Preshift / Onshift/ Weekly Examinations
A Matter of Life and Death

Following are details of coal mine accidents resulting in 3 or more fatalities over the past 30 years which were directly attributed to inadequate examinations.

Date	Mine Name	# of victims	Standard Cited	Citation Text
10/27/1980	Frank Crawford Coal #1	3	75.303 75.304	There were no records indicating that the examinations required by Subpart D- Ventilation, 30 CFR 75, were being conducted, and the investigation revealed that there was not a certified person at the mine and no certified person had been designated to make such examinations.
11/07/1980	Ferrell # 17	5	75.505	A sworn statement taken from the section foreman during the investigation of the mine explosion revealed at on September 28, 1980, he did not examine at least one entry of each intake and the return air courses of 1 east and 2 south in its entirety during the weekly examinations for hazardous conditions. He stated that when making such examinations, he would travel in the track entry (neutral entry) and go into the intake and return entries at different locations and then return to the track entry.
			75.303	Sworn statements taken during the investigation of a mine explosion that occurred at the Ferrell No. 17 mine on November 7, 1980, revealed that preshift examinations were not made each shift prior to miners entering the 2 south area for the purpose of removing mining equipment. The equipment was removed during a 2-week period in late August and early September 1980.

Date	Mine Name	# of victims	Standard Cited	Citation Text
			75.314	Sworn statements taken during the investigation of a mine explosion that occurred at the Ferrell No. 17 mine on November 7, 1980, revealed that it was common practice at this mine not to make the required examinations in idle and/or abandoned areas of the mine for methane and oxygen deficiency and other dangerous conditions by a certified person not more than 3 hours before the pumpmen were permitted to enter or work in such areas. The pumpmen who were required to enter such areas were not equipped with methane detectors or flame safety lamps.
			75.303	Sworn statements taken during the investigation of a mine explosion that occurred at the Ferrell No. 17 mine on November 7, 1980, revealed that it was a common practice not to make the required preshift examinations of the haulageways and travelways within three hours preceding the oncoming shift. Three foreman, who regularly conduct preshift examinations at this mine, stated that the haulageways and travelways were examined at the start of the shift while enroute to the respective sections.
			75.314	Sworn statements taken during the investigation of a mine explosion that occurred at the Ferrell No. 17 mine on November 7, 1980, revealed that the idle 2 south off 1 east main area was not inspected for methane and for oxygen deficiencies and other hazardous conditions by a certified person not more than 3 hours before 5 miners were permitted to enter these areas at approximately 2:30 a.m. on November 7, 1980. The 3rd shift foreman assigned these 5 miners to go to 2 south off 1 east main and retrieve track rails at about 1:55 a.m. on November 7, 1980. The 5 miners were killed at approximately 3:30 a.m. on November 7, 1980, as result of an explosion that occurred in 2 south off 1 east main portion of the mine.

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			75.303	Sworn statements taken during the investigation of a mine explosion that occurred at the Ferrell No. 17 mine on November 7, 1980, revealed that a preshift examination was not made in 3 east off 2 north within 3 hours of 5 miners entering such areas at approximately 1 a.m. on November 7, 1980. These 5 miners were assigned to go to 3 east off 2 north and retrieve track rails by their supervisor, the general labor foreman, on the surface prior to entering the mine on the 12:01 a.m. to 8 a.m. shift for November 7, 1980.
			75.303	Sworn statements taken during the investigation of a mine explosion that occurred at the Ferrell No. 17 mine on November 7, 1980, revealed that a preshift examination was not conducted in 1 east prior to miners recovering belt structure from that area on or about October 24, 1980.

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06/21/1983	McClure #1	7	75.303	The preshift examination of the 2 Left section conducted for the oncoming evening shift of June 21, 1983, and the examination of the belt entry conducted after the shift had begun were inadequate. The preshift examiner did not determine the effect on the ventilation system of the active 2 left section when a ventilation control was not installed in the left crosscut (No. 40) off the No. 3 entry setup entries. The belt examiner neither made methane tests in the belt entry nor took air readings to determine that the air current in the belt entry was traveling in its normal course and velocity. The absence of ventilation control in the left crosscut off No. 3 entry (No. 40) permitted a significant portion of the ventilation current for the 2 left sections to be coursed through the longwall setup entries thereby reducing the normal volume and velocity of the ventilating currents in the 2 left belt cut of the 2 left section. This reduced volume and velocity of the 2 left entries and the methane was subsequently ignited at 10:15 p.m. on June 21, 1983. The explosion resulted in the death of 7 miners and injury to 3 others.

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			75.304	The onshift examination(s) of the 2 Left section conducted on June 21, 1983 by the designated and certified examiner(s) was inadequate. The left crosscut of No. 3 entry (No. 40) of 2 Left had been cut through into the No. 2 longwall setup entry and a ventilation control had not been installed in the crosscut. This permitted a significant portion of the ventilating current for the 2 left section to be coursed from the longwall setup entries through the crosscut instead of traveling in its normal route. This flow of air through the crosscut resulted in a reduced volume and velocity of the ventilating current in the 2 Left intake entries outby the last open crosscut in 2 Left. The onshift examiner(s) did not determine the potential hazards created by the ventilation change made when the ventilation control was not installed and did not detect hazardous conditions that developed after the change was made. The ventilation permitted an explosive mixture of methane to accumulate and the methane subsequently ignited at 10:15 p.m. on June 21, 1993. The explosion resulted in the death of 7 miners and injury to 3 others.

