

**West Virginia Office of Miners' Health Safety and  
Training**

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**November 30, 2012**

**Report of Investigation  
Underground Coal Mine Fatality  
(CRUSHING)**

**White Buck Coal Company  
Pocahontas Mine  
Permit Number U00300705A**

**Region IV Office  
550 Industrial Drive  
Oak Hill, West Virginia 25901  
McKennis Browning, Inspector-at Large**

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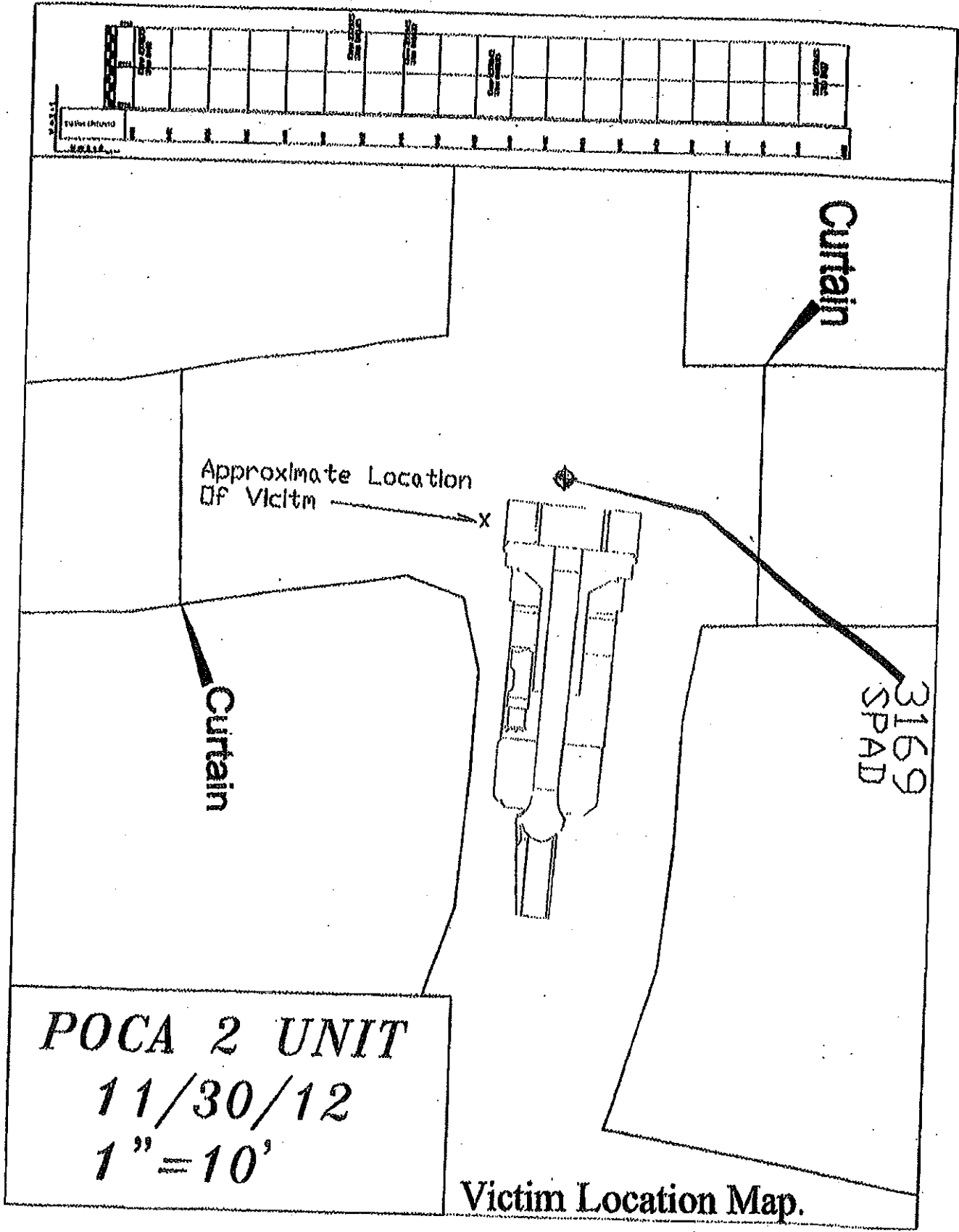
