*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

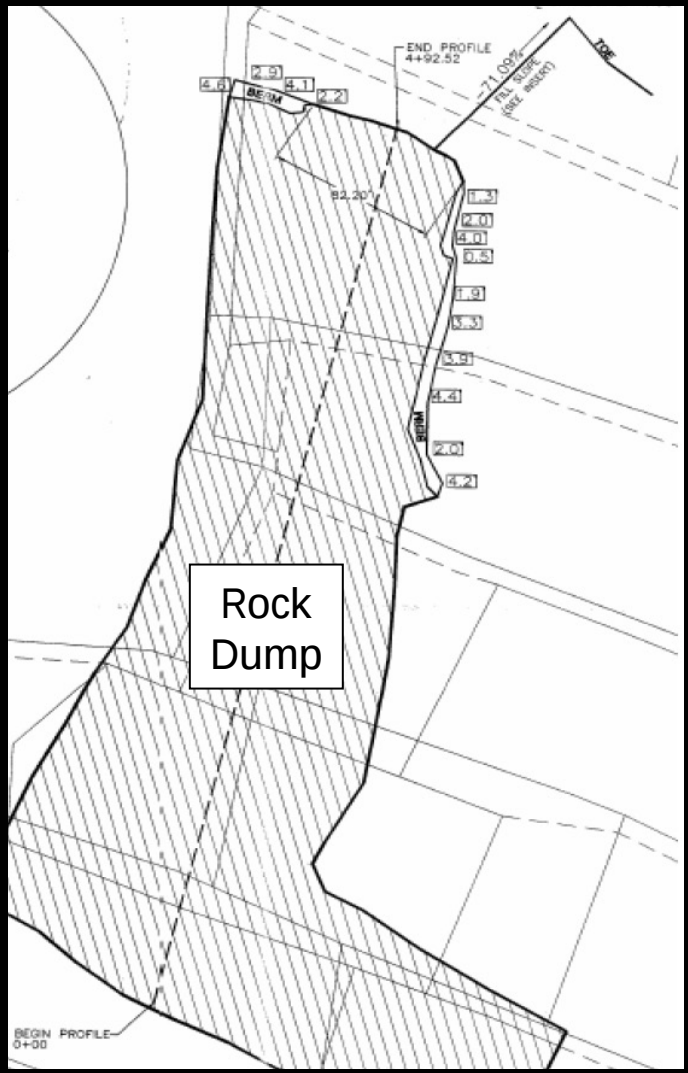
Coal Mine Fatal Accident 2003-19

Operator:	Uptown Motors, Inc.
Mine:	Guthrie Creek Mine
Accident Date:	June 26, 2003
Classification:	Powered Haulage
Location:	District 11, Parrish, AL
Mine Type:	Surface
Employment:	35
Production	900 tons/day

ACCIDENT DESCRIPTION

- On Thursday, June 26, 2003, a rock truck operator (victim) started his shift at approximately 6:00 a.m. in the mine equipment parking lot.
- He started his 2002 Caterpillar model 777D rock truck and traveled to the pit area where he got in line and waited to be loaded.
- The Caterpillar 992 front-end loader operator contacted the rock truck operator on the radio. Following a brief conversation, the victim‘s truck was loaded with spoil by the 992 front-end loader. No further radio contact was made with the victim prior to the accident.
- The victim proceeded out of the pit and traveled up the haulage road, which follows a gradual incline, crossed the East Haul Road, and turned north toward the pit dumping location.

ACCIDENT DESCRIPTION



- The round trip distance from the pit to the dumping location was approximately 3/8 of a mile.
- The victim made an undetermined number of trips to the dumping point location.
- The road conditions were dry and the weather was clear.
- The dumping location approach measured ~112’ in width, 492’ in length, and a had an uphill grade of 2%.

