at the conveyor belt drives. Gibson walked outby, and notified Williams. Williams told Gibson he would get someone to go with him and take care of the problem. Williams then instructed David Paul Lane, Mechanic, to get a can of WD-40 and correct the problem of the tram sticking on Gibson's shuttle car.

Gibson walked inby, along the conveyor belt, to his shuttle car. Lane retrieved the WD-40 lubricant from the personnel carrier, and walked inby to the crosscut between the #4 and #5 entries, where Gibson and the shuttle car should have been located. Gibson had taken the shuttle car to get another load of coal from the continuous mining machine.

Gibson arrived at the continuous mining machine, and then stopped and sprayed the tram pedal of the shuttle car with a can of electrical contact cleaner. Electrical contact cleaner is a fluid solvent which is used to clean electric and mechanical equipment. At approximately 7:05 a.m., Mullens loaded the shuttle car and Gibson traveled back to the section loading point. Lane, who was standing inby the section dumping point when Gibson arrived, observed Gibson stop the shuttle car and begin unloading the coal into the feeder.

While the shuttle car was dumping into the feeder, Hill was positioned approximately 30 to 40 feet outby the feeder. From this location, Hill was in a position to see the shuttle car and hear the shuttle car chain conveyor as it was unloading the machine. During this time, Hill was training the conveyor belt. Due to newly installed conveyor belt, and the arrangement of the mining faces, the #2 shuttle car was the only shuttle car

that was hauling coal from the continuous mining machine during that particular time. The Joy shuttle car was not immediately removed from service by Hill. Gibson had made Hill and Williams aware that an unsafe condition existed on the shuttle car. The agents of the operator failed to take immediate and appropriate action to remove the shuttle car from service until repairs could be made.

Lane called out to Gibson and showed him a can of WD-40 lubricant. After dumping the load of coal, Gibson allowed the shuttle car to drift away from the feeder. Gibson got out of the shuttle car, knelt down beside the deck, and began cleaning the loose coal and rock that had accumulated in the operator's deck. Lane walked over to the deck of the shuttle car and traveled to a location beside Gibson. Lane knelt down beside Gibson (outside the deck of the shuttle car) on the load end (inby end) of the shuttle car. Both men were on their knees outside the deck of the shuttle car, positioned between the shuttle car and the inby solid rib line of the crosscut. Lane sprayed WD-40 lubricant on the tram pedal located on the dump end of the shuttle car, and handed the can of WD-40 to Gibson to spray the tram pedal on the other end of the deck. Lane, while handing the can of WD-40 to Gibson, felt the shuttle car move. The wheels of the shuttle car were turned to travel outby in the #4 entry intersection, and as the shuttle car moved, it traveled toward the adjacent coal rib.

As the shuttle car moved toward the adjacent coal rib, Gibson was pinned by the shuttle car. Lane, also positioned between the shuttle car and the coal rib, was rolled down the inby solid rib line by the moving shuttle car. Lane was freed when the shuttle car reached the end of the rib and traveled into the open intersection of the #4 entry. The shuttle car continued traveling outby in the #4 entry, damaging the continuous-mining machine trailing cable and water supply line. The shuttle car then became entangled in its trailing cable, and pulled the trailing cable plug from the section power center, causing the circuit breaker to trip. The shuttle car traveled several more feet and came to rest after running into the inby end of the section power center.

Members of the crew heard the loud bang of the shuttle car hitting the section power center and Lane calling for help, and immediately provided assistance. First-aid was rendered to both Lane and Gibson. Both miners were transported to the surface area of the mine. Lane was transported to by Health Net helicopter to Charleston Area Medical Center, located in Charleston, West Virginia. Gibson was pronounced dead at the mine site by the Mercer and Wyoming County Medical Examiner.