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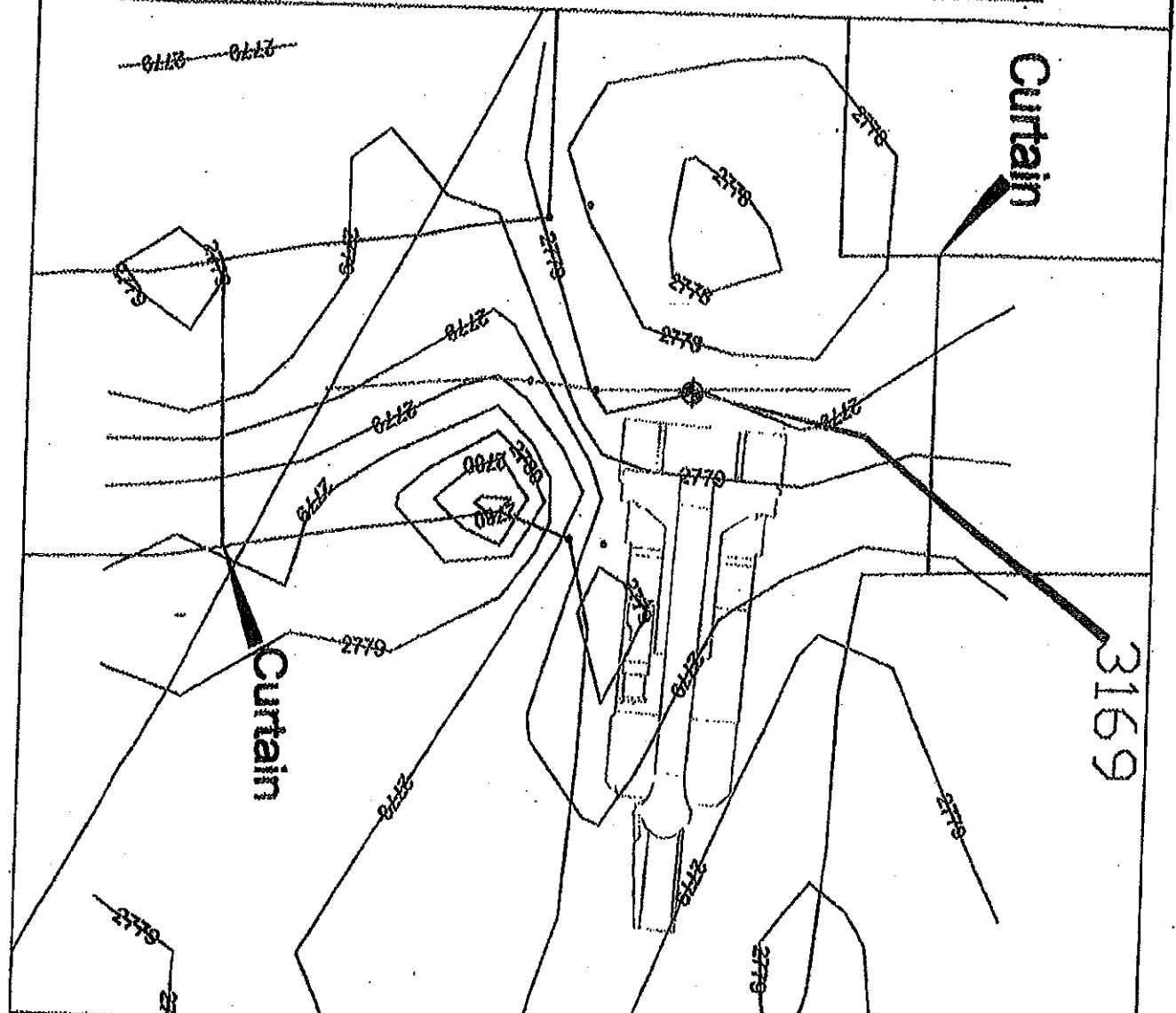
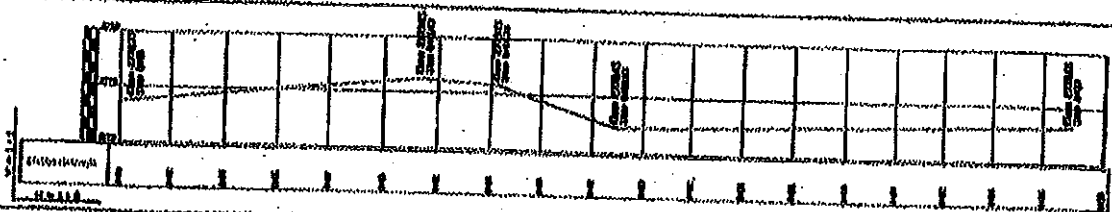
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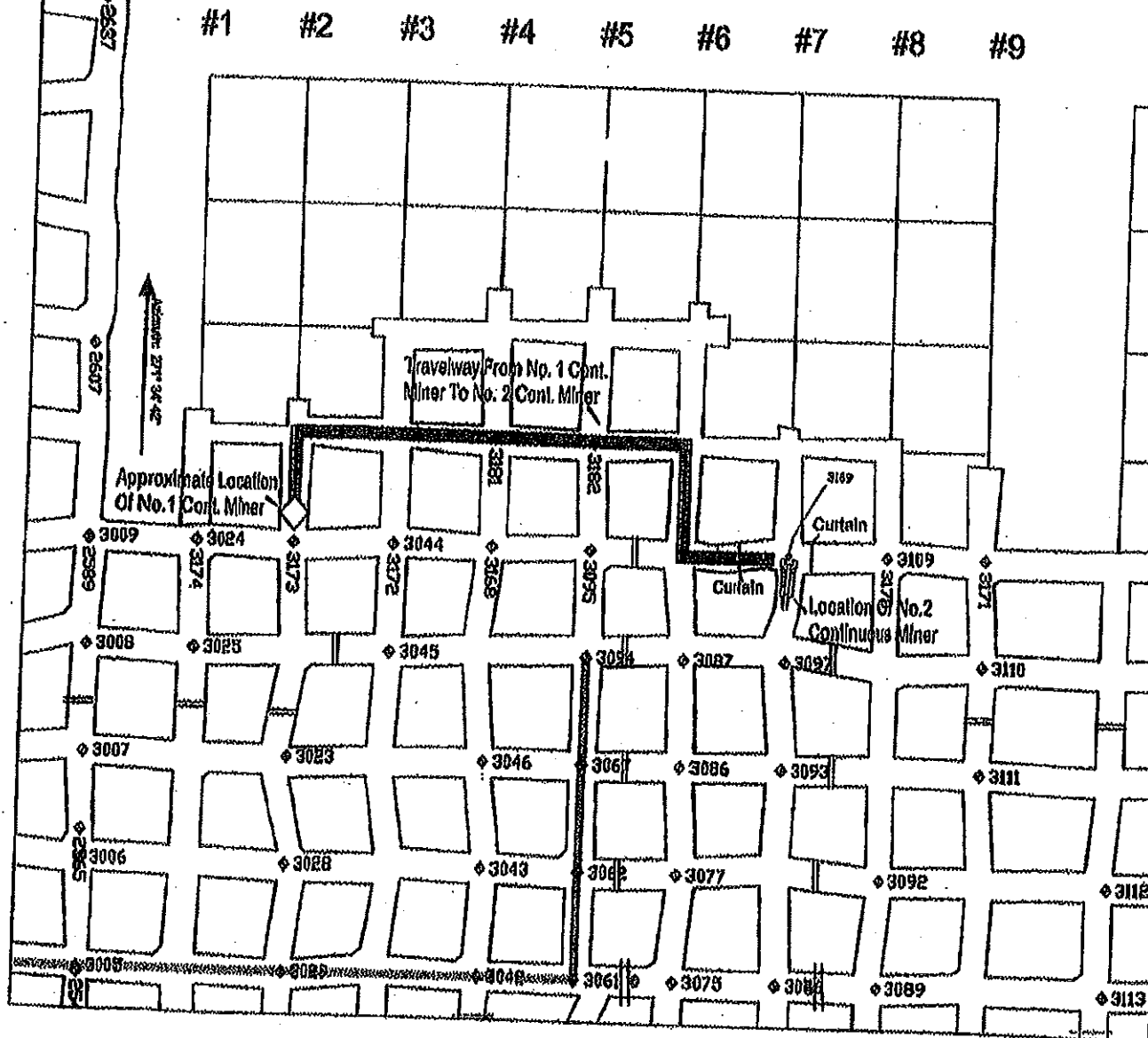
**POCA 2 UNIT**  
**11/30/12**  
**1" = 10'**

