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.
Coal Mine Fatal Accident 2007-07

Operator: Eighty Four Mining Company
Mine: Mine 84
Accident Date: April 5, 2007
Classification: Stepping or Kneeling on Object
Location: District 2, Washington County, Pennsylvania
Mine Type: Underground Coal Mine
Employment: 528
Production: 17,000 tons/day
At approximately 1:00 p.m. on Thursday, April 5, 2007, a 50-year old continuous miner operator, with 27 years of mining experience, was injured in the 7B-8B cut-through entry. The accident occurred as he was walking behind the center roof-bolting machine to check for slack cable needed to allow the machine to move forward. The victim slipped on the mine floor which caused him to twist his left ankle and fall to the floor. The initial injury was first believed to be a sprained left ankle but was later determined to be a simple fractured left fibula.

The victim was given first aid at the mine and transported to Canonsburg Hospital and treated. On April 11, 2007 a cast was put on the ankle. The victim died on April 28, 2007. The coroner concluded that the victim died as a result of pulmonary thromboembolus, due to deep vein thrombosis of the left leg due to blunt force trauma of the leg sustained as he fell at work on April 5, 2007.
Root Cause Analysis

Root Cause: Historically, the mine floor can be wet which results in slippery walking conditions. This particular entry was wet and slippery with firm bottom conditions. Sloughage of the roof and ribs was normal in the area.

Corrective Action: Mine management developed a program to conduct thorough visual examinations of work areas prior to performing any work and thereafter as conditions change. Also, obstructions that may cause slipping and tripping hazards will be removed. Management instructed miners to be aware of footing and surrounding areas while walking.
ENFORCEMENT ACTIONS

No enforcement action taken
Best Practices

• Conduct thorough visual examinations of work area prior to performing any work in the area and thereafter as conditions warrant.
• Remove obstructions and items from the work area that may cause possible slipping and tripping hazards.
• Be aware of footing and surrounding areas while working.