

**UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION
Metal and Nonmetal Mine Safety and Health**

REPORT OF INVESTIGATION

**Surface of an Underground Nonmetal Mine
(Limestone)**

Fatal Fall of Person Accident

February 8, 2004

**Gensimore Trucking Inc.
Contractor I.D. D133**

at

**Graymont (Pa) Inc.
Graymont (PA) Inc., Pleasant Gap
Pleasant Gap, Centre County, Pennsylvania
Mine I.D. No. 36-06468**

**Bret A. Park
Mine Safety and Health Inspector**

**Dale R. Dinning
Mine Safety and Health Inspector**

**Donald W. Conrad
Mine Safety and Health Specialist**

**Originating Office
Mine Safety and Health Administration
Northeast District
547 Keystone Drive, Suite 400
Warrendale, Pennsylvania 15086-7573
James R. Petrie, District Manager**



OVERVIEW

On February 8, 2004, Richard J. Bailey, contract truck driver (yard shifter), age 57, was fatally injured, when he fell from the top of an enclosed bulk tank trailer. Bailey was at the trailer staging area of the parking lot preparing to attach his tractor to the trailer. He used the rear access ladder to climb on top of the trailer. He opened two of the hatches, lost his balance, and fell 12 feet to the ground.

The accident occurred because the procedures that were in place to open and close the hatches on top of the bulk trailers were not being followed or closely monitored. A truck driver accessed the top of the trailer without wearing fall protection where there was a danger of falling.

GENERAL INFORMATION

Graymont (PA) Inc., Pleasant Gap, (Graymont) an underground and surface limestone operation, owned and operated by Graymont (Pa) Inc. was located at 965 E. College Avenue, Pleasant Gap, Centre County, Pennsylvania. The principal operating official was Paul T. Gori, vice president of operations. The underground mine normally operated two 8-hour shifts per day, five days a week and the plant normally operated three 8-hour shifts per day, seven days a week. Total employment was 57 persons underground and 89 surface.

Limestone was mined underground, transported to the surface, and processed into lime or crushed stone at the plant. The final products were sold for use in the construction, agriculture, and chemical industries.

Bailey was employed by Gensimore Trucking Inc., Pleasant Gap, (Gensimore) Centre County, Pennsylvania. Gensimore was contracted by Graymont to haul the final product from the mine site to customers. Bailey was employed as a "yard shifter" and was assigned the duties of transporting the empty trailers to the plant for loading and returning them to the parking lot.

The last regular inspection of this operation was completed on February 4, 2004.

DESCRIPTION OF THE ACCIDENT

On February 7, 2004, Richard J. Bailey (victim) arrived at the site at approximately 11:00 p.m. He traveled to the kiln floor and talked to Graymont employees William McElwain, laborer, and Thomas Bird, kiln helper. Bailey informed McElwain that he had four bulk trailers ready for loading that night and proceeded to the load out facility. McElwain loaded the first bulk trailer and Bailey transported it to the scales. He crossed the scales with the loaded trailer at 12:03 a.m. and transported it to the trailer parking lot.

Bailey disconnected the tractor from the trailer he had just hauled. He did not move the tractor and left the lights on. Bailey walked to an empty trailer, climbed the rear ladder of the trailer to access the top, and opened the two middle hatches in preparation for loading. William Gill, a driver for Gensimore, pulled into the parking lot to drop an empty trailer and saw the tractor parked with its lights on. Gill parked his truck and waited for Bailey to return. After about half an hour, Gill became concerned and began to look for Bailey. In the meantime, Glenn Shiderly, a driver for Gensimore, pulled into the lot to drop a trailer that was loaded with another product and pick up a trailer loaded with lime. Gill and Shiderly talked briefly about Bailey's absence. Gill then left the parking lot in his tractor.

Shiderly walked between the loaded and empty trailers looking for Bailey when he noticed the hatches were open on the empty trailer. He decided to look in the open hatches of the trailer with a flash light and climbed the ladder on the back of the trailer. Shiderly looked inside the trailer and did not observe anything. He started back down the ladder when his light shined on Bailey lying on the ground.

Bailey was unresponsive and did not have a pulse. Shiderly ran to the scale house where he told George Callahan, Gensimore truck driver, about the accident. Callahan called 911, while Steven Herman, Gensimore truck driver, ran to the parking lot, covered Bailey with his coat, and checked for a pulse but found none.

McElwain and Bird traveled to the parking lot, where they also checked Bailey. Emergency medical personnel responded along with the county coroner who pronounced Bailey dead at the scene. Death was attributed to a cerebral concussion.

INVESTIGATION OF THE ACCIDENT

MSHA was notified of the accident at 2:35 a.m., on February 8, 2004, by a telephone call from David Abberegg, production supervisor, to James Petrie, district manager. An investigation was started the next day. An order was issued pursuant to section 103(k) of the Mine Act to ensure the safety of the miners. MSHA's accident investigation team traveled to the mine, conducted a physical inspection of the accident scene, interviewed employees, and reviewed documents and work procedures relevant to the accident. The accident investigation was conducted with the assistance of mine management, employees, a representative of the miners, and the Pennsylvania Bureau of Deep Mine Safety.

