West Virginia Office of Miners’ Health, Safety & Training

January 4, 2016

Report of Investigation
Underground Coal Mine Fatality
(Machinery Accident)

Greenbrier Minerals, LLC
Lower War Eagle Mine
Permit Number U-4002-99B

Region 2
891 Stewart Street
Welch, West Virginia 24801
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Remote Discharge "A" Frame
With Hold Down Roller

Hold Down
Roller

"A" Frame &
Crossbars

Belt Frame 7' wide X 12' long
Ground to Top of frame - 10'
Ground to Roof - 15'
Ground to Bottom of Belt - 10'3"
General Information

The Greenbrier Minerals, LLC Lower War Eagle Mine is located along Route 10 in the Oceana District in Wyoming County, West Virginia about a mile from the community of Cyclone. This mine has a single entry 900 foot slope leading into the Lower War Eagle Seam. The average seam height is around 42” inches. This mine has four continuous miner sections with three on advance and one on retreat. This mine employs 193 persons working three shifts with coal production on the day and evening shifts while the midnight shift is down for maintenance and idle work such as belt moves, power moves and the preparation for running coal. At present there are sixteen belts that includes the surface stacker belt.

A fatal machinery accident occurred shortly after midnight on Monday, January 4, 2016 at the Greenbrier Minerals, LLC Lower War Eagle Mine.

The accident occurred near the No. 1 belt drive when Mr. Peter Sprouse, the midnight shift belt foreman, was caught between the belt and a six inch hold down roller located between the No. 1 drive and the junction head roller. Mr. Sprouse was alone and had arrived at this location at approximately 12:00 a.m. The No. 1 belt was running at the time of his arrival and continued to run until approximately 12:09 a.m. The victim was discovered by Mr. Dave Johnson and Mr. Nick Browning.

Mr. Sprouse was transported to the surface and was placed in the awaiting STAT EMS #2 ambulance. The county coroner, Scott Daniels, arrived at 3:08 a.m. and made his assessment of the victim. Mr. Sprouse was transported to the Stafford Funeral Home around 3:40 a.m.

The West Virginia Division of Homeland Security and Emergency Management (WVDHSEM) was notified on January 4, 2016 at 1:08 a.m. by Mr. Dallas Parsons, the mine tracking and communications dispatcher. John O’Brien, the Region 2 Inspector-at-Large of the Office of Miners’ Health, Safety and Training (OMHST), was notified by the WVDHSEM at 1:18 a.m. Mr. O’Brien immediately dispatched Doug Depta, OMHST Assistant Inspector-at-Large and Steve Stanley, OMHST Electrical Inspector, to the mine. Michael Green, OMHST District Inspector, was notified of the accident and traveled to the mine to assist in the investigation.
Description

Mr. Peter Sprouse arrived at the mine and began his shift at 8:00 p.m. on Sunday, January 3, 2016. Initially, Mr. Sprouse and Mr. Nick Browning were assigned to preshift the belts. Mr. Browning would fireboss the upper belts and Mr. Sprouse would fireboss the lower belts. After completing his fireboss examinations, Mr. Sprouse came outside and recorded his findings in the appropriate preshift books. Mr. Browning was close to the location of his next job assignment (changing the 2C belt tail skirts); therefore, Mr. Browning called out his preshift reports to Mr. Sprouse. Mr. Sprouse instructed Mr. David Johnson to ride inside the mine with the midnight shift crew and meet with Mr. Browning to assist in changing the 2C belt tail skirts. Upon completion of that job, Mr. Browning and Mr. Johnson were instructed by Mr. Sprouse to bring their tools to the No. 1 drive area and help him change out a six inch hold down roller. Shortly afterwards, Mr. Sprouse went underground and the tracking system shows he arrived at the No. 1 belt drive at approximately 12:00 a.m.

Shortly before 1:00 a.m. Mr. Johnson and Mr. Browning arrived at the No. 1 belt drive area to assist Mr. Sprouse in changing out the six inch hold down roller and started unloading the tools needed to change the roller. Mr. Browning walked over to the hold down roller and discovered Mr. Sprouse positioned between the hold down roller and the bottom of the bottom belt and called to Mr. Johnson for help. Mr. Browning is an EMT, but his certification has lapsed. Mr. Browning assessed Mr. Sprouse’s condition including a check for a carotid pulse but could not find one. Mr. Browning then went to the mine phone and called outside notifying Mr. Dallas Parsons, the mine tracking and communications dispatcher, to get an ambulance and to notify Mr. Jason Acord, the midnight shift foreman, of the accident. Mr. Johnson removed electrical power then tagged and locked out the No. 1 drive. Mr. Acord was notified of the accident and was the next to arrive at the accident site. Mr. Johnson and Mr. Browning went back to the belt and started installing a 3 ton chain ratchet in preparation to free Mr. Sprouse from the belt. After examining the accident site, Mr. Acord used the mine phone to call Mr. Parsons, instructing him to notify the state and federal agencies, place HealthNet on standby, and call all sections and have them cease work and standby at the section power centers for further instructions. He also had Mr. Parsons notify company safety personnel and the general mine foreman, Mr. Jamey New. During this time other personnel
arrived to assist in freeing Mr. Sprouse from the belt. This was achieved by a combination of lifting the belt with a slate bar and releasing tension on the belt by slowly letting off the pressure of the belt take-up. Once he was freed, Mr. Sprouse was placed on a backboard and carried to a Mack 10 rubber tired ride, then transported to the surface and placed in an ambulance until the county coroner could arrive. The coroner examined Mr. Sprouse and determined he did not need to be transported to the hospital. Mr. Sprouse was transported to the Stafford Funeral Home in Oceana.

