

## FINDINGS OF FACT

1. The Aracoma Coal Company's Alma No. 1 Mine is ventilated by three main fans, one blowing and two exhaust.
2. On January 19, 2006 one hundred fifty-seven (157) persons reported for work at the Alma No. 1 Mine, one hundred twenty-five (125) employees and thirty-two (32) contractor employees.
3. This mine utilizes one longwall mining section and two continuous miner sections for coal production.
4. Mine transportation recently switched from a battery operated track system to rubber-tired diesel equipment.
5. CSE SR-100 self-rescuer devices are utilized at this mine.
6. The No. 9 headgate longwall section was utilizing the tailgate blockage plan on January 19, 2006 as a result of a roof fall.
7. The No. 3 continuous miner section was idle on the evening shift on January 19, 2006.
8. An accurate map of the mine was not provided on January 19, 2006.
9. The fire hose outlets provided at the mother drive storage unit area for the No. 9 longwall belt could not be utilized because the shut-off valve for the water supply for the fire hose outlets was found in the closed position.
10. The water sprinkler fire suppression system installed on the No. 9 headgate longwall belt conveyor drive area could not activate in the event of a fire or a rise in temperature because the water supply valve was found in the closed position.
11. The air direction on the longwall belt was not traveling in the proper direction in that air was traveling outby toward the discharge instead of inby toward the longwall working sections.
12. The No. 2 section was utilizing air that ventilated the No. 2 section 48-inch belt conveyor as a supplement to face ventilation. No device was provided on the section to alert persons of rising carbon monoxide levels.
13. The No. 9 headgate mother belt storage unit was not properly maintained thus allowing the belt to run out of alignment.
14. Ventilation controls were missing, allowing smoke to enter the primary intake escape-way for the No. 2 section.
15. Nine subpoenas were issued during this investigation.
16. Eighty-three (83) interviews were conducted.

## CONCLUSION

Mr. Don Israel Bragg, age 33, and Mr. Ellery Elvis Hatfield, age 46, were fatally injured when they became separated from their crew after encountering thick black smoke in their primary intake escapeway while attempting to evacuate from the No. 2 section during a conveyor belt fire at the No. 9 headgate mother drive. Both expired as a result of asphyxiation due to or as a consequence of an underground mine fire with suffocation and carbon monoxide intoxication.

## ENFORCEMENT ACTION

During the course of this extended investigation, several inspections were conducted. A total of one hundred and sixty-eight (168) notices of violations were issued. Seven (7) of the violations were determined to have contributed to the occurrence of this accident. Sixteen (16) individual personal assessments were also issued. Seven (7) recommendations for withdrawal or suspension of certifications were issued.

The Office of Miners' Health, Safety & Training issued a control order under Chapter 22A, Article 2, Section 68. The order was issued at 8:45 p.m. on January 19, 2006 to preserve the accident scene and was terminated at 12:50 p.m. on July 17, 2006.

### **The following is a list of the contributing violations:**

(V-1) Title 36, Series 6, Section 4 4.1(j): Based on testimony and evidence received during an investigation following a fatal mine fire, the approved longwall mining plan was not being complied with on the No. 9 longwall headgate section in that the mother drive beltline ventilating air current that is normally used to supplement the intake air current to the longwall face was traveling in the opposite direction. The ventilating air current that is required to travel toward the longwall face along the beltline was reversed, resulting in the air current traveling toward the mother drive head.

(V-2) Chapter 22A, Article 2, Section 58 (d)(1): Based upon testimony received and evidence obtained during an investigation of a fatal mine fire that occurred on January 19, 2006, it has been determined that no water was available at the fire hose outlets on the mother drive belt for the No. 9 headgate longwall section. The fire hose outlet valve on the two-inch supply waterline at the fire location was opened and no water was available. The main cutoff valve for the two-inch water supply line for the longwall belt was found in the closed position. The cutoff valve is located near the longwall belt discharge roller.

(V-3) Chapter 22A, Article 2, Section 58 (f): Based on testimony and evidence obtained during a fatal mine fire investigation, it was determined that a fire hose with fittings suitable for connection with each belt conveyor waterline system was not provided at or near the No. 9 headgate longwall belt drive and take-up area. The connector on the fire hose provided was too large in diameter for the fire hose outlet and could not be attached to allow water to be used to fight a mine fire. Additionally, the same problem existed on the No. 9 headgate longwall belt on December 23, 2005 according to testimony provided by Brandon Conley, a smoldering fire occurred December 23, 2005 and he could not get the fire hose to connect to the water hose outlet. He stated this condition was reported to management at that time.

(V-4) Chapter 22A, Article 2, Section 60(b): Based on testimony and evidence obtained during a fatal mine fire investigation, a separate and distinct intake air escapeway is not provided from the active North East Mains No. 2 Section to the surface. Required ventilation controls were not provided at the No. 7 belt tailpiece area. This condition allowed heavy black smoke to enter the primary intake escapeway following a belt fire that occurred on January 19, 2006.