INVESTIGATION OF THE ACCIDENT

The Mine Safety and Health Administration (MSHA) was notified of the accident at 7:45 a. m. on Monday, October 30, 2006 when Donnie Coleman, safety consultant/trainer for Double Bonus Coal Company, notified Ted Tilley, acting Supervisor at the Pineville field office. MSHA personnel from the Pineville field office were immediately

dispatched to the mine. A 103(k) order was issued to insure the safety of all persons during the accident investigation.

The investigation was conducted with the cooperation of the Approval and Certification Center (MSHA - Technical Support), the West Virginia Office of Miners' Health, Safety and Training (WVOMHST), the International Safety Representatives of the United Mine Workers of America, the Joy Mining Machinery Company and the mine operator and employees.

The accident scene was photographed, sketched and surveyed. Interviews were conducted of persons considered to have knowledge of the facts concerning the accident. A list of the persons who participated in the investigation is contained in Appendix A. The on-site portion of the investigation was completed, and the 103(k) Order was terminated on November 20, 2006.

DISCUSSION

Training

An inspection of the training records indicated that Gibson and Lane received training in accordance with 30 CFR, Part 48.

Records

During the interviews, several employees stated that the tram pedals had stuck on the #2 shuttle car, serial #ET17407, several times a week prior to the mining accident. Each time this condition occurred, loose coal was cleaned away from the tram pedals. Also, WD-40 brand lubricant or Electric Clean was sprayed on the tram pedals and the torsion spring surrounding the protruding shaft on the control station enclosure located in the center of the deck.

Maintenance work orders and repair reports for 29 days prior to the accident were examined. Production reports for both day and evening shifts for 29 days prior to the accident were also examined. The records did not indicate the sticking tram pedals on the shuttle car or reflect the times that WD-40 Brand lubricant or Electric Clean had been used to free the sticking tram pedal.

Equipment Examinations

Equipment examination records were reviewed for 4 weeks prior to the accident,

The person who performed the weekly examination of the #2 shuttle car was interviewed, and the examination records for four weeks prior to the mining accident were reviewed for deficiencies.

There were no records or recollection of deficiencies found or corrections made to the tramming mechanism of the #2 shuttle car. The weekly examiner, who is also the evening shift section electrician on the MMU-003 working section, stated that he had not worked on the tram pedals.

#2 Shuttle Car

General Information: The machine involved in the accident contained a tag in the operator's deck which stated Model 21SC04-64HE shuttle car, serial number ET17407, manufactured by Joy Mining Machinery, approval number 2G-4163A-00. The shuttle car is a standard type, the operator's deck is located on the right side of the machine when facing toward the mining faces (inby). The deck has two opposite facing seats that enabled the operator to change seating positions to face the direction of travel. A dual tram and brake pedal arrangement allows the operator to control the tram pedal with the right foot and the brake pedal with the left foot at each seat location.

Tramming System: The shuttle car was provided with a single pump/traction motor switch with five positions: off, slow tram, medium tram, fast tram, and pump start (pump start is a momentary position). Each tram pedal was connected to its own cross shaft located on the floor of the cab behind each seat. Each of the two cross shafts was supported by two journal bearings. Each bearing was provided with grease fittings to permit lubrication. The cross shafts were connected by mechanical linkage to a common tram switch located inside the control station enclosure at the center of the operator's compartment. When either tram pedal was pushed, the corresponding cross shaft rotated, the mechanical linkage moved, and the common tram switch is actuated. The return action of the tram pedal and linkage was provided by a torsion spring which surrounded the protruding shaft on the control station enclosure, and a return spring which was integrated with the tram switch inside the control station.

The shuttle car was designed so that the pump and traction motors would not start while the tram pedal was depressed. After the pump/traction motor switch was placed in the "start" position, it was designed to spring return to the "fast tram" position for normal operation. Placing the pump/traction motor switch at the slow or medium tram positions limited the shuttle car to slow or medium speeds, respectively, even when the tram pedal was fully depressed. The maximum rated speed of the shuttle car was approximately 4.5 mph.