ACCIDENT DESCRIPTION

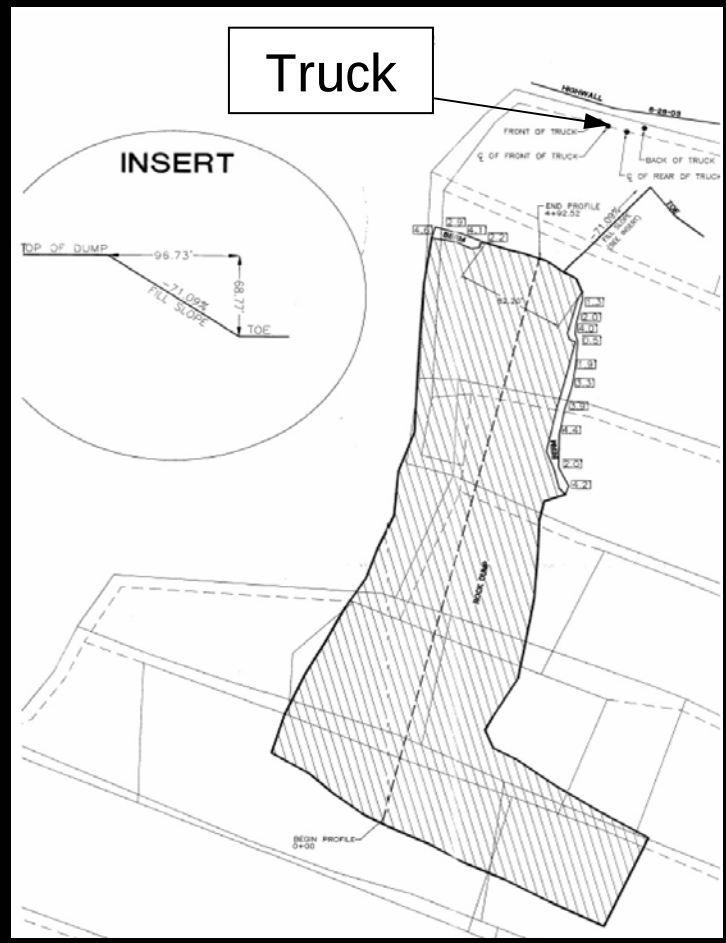
- While in the process of backing the loaded rock truck towards the edge of the dumping point, the truck overtraveled, went down the spoil embankment, struck the highwall at the bottom of the spoil, and overturned.
- Between 7:05 a.m. and 7:10 a.m. a second truck driver saw the victim‘s truck wrecked at the bottom of the spoil pile and called for help on his CB radio and informed the rest of the crew of the accident.

ACCIDENT DESCRIPTION

- A third truck driver climbed down the spoil pile to the truck and called to the victim, but got no response.
- The crew began to build an access road to the truck. When the road reached the truck, paramedics were on the scene.
- A paramedic and drill operator found the victim inside the cab of the truck. The paramedic checked the victim's pulse and found none.
- Paramedics cut the seat belt that the victim was wearing to facilitate his removal from the truck.
- The County Coroner arrived on the scene and pronounced the victim dead at 8:15 a.m. An autopsy was not performed.

ACCIDENT SCENE

- The section of the pit were the accident occurred was being filled in by spoil material. A total of 5 rock trucks were dumping at this location on the morning of the accident.
- The victim hauled an unknown number of loads of spoil on the morning of the accident. The load trip counter on his truck had not been reset prior to the start of his shift. The other trucks that were dumping at this location that morning had trip load counts that indicated 5-7 loads had been dumped up to the time when the accident was discovered.
- The truck traveled backwards down a 71% grade for ~119'. The truck's parking brake system was not applied and the transmission was in the reverse gear position.



ACCIDENT SCENE

- There was no berm provided at the edge of the 001 Pit Dumping point for 82’.
- The daily on-shift examination record showed no hazardous conditions recorded for the 001 Pit Dumping location.
- 30 CFR 77.1713(a) requires the operator to correct hazardous conditions, such as the lack of berms at active dumping locations, identified during such examinations.

ACCIDENT SCENE

- There was no indication of ground failure at the edge of the dumping point that would have destroyed evidence of any berm that may have existed prior to the accident.

TRAINING

- The victim had 20 years of experience as a truck driver, with 2½ years of experience driving for the Guthrie Creek Mine.
- The victim had not received the required Part 48 experienced miner training when he was first employed at the mine.
- However, he had received annual refresher training since that time, which included instruction on recognition of hazards. Therefore, the lack of experienced miner training was not a contributing factor to the accident.