The tracking system records indicate that Mr. Sprouse entered the No. 1 belt head area at 12:00 a.m. The system monitoring the belts indicates that the No. 1 belt started at 10:34 p.m. and ran continuously until the belt maintenance crews finished their assigned work and requested Mr. Parsons shut off the belts at 12:09 a.m. Accordingly, Mr. Sprouse’s accident occurred sometime between 12:00 a.m. and 12:09 a.m. on January 4, 2016.

It is not entirely clear what exact task Mr. Sprouse was doing at the time of the accident; but, based upon conditions observed in the area, it appears he was preparing for the removal of the hold down roller. Conditions observed during the investigation indicate Mr. Sprouse was working in close proximity to the No. 1 belt which, according to the belt monitoring systems, was running at the time of the accident. The nuts on the two bottom bolts securing the six inch hold down roller’s clearance side pillar block bearing were discovered to be loose and it is presumed that Mr. Sprouse loosened these nuts in preparation for removal of the hold down roller. Additionally, no ladder was found at the accident site although the hold down roller is located approximately ten feet off the mine floor.

**Conclusion**

On January 4, 2016, Mr. Peter Sprouse, the midnight shift belt foreman, received fatal injuries when he was caught between a six inch hold down roller and the bottom of the bottom belt located at the No. 1 belt discharge area.
Findings of Fact

1. A post-accident inspection of the No. 1 belt drive controls showed all on-off, sequence, slip, start-up alarm, etc. control circuits were properly operating.
2. Tag out and lock out procedures were not followed to prevent the belt from moving while repairs were being performed.
3. At no time prior to Mr. Sprouse undertaking the repair to change out the six inch hold down roller was there a request to shut off the No. 1 belt.
4. Mr. Parsons, the dispatcher, stated that Mr. Sprouse used his hand held radio to notify him that he was entering the mine.
5. The nuts on the two bottom bolts securing the six inch hold down roller’s clearance side pillar block bearing had been loosened. A ratchet with a socket matching the two loosened nuts was found on Mr. Sprouse’s mantrip.
6. On/off switches were located at the No. 1 belt head area. These switches interrupted the flow of electrical power to the No. 1 belt. The belt power center and the belt starter box servicing this belt were both located within a 50’ foot proximity of the accident site.

Enforcement Action

The following actions were taken as a result of the investigation.

A non-assessed control order was issued in accordance with Chapter 22A, Article 2, Section 68 of the West Virginia Code to preserve the accident scene after the recovery of the victim and until the investigation of the accident site by OMHST personnel had been completed.

The West Virginia Office of Miners’ Health, Safety and Training issued one Special Assessed Notice of Violation under 22A-2-43a(c)(1) to Greenbrier Minerals, LLC during this investigation.
Recommendations

In accordance with Title 56, Series 8, Section 9.4 of the West Virginia Mining Laws, the comprehensive mine safety program for the Lower War Eagle Mine is to be modified to include beltline safety precautions and guidelines being submitted by the operator to prevent a reoccurrence. In addition, everyone at the mine is to be instructed on the modifications before normal work activities resume.

Acknowledgements

The West Virginia Office of Miners’ Health, Safety and Training gratefully acknowledges the cooperation of the employees of the Greenbrier Minerals, LLC, Lower War Eagle Mine and the Mine Safety and Health Administration.
MINE INFORMATION

COMPANY _Greenbrier Minerals, LLC_____________________________.
MINE NAME _Lower War Eagle, Mine_______________________________.
WV PERMIT # _U00400299B_________ MSHA MINE ID #. 46-09319_________.
ADDRESS _P.O. Box 446 Man, WV 25635_______________________________.
COUNTY _Wyoming________________________ PHONE NUMBER 304-583-5721_____________.
DATE PERMIT ISSUED _1-2-2015_______________________________________.
WORKING STATUS _Active___________________________________________.
MINE LOCATION _Route 10 Tony Fork Road, Cyclone_______________________.
UNION ______________________ NON-UNION___ x _______________________.
ANNUAL PRODUCTION _729,326 Tons_____________________________________.
TOTAL EMPLOYEES _193_________ NUMBER OF SHIFTS _3_______.
COAL SEAM NAME AND AVERAGE THICKNESS _Lower War Eagle 42”_____________________.
ACCIDENT RATE _3.24_________ LOST TIME ACCIDENTS _6___________.
TYPE OF HAULAGE _BELT_______________________________________________.
WVOMHS&T REGIONAL INSPECTOR _Michael Green_______________________.
DATE OF LAST INSPECTION _12-30-2015_______________________________.
WVDHSEM NOTIFIED BY _Dallas Parsons_______________________________.
NOTIFICATION TIME _1-4-2016 1:08a.m.___________________________________.
CMSP ANNIVERSARY DATE _12-29-2016_______________________________.
CMSP CONTACT PERSON _Aaron Price__ Manager of Safety_____________________.

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