Braking System: The shuttle car was equipped with a Joy wet disc brake system. The brake head assembly was an enclosed, multi-disc design. It provided both service and emergency-parking brake capability. There were separate pistons inside the brake head for service brake application and emergency-parking brake release. Both systems used hydraulic oil from the main hydraulic tank on the machine. When an equipment operator actuated the brake pedal, the service brake was applied with pressure from a

power-assisted master cylinder which modulated pressure from the hydraulic pump. The emergency-parking brake was spring-applied and hydraulically-released.

The emergency-parking brake was designed to apply when the emergency deenergization device (panic bar) was activated. It was also designed to automatically apply whenever the shuttle car was deenergized. The emergency-parking brake was released with a manual control that did not operate any other functions. The emergency-parking brake could be manually applied, without de-energizing the equipment, from either seat location. The shuttle car had a manual hand pump in the operator's compartment that could be used to release the brake while the shuttle car was deenergized. To maintain the release pressure developed by the hand pump, a spring-return button in the operator's compartment had to be continuously held down by the operator.

A brake head assembly was mounted to the primary reducer housing on each side of the machine. A wear indicator pin was located on each brake head assembly housing. One end of the indicator pin protruded through the housing, and other end rested on the emergency-parking brake pressure plate. A spring pushed the pin in as the friction material became worn. According to the Joy Technical Publication TJSC0048-0501, when the pin retracts flush with the housing, while the emergency-parking brake is applied, the worn disc pack should be replaced.

Emergency Deenergization Device: The panic bar, accessible from either seat, was mechanically linked to the emergency stop button located on the control station enclosure. De-energization of the machine, including the tram motors, occurred with an applied force of 5 pounds and a panic bar movement of one inch.

Operating Unsafe Mining Equipment

The #2 shuttle car was not immediately removed from service. The Section Foreman and the Chief Electrician, agents of the mine operator, were made aware by the shuttle car operator that an unsafe condition existed on the shuttle car that was being operated. The tram pedal was sticking in the tram position on the shuttle car. The Shuttle Car Operator continued operating the shuttle car until the mechanic arrived at the section dumping point to perform the repair.

ROOT CAUSE ANALYSIS

A root cause analysis was conducted to identify the most basic 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 recurrence of the accident.

Root Cause: The operator's management systems and policies did not ensure that the #2 shuttle car's cross shafts and four journal bearings that support the two cross shafts were properly lubricated. Improper lubrication and fine coal particles caused the tram pedal to stick, causing an unsafe operating condition.

Corrective Action: The written mine training program was revised to include the following safety precaution under task training; "The operating decks on shuttle cars will be cleaned and properly greased prior to being placed into production on each shift." Management and miners were trained in the new safety precaution.

Root Cause: The agents of the operator failed to take immediate action to remove the shuttle car from service until repairs could be made to correct the unsafe condition. The foreman had reason to know that the shuttle car was still in operation and did not take the expected and appropriate action of removing the machine from service.

Corrective Action: The operator must react immediately when aware an unsafe condition exists. The operator must immediately remove the equipment from service until repairs are completed that restore the equipment to a safe operating condition. The operator implemented additional management systems and oversight policies to ensure that repairs to equipment were adequately made in accordance with manufacturer's specifications and recommendations. Management and maintenance personnel were instructed in the new systems and policies.

Root Cause: The #2 shuttle car was not deenergized and blocked against motion before cleaning of the deck and repair of the tram controls was performed. Two miners were positioned outside the deck of the shuttle car while the shuttle car was energized, the tram control was in the fast tram position, and the park brake was not set.

Corrective Action: The written mine training program was revised to include, "Mobile equipment operators shall not leave the equipment operating deck with the equipment running; and the shuttle car circuit breaker shall be de-energized prior to performing any repair or maintenance; this includes cleaning out the operator deck." Management and miners were trained in the requirements of the new safety precautions.

CONCLUSION

The accident occurred because the operator, being aware of the unsafe condition on the #2 shuttle car, did not remove the #2 shuttle car from service immediately. The accident occurred because the shuttle car was left unoccupied and energized, the park brake was not set and the controls were set to fast tram. The accident occurred because the shuttle car was not properly maintained, effective procedures were not in place to safely perform repairs, material was allowed to accumulate in the operator's deck of the shuttle car, and the miners were positioned in a hazardous location.