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02/16/984	Greenwich Collieries #1	3	75.303(a)	According to the preshift examination books, sworn statements given voluntarily during the investigation, and the absence of initials, time and dates in the D-3 area, a preshift examination was not made by a certified person within three hours immediately preceding the entry of three miners into this area to perform work on the water pumping system on the 12:00 midnight shift, February 16, 1984. This condition was observed during the investigation of a multiple fatal mine explosion which occurred in the D-1, D-3, and D-5 areas of the mine.
			75.316	According to sworn statements by company officials and in the absence of a record of the weekly examinations in the mine record books, the D-1 to D-3 bleeder system was not being examined weekly. This condition was observed during the investigation of a multiple fatal mine explosion which occurred in the D-1, D-3, and D-5 areas of the mine.

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08/15/1985	R and R Coal #3	3	75.303	Preshift Examination of the mine by a certified person had not been conducted or recorded in the preshift book since July 1985.
			75.304	On-shift examinations for hazardous conditions by certified persons were not made or recorded in the book located on the surface.
			75.305	Weekly examinations were not being conducted by a qualified person or recorded in a record book.
				Examinations for methane immediately before shots were fired and after blasting were not made by a qualified person, nor was a device available to make an examination.

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09/13/1989	Pyro #9 Slope	10	75.303	A preshift of Longwall panel “O” recovery area was not conducted for the day shift crew (7:00 a.m. to 5:00 p.m.) of September 13, 1989. A preshift examination was required in the area between 4:00 a.m. and 7:00 a.m. on September 13, 1989.
			75.324	Methane concentrations of up to 6.5 percent were detected on the face of Longwall panel “O” on the day shift of Saturday, September 9, 1989. Foreman in the recovery area were aware of these concentrations and helped install curtains to remove the methane but no examination was conducted to determine the source and cause of the methane accumulations. Reports by the mine foreman for this shift failed to record the presence of those hazardous accumulations of methane or show the action taken to correct the condition. The failure to record these methane accumulations in the approved record books prevented management officials and other interested persons from learning of the hazardous condition and initiating corrective action.
			75.324	Methane concentrations of up to 9 percent were detected on the face of Longwall panel “O” on the day shift of Saturday, September 9, 1989. Foreman in the recovery area were aware of these concentrations and helped install curtains to remove the methane but no examination was conducted to determine the source and cause of the methane accumulations. Reports by the mine foreman for this shift failed to record the presence of those hazardous accumulations of methane or show the action taken to correct the condition. The failure to record these methane accumulations in the approved record books prevented management officials and other interested persons from learning of the hazardous condition and initiating corrective action.

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12/07/1992	Southmountain #3	8	75.360(b)(3)	The 001 preshift examination conducted between the hours of 9:30 p.m. and 10:30 p.m. on December 6, 1992 for the oncoming midnight shift on the 1 Left 001 section, was not conducted in its entirety. The No. 1 entry (intake) and Nos. 5 and 6 entries (return) at the pillar line were not examined. Methane may have been present in the No. 1 entry at this time.

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09/23/2001	Jim Walter #5	13	75.360(b)(3)	One September 23, 2001, two separate explosions occurred in 4 Section, resulting in fatal injuries to thirteen miners. The accident investigation revealed that an adequate preshift examination was not conducted in 4 Section where persons were scheduled to perform maintenance work during the oncoming afternoon shift on September 22, 2001. A hazardous condition consisting of inadequate rock dust existed but was not identified by the examiner. The condition was obvious, widespread, and in the areas traveled by the examiner. . . The condition contributed to the severity and extent of the second explosion that resulted in fatal injuries.
			75.362(a)(1)	The accident investigation revealed that an adequate on-shift examination was not conducted in 4 Section where to mechanics were assigned to work during the afternoon shift on September 22, 2001. A hazardous condition consisting of inadequate rock dust existed, but was not identified by the examiner. The condition was obvious, widespread, and in areas traveled by the examiner. . . . The condition contributed to the severity and extent of the second explosion that resulted in fatal injuries.

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			75.360(b)(3)	The accident investigation revealed that an adequate preshift examination was not conducted in 4 Section where persons were scheduled to perform maintenance work and install roof bolts during the oncoming day shift on September 23, 2001. The examination was incomplete in that an examination of the working places was not conducted where miners were scheduled to roof bolt the unsupported roof areas. The main mine fan had been off during the previous shift, creating the potential for methane accumulations in the long crosscuts between No. 2 and No. 3 Entries as well as in the face areas. The examiner was not made aware of these circumstances and was instructed by mine management to limit the examination to the electrical installations only. In addition, a hazardous condition consisting of inadequate rock dust existed but was not identified by the examiner. . . This was the area where coal dust became the primary fuel for the second explosion. The condition contributed to the severity and extent of the second explosion that resulted in fatal injuries.
			75.360(b)(3)	The accident investigation revealed that an adequate preshift examination was not conducted in 4 Section where persons were scheduled to install cribs during the oncoming afternoon shift on September 23, 2001. A hazardous condition consisting of inadequate rock dust existed but was not identified by the examiner. This was also the area where coal dust became the primary fuel for the second explosion. The condition contributed to the severity and extent of the second explosion that resulted in fatal injuries.