**Floor Elevations & Contours**

# White Buck Coal Company Pocahontas Mine U-3007-05A

Travel Route Of Maintenance Scoop  
T3994921025  
From No.1 Continuous Miner  
To No. 2 Continuous Miner

Scale: 1" = 100'



**Report of Investigation  
Underground Coal Mine Fatality  
White Buck Coal Company  
Pocahontas Mine, Permit Number U00300705A**

**GENERAL INFORMATION**

This report is based on an investigation conducted in accordance with Chapter 22A, Article 1, Section 14 of the Code of the State of West Virginia.

Steven A. O'Dell, an employee of White Buck Coal Company, was fatally injured in an accident at approximately 1:20 A.M. on November 30, 2012. Mr. O'Dell was working as the section electrician on the No. 2 working section when he was crushed between the left side of the No. 2 continuous mining machine cutting head drum and the battery end of the maintenance scoop (Serial # T3394921025).

Quinwood Ambulance Service was notified of the accident at 1:46 A.M. on November 30, 2012 by Hank Utberg, midnight shift Dispatcher of White Buck Coal Company's Pocahontas Mine. McKennis Browning, Region 4, Inspector-at-Large of the West Virginia Office of Miners' Health, Safety and Training was notified of the accident by the WV Emergency Operations Center at 2:05 A.M. A joint investigation with the Mine Safety and Health Administration (MSHA) was started immediately.

**DESCRIPTION**

The White Buck Coal Company, Pocahontas Mine is located on Anjean Road near Rupert, West Virginia in Greenbrier County. The underground mine has two working sections mining in the Pocahontas No. 6 Coal Seam. This coal seam is approximately 44 inches thick with average overall mined height of approximately 6 to 6 ½ feet. This mine has 95 employees and operates 5 days per week and every other Saturday. Normally, the day and evening shifts are production shifts with the midnight shift conducting maintenance activities and performing section belt and power moves.

On November 29, 2012, a safety meeting was conducted with the midnight shift just prior to the two crews traveling into the mine at approximately 10:30 P.M. Eight employees traveled by rail to the No. 2 working section arriving at approximately 11:15 P.M. Typical routine maintenance and section work were being performed. Steven O'Dell and Aaron Childers began performing routine maintenance work on the No. 1 continuous miner in the No. 2 entry at approximately 11:40 P.M.

At approximately 12:10 A.M. Steven O'Dell departed the No. 2 entry, where he had been performing work on the No. 1 continuous miner with Aaron Childers. At this time, Steven O'Dell traveled across the No. 2 section to the No. 7 entry where the No. 2 continuous miner was located, and began to perform work in preparation for removing the cutter head drums on the next scheduled maintenance shift. At approximately 12:45 P.M. Steven O'Dell returned to the No. 2 entry where Aaron Childers was continuing to work on the No. 1 continuous miner. His purpose was to retrieve a drill bit from the model 35-C Fairchild Scoop, Serial # T339-492-1025, located near the No. 1 continuous miner.

At approximately 1:17 AM, both Aaron Childers and Steven O'Dell left No. 2 entry to travel to No. 7 entry to complete the work on the No. 2 continuous miner. Steven O'Dell walked to No. 7 entry while Aaron Childers operating the maintenance scoop followed Steven O'Dell across the section. They traveled via the last open line of crosscuts (see drawing page number 5) to the

No. 6 entry. They turned outby in No. 6 entry and traveled for one break, again turning and traveling through the No. 6 to No. 7 crosscut. The No. 6 entry from the last line of crosscuts outby for one break is a slight incline and the bottom conditions are moist to wet.