Approved by:

_____ _____

Robert G. Hardman Date
District Manager

ENFORCEMENT ACTIONS

1. A 103(k) order, No. 7259164 was issued to ensure the safety of the miners until the investigation could be completed.

2. A 104(d)(1) citation, No. 7259168, was issued citing 30 CFR, section 75.1725(a) and stating in part that the #2 shuttle car, serial #17407, operating on the MMU-003 working section, was not maintained in a safe operating condition. The tram pedal was sticking while the shuttle car was in operation on the active mining section. The Section Foreman and the Chief Electrician, agents of the mine operator, were made aware by the shuttle car operator that an unsafe condition existed on the shuttle car that was being operated. The agents of the operator failed to take immediate and appropriate action to remove the shuttle car from service until repairs could be made. The shuttle car operator continued operating the shuttle car until the mechanic arrived at the section dumping point to assist the shuttle car operator in making proper repairs. The shuttle car remained energized. The pump motor of the #2 shuttle car was running while the repair work was being performed. The park brake was not set. The tram pedal on which the work was being performed was engaged and became stuck. The shuttle car operator was pinned between the shuttle car and the solid rib, causing fatal injuries. The mechanic was rolled along the solid rib line, causing serious life threatening injuries. The violative condition is contributory to the fatal mining accident which occurred October 30, 2006.

3. A 104(a) citation, No. 7259169, was issued citing 30 CFR, section 75.1725(c) and stating in part that repairs were begin performed on the #2 shuttle car, Serial #17407, located on MMU-003 working section, while the power was on and the machine was not blocked against motion. The shuttle car was energized while repair work was being performed on the tram pedal that was sticking. The park brake was not set. The two persons performing the repair work were located outside the deck of the shuttle car, between the shuttle car and the solid rib. The tram pedal on which the work was being performed was engaged and stuck. When the shuttle car moved, the shuttle car operator was pinned between the shuttle car and the solid rib, causing fatal injuries. The mechanic was rolled along the solid rib line, causing serious life threatening injuries. The violative condition is contributory to the fatal mining accident which occurred October 30, 2006.

Appendix A
Persons Participating in the Investigation

Double Bonus Coal Company

Kenneth C. Lambert	President
Dale Lusk	Mine Foreman
Troy Hill	Section Foreman
Charles (Dusty) Williams	Chief Electrician
Donnie Coleman	Safety Consultant/Trainer
Kevin Blankenship	Mechanic
Jamie Carter	Section Foreman
Ronald Dunn	Maintenance Foreman
Frank Gillespie Jr.	Electrician
Erby Hall Jr.	Roof-Bolting-Machine Operator
Danny Hatfield	Shift Foreman
James Lowery	Shuttle-Car Operator
David Paul Lane	Mechanic
Dalley Maynard Jr.	Shuttle-Car Operator
Johnny Monk	Roof-Bolting-Machine Operator
Chris Mullens	Continuous-Mining-Machine Operator
Keith Smith	Scoop Operator
William Webb	Shuttle-Car Operator

Bluestone Mining

Pat Graham	Safety Director

United Mine Workers of America

Gary Trout	International Safety Representative
Max Kennedy	International Safety Representative

Joy Mining Machinery

Lawrence Lepidi	Director Law and Government Affairs
Douglas Anderson	Designer
Donald Dickerson	Supervisor/Engineer
Lloyd Fox	Field/Service Representative

West Virginia Office of Miner's Health, Safety and Training

Fred B. Stinson	Inspector-at-Large
Donald L. Dickerson	Assistant Inspector-at-Large
Terry Farley	Accident Investigator
Paul Smith	Underground Inspector
Greg Norman	Underground Inspector
William R. Lawson	Electrical Inspector