DISCUSSION

Location of the Accident

The accident occurred at the parking lot for the bulk tank trailers. The parking lot was on the mine property but isolated from the plant. The area was used by the contractor truck drivers to drop off empty tanker trailers and pick up loaded trailers. The weather conditions at the time of the accident were clear and cold, with snow on the ground.

The Bulk Trailer

The bulk trailer was manufactured by Fruehauf, model # HAB-T2-JX 1530. The trailer was provided with a ladder on the rear. The top of the trailer was coated with a gritty material for traction. The trailer top had a rail on both sides of the hatches that was four inches high and extended from the ladder past all of the hatches. The height of the trailer was 12 feet from the top to the ground. The top of the trailer was free of ice and snow.

Bulk Load Out Facility

The bulk trailers were loaded at the plant's bulk load out facility. The facility was provided with a static line which extended the entire length of the bulk trailers. The line was used to hook a lanyard and safety belt for accessing the top of the trailers when opening or closing the hatches of the trailer. Management required truck drivers to open or close the hatches at this location, not in the parking lot where the trailers were parked.

Training

Bailey had 17 years mining experience, all with Gensimore, at this mine. He had worked for the trucking company for 19 years. Bailey had received his new miner training from Graymont in March, 2000. He did not receive Part 48 annual retraining after March, 2000. A Part 48 violation was issued; however, it was not determined to be contributory to the accident.

ROOT CAUSE ANALYSIS

A root cause analysis was conducted and the following causal factor was identified:

Causal Factor: A truck driver accessed the top of a trailer, without wearing fall protection, to open the hatches on the trailer. The procedures that were in place to open and close the hatches on top of the bulk trailers were not being followed or closely monitored.

Corrective Action: Conduct a risk analysis before starting a task to identify hazards and implement measures to ensure persons are properly protected. Develop and implement a written plan that ensures fall protection will be worn by truck drivers where there is a danger of falling. Monitor work tasks to reinforce safe procedures and obtain feedback from employees on use of fall protection systems. Train all personnel to help them recognize and understand procedures to safely perform tasks.

CONCLUSION

The accident occurred because the procedures that were in place to open and close the hatches on top of the bulk trailers were not being followed or closely monitored. A truck driver accessed the top of the trailer, without wearing fall protection, to open the hatches on the trailer.

ENFORCEMENT ACTIONS

Graymont (Pa) Inc.

Order No. 6015040 was issued on February 9, 2004, under the provisions of Section 103(k) of the Mine Act:

A fatal accident occurred at this operation on February 8, 2004, when a contractor truck driver was found lying next to an empty bulk tanker. This order is issued to assure the safety of all persons at this operation. It prohibits all activity near the vehicle until MSHA has determined that it is safe to resume normal operations in the area. The mine operator shall obtain prior approval from an Authorized Representative for all actions to restore operations to the affected area.

This order was terminated on February 11, 2004. The conditions that contributed to the accident have been corrected and normal mining operations can resume.

Gensimore Trucking Inc.

Citation No. 6005588 was issued on March 4, 2004, under the provisions of Section 104(a) of the Mine Act for a violation of 30 CFR 57.15005:

On February 8, 2004, a fatal accident occurred at this mine site when a contract truck driver (yard shifter), and employee of Gensimore Trucking, fell approximately 12 feet from the top of a bulk lime trailer, owned by Gensimore. The trailer was located in a parking lot area of the mine site. The victim climbed a ladder attached to the rear of the trailer and was not secured by a safety belt and lifeline while he opened two of the access doors.

This citation was terminated on March 4, 2004. The yard shifters were provided with full body harnesses and instructed to wear them at all times. Signs were posted in the parking lot instructing the drivers not to access to top of the trailers in the area. A letter was sent to all carriers and contractors reminding them of the company's safety program and their assignments.

Approved by: _____
James R. Petrie, District Manager

Date: April 6, 2004

APPENDICES

- A. Persons Participating in the Investigation.
- B. Persons Interviewed

APPENDIX A

Persons Participating in the Investigation

Graymont (Pa) Inc.

Robert A. Biggans.....maintenance superintendent
David M. Aberegg.....production supervisor/safety coordinator
Paul T. Gori.....vice president of operations
Richard L. Fenush.....plant superintendent
Terrance D. Thompson.....safety coordinator

Boilermakers, Local D92

Raymond H. Brown.....miners' representative

Pennsylvania Bureau of Deep Mine Safety

Michael J. Buble.....anthracite deep mine inspector supervisor
John A. Bentzel.....anthracite and industrial minerals inspector

The Pennsylvania State Police

Warren F. Sasserman.....trooper

Centre County Coroners Office

Judy Pleskonko.....deputy coroner

Mine Safety and Health Administration

Bret A. Park.....mine safety and health inspector
Dale R. Dinning.....mine safety and health inspector
Donald W. Conrad.....mine safety and health specialist

APPENDIX B

Persons Interviewed

Gensimore Trucking Inc.

Daniel E. Genismore.....owner
Bradley S. Gensimoreowner/safety director
Franklin J. Rudy.....truck driver
William E. Gill.....truck driver
Glenn F. Shiderly.....truck driver
Steven W. Herman.....truck driver
George W. Callahan.....truck driver

Graymont (Pa) Inc.

Thomas G. Bird.....kiln helper
Willaim McElwain.....laborer