The maintenance scoop traveling batteries end first, turned from the No. 6 entry into the No. 6 to No. 7 crosscut and momentarily lost traction due to the combination of grade and moist to wet bottom conditions. Aaron Childers saw Steven O'Dell travel around the corner from No. 6 entry into the No. 6 to No. 7 crosscut towards the No. 2 continuous miner. As the maintenance scoop gained traction, Aaron Childers continued around the corner from No. 6 entry into the No. 6 to No. 7 crosscut at approximately 1:19 A.M. and preceded through the fly pads. After the operators compartment of the maintenance scoop had completely cleared the fly pads, Aaron Childers felt the scoop hit the No. 2 continuous miner (he stated he did not see it). Aaron moved the maintenance scoop away from the No. 2 continuous miner got out of the scoop and went to the continuous miner and observed Steven O'Dell lying on the mine floor between the battery end of the maintenance scoop and the left side drum of the No. 2 continuous miner. Aaron immediately went for help. He found Harold Fain and Shawn Hamrick (EMT'S) near the section power center.

Harold Fain went to the No. 7 entry and found Steven O'Dell lying on his left side on the mine floor between the left outside end of the No. 2 continuous miner drum and the battery end of the maintenance scoop.

Shawn Hamrick called outside from the section telephone located at the power center and requested an ambulance at approximately 1:24 A.M. He then traveled to the accident scene in No. 7 entry and called Frank McMillion (EMT), Shift Foreman, who had arrived on the section just prior to the accident, and Robbie Amick (EMT) on his hand held radio. As they arrived at the accident scene at approximately 1:30 A.M., Robbie Amick and Shawn Hamrick began a patient assessment of Steven O'Dell while the remaining crew members retrieved first aid equipment.

Steven O'Dell was placed on the backboard, given oxygen, treated for shock, and transported to the end of the track. He was then placed on a track mounted personnel carrier for transport to the surface. Frank McMillion, Robie Amick, Harold Fain, Aaron Childers and Shawn Hamrick transported Steven O'Dell arriving on the surface at approximately 2:15 A.M.

Steven O'Dell was immediately transferred to an awaiting ambulance for transport to Greenbrier Regional Medical Center. After a patient assessment by the ambulance crew, permission was requested to cease efforts to revive the victim. Steven O'Dell was pronounced dead while en-route per Dr. Sitler at 2:29 A.M. He was transported to Greenbrier Valley Medical Center.

### FINDINGS OF FACT

1. Steven A. O'Dell was working as the electrician on the No. 2 working section. This was his normally assigned job. He had been on this job for approximately 1 year 4 months.
2. The seam thickness at this mine is approximately 44 inches. The overall height in the area of the accident was approximately 5.5 feet – 7 feet. (The bottom in No. 7 entry had been graded)
3. The bottom conditions in No. 7 entry and No. 6 right break were damp to wet.
4. The check curtains hung in No. 6 right break was 26 feet from the left edge of the continuous miner drum.
5. The scoop operator deck was through the curtain when the back of the maintenance scoop (Serial # T3394921025) contacted the miner head.
6. Approximately 8' of distance existed between the left side of the No. 2 continuous miner drum and the battery end of the maintenance scoop once the maintenance scoop canopy has cleared the fly in No. 6 right break.
7. The scoop was modified by permanently mounting the welder and breaker box on the off side of the operators' compartment which limited the visibility of the operator.
8. There was extraneous material on the scoop that limited the visibility of the operator.
9. Available equipment and maintenance records did not indicate that any problems existed with the maintenance scoop (Serial # T3394921025) or the No. 2 continuous miner.
10. An inspection of the maintenance scoop revealed no defects other than the visibility issue that would affect safe operation.
11. An inspection of the No. 2 continuous miner showed no defects that would affect safe operation.

### CONCLUSION

While the victim was performing assigned maintenance work on the No. 2 continuous mining machine in the No. 2 working section, he was crushed between the left side of the No. 2 continuous miners' cutter head drum and the battery end of the maintenance scoop.

### ENFORCEMENT ACTION

A non-assessed control order was issued in accordance with Chapter 22A, Article 2, Section 68 of the West Virginia Mining Laws in order to preserve the scene of the accident and complete an investigation. The WV Office of Miners' Health Safety and Training issued 7 violations, 1 order, and 1 special assessment violation during this investigation. The following enforcement actions were issued to White Buck Coal Company, Pocahontas Mine.