Mine Safety and Health Administration

Robert G. Hardman ..... District Manager
Ernie Ross, Jr. ..... Supervisory CMS&H Inspector
Ted Tilley ..... Acting Supervisory CMS&H Inspector
Martin Carver ..... CMS&H Inspector/Accident Investigator
Donald Fink ..... CMS&H Inspector/Electrical
James Honaker ..... CMS&H Inspector/Electrical
Ronald Medina ..... Mechanical Engineer Approval Center
Wayne L. Carey ..... Electrical Engineer Approval Center
James R. Humphrey ..... CMS&H Inspector/Accident Investigator

Appendix B

Summary Evaluation of the #2 Shuttle Car ET17407
October 31, 2006
By the Electrical, Mechanical and Engineering Safety Division, Approval and Certification Center

Tramming system testing: The tram pedal, for forward travel, operated freely and spring-returned to the neutral position when released. The tram pedal for reverse travel was operated numerous times and consistently stuck when placed in the full tram position. The lack of return action was due to grit and coal that accumulated around the cross shafts and in the four journal bearings that supported the two cross shafts. After the area around the cross shafts was cleaned and the cross shaft bearings were greased, both pedals operated freely through the full range of motion and spring-returned to the released position when released.

The design feature that prevented the pump and traction motors from starting if the tram pedal was depressed operated as designed.

Tramming and braking control positions as found: The tram pedal for reverse travel was found stuck in the full tram position. (This is the direction the shuttle car moved when the accident occurred.) The tires were found to be positioned to make a left hand turn in this direction of travel. The tram pedal for forward travel was in the folded down/neutral position. The two service brake pedals were also folded down. The pump/traction motor switch was found in the "fast" tram position. The emergency-parking brake was found to be applied, which indicated this brake functioned as designed.

Braking system test and evaluation: Initial testing was done with the shuttle car elevated on blocks and all four tires off the ground. Pull-through tests showed that the service brake and emergency-parking brake each had the capacity to prevent the wheels from turning when the shuttle car was energized and either tram pedal was fully depressed. When the panic bar was activated, the tram motors were quickly deenergized and the emergency-parking brake activated without delay. The emergency-parking brake applied automatically whenever the shuttle car was deenergized. The emergency-parking brake could only be released with a manual control that did not operate any other functions. The feature to allow emergency-parking brake application while the machine was energized functioned. The manual hand pump operated to release the emergency-parking brake while the machine was deenergized. To maintain the release pressure developed by the hand pump, the spring-return button in the operator's compartment had to be continuously held down by the operator. When this button was released, the brake reapplied.

After the shuttle car was placed back on the ground, dynamic service brake and emergency-parking brake tests were conducted. These tests were done with the shuttle car in the empty condition, as it was found following the accident. The emergency-parking brake stopped the shuttle car without delay when the panic bar was activated. The service brake could also quickly stop and hold the shuttle car.

The wear pin indicator on the right side brake head assembly protruded 1/8 inch from the housing, and the indicator pin on the left brake head assembly was flush with the housing. The protruding wear pin indicated the brake friction material thickness in the right side brake head was in the acceptable range specified by Joy, and the indicator pin on the left side brake head indicated the disc pack had reached the point where Joy recommends brake disc pack replacement.

Conveyor switch position as found: Following the accident, the conveyor switch was found in the "run" position.

Panic bar operation: Activating the panic bar also applied the emergency-parking brake without delay.

Steering: The shuttle car was operated and no steering defects were found.

Remote control: The shuttle car was capable of remote control operation. A nearby continuous-mining machine also had remote control. In order to rule out the possibility that the shuttle car was inadvertently controlled by the continuous-mining machine's remote control, the continuous-mining machine's remote control was operated within five feet of the shuttle car. All functions on the continuous-mining machine's remote control were exercised. No movement occurred.