TRUCK INFORMATION

- The 2002 Caterpillar (CAT) Model 777D, rigid body, rear dump haul truck had a GVW was 355,000 lbs. The maximum payload capacity was 200,000 lbs.
- The truck was reportedly fully loaded immediately before the accident. No material remained in the truck's bed after the accident.
- It was reported that the backup alarm and backup lights were operating when the wrecked truck was first discovered, indicating that the transmission was in reverse at the time of the accident. This was confirmed by inspecting the transmission's internal rotary selector spool, which was found to be in the reverse position.
- No defects were found with the machine that would have affected the operator's ability to control the machine.
- Some additional functional tests of the service brakes, secondary brakes, park brake, retarder, and reverse neutralizer have been requested.
- Pre-operational checklists were not completed at this mine. The truck operator on the work shift prior to the accident stated that the retarder lever appeared to be rotated too far in one direction but that the retarder worked properly.

ROOT CAUSE ANALYSIS

Causal Factor: A berm was not provided at the edge of the 001 Pit dumping point to prevent overtravel or overturning.

Corrective Actions: Dumping location practices and procedures should be reviewed to ensure that the dumping process does not create hazards to persons that are required to work in those areas.

ROOT CAUSE ANALYSIS

Causal Factor: The failure to identify and correct conditions that posed a hazard to personnel in the active work area.

Corrective Actions: Dumping location practices and procedures should be reviewed to ensure that the dumping process does not create hazards to persons that are required to work in those areas. Workplace examinations should be conducted frequently for changes affecting safe operation and prompt correction of hazards when observed. Examiners should be adequately trained to detect hazards.

CONCLUSION

The rock truck operator received fatal injuries as a result of a surface haulage accident at the Guthrie Creek Mine. The accident occurred because berms, bumper blocks, safety hooks, or similar means to prevent overtravel and overturning were not provided at the 001 Pit dumping point location. Contributing to the accident was failure to identify and correct this condition during examinations of the work area. No defects that would affect the operation of the truck were found during the investigation.

ENFORCEMENT ACTIONS

104(d)(1) Citation for a violation of 30 CFR 77.1605(l)

Berms, bumper blocks, safety hooks, or similar means were not provided to prevent overtravel and overturning at the 001 Pit dumping location of the Guthrie Creek Mine. A fatal surface haulage accident occurred on June 26, 2003 when a Caterpillar Model 777D rock truck driven by Bobby Rawls backed towards the edge of the dump and overtraveled. The truck traveled down the spoil embankment, struck the highwall at the base of the spoil, and overturned. The area where the victim, along with 4 other trucks, was dumping had no berm provided for a distance of 82 feet. The spoil embankment had a slope of approximately 71 degrees. This mine was cited for non-compliance of 30 CFR 77.1605(l) during the current AAA inspection. Citation No. 7671227 was issued citing 4 dumping locations other than the 001 Pit dumping location (accident scene) where berms, bumper blocks, safety hooks, or similar means were not provided to prevent overtravel and overturning. The condition at the cited locations was extensive and obvious to the most common observer.

ENFORCEMENT ACTIONS

104(d)(1) Order for a violation of 30 CFR 77.1713(a)

The operator failed to conduct an adequate on-shift daily examination to detect hazardous conditions at the active 001 Pit dumping location work area on June 26, 2003. A hazardous condition existed in that the edge of this dump was not provided with berms, bumper blocks, safety hooks, or similar means to prevent overtravel and overturning at the dumping location. A fatal surface haulage accident occurred on June 26, 2003, when a Caterpillar Model 777D rock truck driven by Bobby Rawls backed towards the edge of the 001 Pit dumping location and overtraveled. The truck traveled down the spoil embankment, struck the highwall at the base of the spoil, and overturned. The area where the victim, along with 4 other trucks, was dumping had no berm provided for a distance of 82 feet.

This mine was cited for non-compliance of 30 CFR 77.1605(l) and 77.1605(k) during the current AAA inspection. The person responsible for making the daily on-shift examination of the active work areas is a certified mine foreman.

BEST PRACTICES

- Provide and maintain adequate berms or bumper blocks at all dumping locations.
- Examine dumping locations for hazards prior to commencing work.
- Utilize a bulldozer with the "dump-short, push-over" method of spoiling material.
- If dumping over a berm, back perpendicularly or at a slight angle, so that the driver side wheels contact the berm first.
- Slope the dump area so that trucks must back up a slight grade.
- Ensure that drivers are trained to recognize and avoid dumping hazards.