Imminent Danger Order: Title 36, Series 34, Section 3.3: The Fairchild Scoop serial #T336-196 being used on the #1 section has been modified in a manner which limits the visibility of the operator and poses a hazard to persons in the vicinity of the scoop. The modifications consist of a welder (bonder) and breaker box for the welder and tool boxes permanently mounted to the top of the scoop. This is written as an imminent danger order under 22A-2-15(a) of the West Virginia Code.



Notice of Special Assessment: Title 36, Series 34, Section 3.3: The Model 35-C Fairchild Scoop Serial # T339-492-1025 used on the #2 section as a maintenance scoop has been modified to a degree that limits the visibility of the operator. This poses a hazard to persons in the vicinity of the scoop. The modifications consist of a welder (bonder) and a breaker box for the welder. The welder and breaker box have been permanently mounted on the off side of the operators' compartment near the batteries. In addition to the modifications, there was extraneous material on the scoop that contributed to the limited visibility. Under 22A-1-21(b)(2)(a). This is a violation of a health or safety rule, is of a serious nature, and involves a fatality. This machine was involved in a fatal accident on 11-30-2012.

### **RECOMMENDATIONS**

In accordance with Title 56, Series 8, Section 9.4 of the West Virginia State Mining Laws, the comprehensive mine safety program for the White Buck Coal Company, Pocahontas Mine shall be modified to include the following:

1. A physical barrier will be installed near the center of the entry, in each opening, prior to maintenance being performed on mobile equipment. The physical barrier is not required inby the last open crosscut while changing bits or water sprays on the continuous mining machine. Areas located outby the last open crosscut or in areas where equipment may be used, such as an intersection, require the use of a conspicuous physical barrier or warning device to be installed.
2. The physical barrier may consist of such items as, and is not limited to 8' wide fencing such as snow fencing or equivalent or high visibility reflective tubing hung from the mine roof to within a foot of the mine floor along with a strobe light at all approaches.
3. The physical barrier shall signify that maintenance is being performed and entry into the designated area is prohibited.
4. Should it become necessary for mobile equipment to enter the designated area, all employees in the designated area and the equipment operator shall communicate with one another and position themselves in a safe location to coordinate movement of the equipment into the designated area. The physical barrier will be removed and once the equipment is moved into the designated area it will be de-energized and the physical barrier reinstalled. The same procedures will be followed when equipment is removed from designated area.
5. A strobe light is required to be worn by all miners while traveling inby the section loading point. The strobe light shall be worn in such a manner to ensure the strobe can be observed while the miner is faced from the rear. Face equipment operators will not be required to wear the strobe lights during the operation of equipment; with the exception of the continuous miner operators.
6. An audible device such as a horn or bell will be sounded before mobile equipment passes through a check curtain.
7. All employees will be trained on haulage safety and the addendum to the safety plan. A record of this plan will be documented on a 5000-23 form.

**ACKNOWLEDGEMENT**

The West Virginia Office of Miners' Health Safety and Training gratefully acknowledges the cooperation of the employees and management of White Buck Coal Company and the Mine Safety and Health Administration during this investigation.

**APPENDIX**

- Mine Information Sheet
- Victim Information Sheet

MINE INFORMATION

COMPANY White Buck Coal Company

MINE NAME Pocahontas Mine

WV PERMIT U00300705A

ADDRESS PO Box 180, Leivasy, WV 26676

COUNTY Greenbrier

DATE PERMIT ISSUED November 25, 2008

LOCATION Anjean Road, near Rupert, WV

UNION \_\_\_\_\_ NON-UNION Yes

DAILY PRODUCTION 5800

TOTAL EMPLOYEES 95 NUMBER OF SHIFTS 3

NAME OF COAL BED Pocahontas #6

SEAM THICKNESS 44 inches

ACCIDENT INCIDENT RATE 0.00 LOST TIME ACCIDENTS 0

TYPE OF HAULAGE Shuttle Car / Belt

WV OMHST INSPECTOR Sam Bell

DATE OF LAST INSPECTION November 16, 2012

NOTIFIED BY WVDHSEM

CMSP – ANNIVERSARY DATE January 20 2013

CMSP – CONTACT PERSON Randy Taylor