Appendix C

Accident Investigation Data - Victim Information

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

Event Number: 4 1 1 3 1 8 3

Victim Information: 1

1. Name of Injured/Ill Employee:	2. Sex	3. Victim's Age	4. Last Four Digits of SSN:	5. Degree of Injury:
Brett N. Gibson	M	31	4055	01 Fatal

6. Date(MM/DD/YY) and Time(24 Hr.) Of Death:
a. Date: 10/30/2006 b.Time: 9:00

7. Date and Time Started:
a. Date: 10/30/2006 b.Time: 5:00

8. Regular Job Title: 050 Shuttle Car Standard

9. Work Activity when Injured: 069 Shuttle Car Operator

10. Was this work activity part of regular job? Yes | X | No

11. Experience	Years	Weeks	Days		Years	Weeks	Days		Years	Weeks	Days		Years	Weeks	Days
a. This Work Activity:	1	26	0	b. Regular Job Title:	1	26	0	c: This Mine:	2	8	0	d. Total Mining:	2	8	0

12. What Directly Inflicted Injury or Illness: 077 Shuttle Car

13. Nature of Injury or Illness: 170 Crushing

14. Training Deficiencies:
Hazard: | | New/Newly-Employed Experienced Miner: | Annual: | Task:

15. Company of Employment:(If different from production operator)
Operator

Independent Contractor ID: (if applicable)

16. On-site Emergency Medical Treatment:
Not Applicable: | | First-Aid: | X | CPR: | | EMT: | | Medical Professional: | X | None: | |

17. Part 50 Document Control Number: (form 7000-1)

18. Union Affiliation of Victim: 2555 United Mine Workers of Amer.

Victim Information: 2

1. Name of Injured/Ill Employee:	2. Sex	3. Victim's Age	4. Last Four Digits of SSN:	
David P. Lane	M	31	0152	02 Permanent total or partial disability

6. Date(MM/DD/YY) and Time(24 Hr.) Of Death:

7. Date and Time Started
a. Date: 10/30/2006 b.Time: 7:05

8. Regular Job Title: 004 Mechanic

9. Work Activity when Injured: 039 Machine maintenance and repair work

10. Was this work activity part of regular job? Yes | X | No

11. Experience:	Years	Weeks	Days		Years	Weeks	Days		Years	Week	Days		Years	Weeks	Days
a. This Work Activity:	0	26	0	b. Regular Job Title:	0	26	0	c: This Mine:	0	6	0	d. Total Mining:		0	0

12. What Directly Inflicted Injury or Illness: 077 Underground mining machines

13. Nature of Injury or Illness: 370 Multiple Injuries

14. Training Deficiencies:
Hazard: | | New/Newly-Employed Experienced Miner: | Annual: | Task:

15. Company of Employment: (If different from production operator)
Operator

Independent Contractor ID: (if applicable)

16. On-site Emergency Medical Treatment:
Not Applicable: | | First-Aid: | X | CPR: | | EMT: | | Medical Professional: | | None: | |

17. Part 50 Document Control Number: (form 7000-1)

18. Union Affiliation of Victim: 9999 None (No Union Affiliation)

Victim Information:

2. Sex	3. Victim's Age	4. Last Four Digits of SSN:	5. Degree of Injury:

6. Date(MM/DD/YY) and Time(24 Hr.) Of Death:

Date and Time Started:

8. Regular Job Title:

9. Work Activity when Injured:

10. Was this work activity part of regular job? Yes | No

11. Experience:	Years	Weeks	Days		Years	Weeks	Days		Years	Week	Days		Years	Weeks	Days
a. This Work Activity:				b. Regular Job Title:				c: This Mine:				d. Total Mining:			

12. What Directly Inflicted Injury or Illness?

13. Nature of Injury or Illness:

14. Training Deficiencies:
Hazard: | | New/Newly-Employed Experienced Miner: | Annual: | Task:

15.Company of Employment:(If different from production operator)

Independent Contractor ID: (if applicable)

16. On-site Emergency Medical Treatment:
Not Applicable: | First-Aid: | CPR: | EMT: | Medical Professional: | None:

17. Part 50 Document Control Number: (form 7000-1)