MAI-2014-18

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

REPORT OF INVESTIGATION

Surface Nonmetal Mine
(Crushed and Broken Limestone)

Fatal Fall of Person Accident
August 25, 2014

Gardenscape of New York
Gardenscape of New York
Gouverneur, St. Lawrence County, New York
Mine I.D. No. 30-00007

Investigators

Matthew H. Mattison
Mine Safety and Health Inspector

Brian T. Righi
Mine Safety and Health Inspector

Blain Shrewsberry
Mine Safety and Health Specialist (Training)

Originating Office
Mine Safety and Health Administration
Northeast District
Thorn Hill Industrial Park
178 Thorn Hill Road, Suite 100
Warrendale, Pennsylvania 15086-7573
Donald J. Foster, Jr., Northeast District Manager

OVERVIEW

On August 25, 2014, Glenn F. Dibble, Truck Driver, age 54, was killed when he fell approximately 8 feet from loaded stacked pallets. He was attempting to retrieve wooden planks from the rafters in a bag storage building.

The accident occurred due to management's failure to establish and implement procedures for persons to safely access materials stored in the bag storage building. Additionally, Dibble did not receive task training addressing safe work procedures for accessing overhead areas and the potential hazards associated with the task.

GENERAL INFORMATION

Gardenscape of New York, a surface crushed limestone operation owned and operated by Gardenscape of New York, is located in Gouverneur, St. Lawrence County, New York. The principal operating officials are David G. Kasmoch, President, and Kevin Dibble, Plant Manager (victim's cousin). The mine typically operates two 10-hour shifts, five days per week. Total employment is 20 persons. Most of the miners work on dayshift from 7:30 a.m. to 4:00 p.m. while a 3-person night shift works from 3:45 p.m. to 1:15 a.m.

Limestone is drilled and blasted from a multiple-bench quarry. A front-end loader is used to load a haul truck which transports the broken limestone to a primary feed hopper for processing. The primary crushing plant consists of a grizzly-type vibrating feeder and a jaw crusher with an under jaw discharge conveyor. The crushed material is conveyed to a scalping screen. The undersized material flows to a conveyor and the oversized material falls into a cone crusher at the secondary plant for additional crushing. When the material exits the secondary plant, it is conveyed to the mill for further reduction. The material is stored in bulk or dried for subsequent bagging. Finished products are sold as bulk or bagged agricultural lime.

The Mine Safety and Health Administration (MSHA) completed the last regular inspection at this mine on July 23, 2014.

DESCRIPTION OF THE ACCIDENT

On the day of the accident, Monday August 25, 2014, Glenn F. Dibble (G. Dibble, victim) reported for work at 7:30 a.m., his usual starting time. G. Dibble was instructed by Kevin Dibble (K. Dibble), Plant Manager, to haul five to six loads of sand from a nearby mine. During the morning, coworkers observed G. Dibble hauling several loads of material in an over-the-road dump truck.

At approximately 12:30 p.m., Murlyn Harris, Front-end Loader Operator, loaded G. Dibble's truck with crusher run material to be delivered off site.

At about 2:00 p.m., the secondary crushing plant shut down with a full load of material in the cone crusher. The cone crusher needed to be emptied before the plant could be restarted. Derek Collier, Crusher Operator, Jeff Jenkins, Plant Operator/Shift Supervisor, and Harris decided to use chains and slings connected to a front-end loader in an attempt to lift the crusher and allow material to flow through.

At approximately 3:00 p.m., Harris observed G. Dibble return to the mine and park his dump truck. About 3:15 p.m., G. Dibble stopped by to assist with the work on the cone crusher. G. Dibble stated that they would need several wooden planks to prevent material from flowing from the stone hopper into the crusher. G. Dibble then stated that he knew where the planks were and left in a pickup truck and traveled toward the bag storage building.

At 3:45 p.m., the 3-person nightshift crew gathered in the breakroom, punched their timecards, and traveled to the milling plant. The crew consisted of two bagging machine operators and an operator/machine tender.

When the work on the cone crusher was completed, Collier, Jenkins, and Harris went to the breakroom to punch out for the shift. Harris noticed that G. Dibble had not returned and assumed that K. Dibble had sent him on some errands. The dayshift crew left the mine at 4:00 p.m.

On Tuesday, August 26, 2014, at 1:25 a.m., the nightshift crew returned to the breakroom at the end of the shift. At that time, they noticed that G. Dibble's motorcycle helmet was on the table in the breakroom. Darren House, Bagger, looked outside and saw that G. Dibble's motorcycle was parked behind the breakroom. Nicholas Trapp, Bagger, noticed that the pickup truck was not parked near the shop as it normally was during nightshift. At that time, Steven Spano, Operator/Machine Tender, checked G. Dibble's timecard and noticed he had not punched out at the end of dayshift. According to interviews, they assumed G. Dibble's motorcycle did not start and he had taken the pickup truck home. The nightshift crew left the mine at 1:45 a.m.

Harris arrived at the mine at 5:12 a.m. and waited in the breakroom for the rest of the dayshift crew to arrive. While waiting, he noticed G. Dibble's motorcycle helmet was still on the table in the breakroom. At 6:00 a.m., Harris and Collier punched their time cards and decided to look for G. Dibble. They saw the pickup truck sitting near the bag storage building, went inside, and found G. Dibble lying between two loaded pallets. He was unresponsive and had no vital signs. They immediately called the local authorities and K. Dibble to report the accident. The New York State Police and the St.

Lawrence County Coroner responded to the mine. At 7:30 a.m., the victim was pronounced dead at the scene by Kevin Crosby, St. Lawrence County Coroner. The cause of death was attributed to blunt force trauma.

INVESTIGATION OF THE ACCIDENT

MSHA was notified of the accident at 6:19 a.m. on August 26, 2014, by a telephone call from Derek Collier, Crusher Operator, to the National Call Center. The National Call Center notified Victor Lescznske, Supervisory Special Investigator, and an investigation was started the same day. An order was issued under provisions of Section 103(j) of the Mine Act. This order was later modified to Section 103(k) of the Mine Act after the arrival of an Authorized Representative at the mine site.

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. MSHA conducted the investigation with the assistance of mine management, employees, and state law enforcement.

DISCUSSION

Location of the Accident

The accident occurred in the bag storage building on the east end of the mine. The structure is a three-sided enclosure built to store and shelter stacked pallets of new bags and other materials needed for the mine (see Figure 1). The earthen floor is covered with fine gravel and free of debris. Wire mesh bag support columns for the onsite dust collectors and wooden planks are stored in the building's rafters approximately 12 feet from ground level.

Weather

On the day of the accident, weather conditions were clear with an average temperature of 80 degrees Fahrenheit and wind approximately 6 mph. Sunrise was at 6:18 a.m. The investigators determined that the weather conditions and lighting were not contributing factors in the accident.

Physical Factors

The evidence gathered during the investigation indicated that the victim had climbed approximately 8 feet on top of two stacked pallets and reached for wooden planks in the rafters above him (see Figures 2 and 3). Each wooden plank was approximately 2-inches thick by 12-inches wide by 12-feet long and weighed 30 pounds. The victim had taken down two wooden planks before falling to the ground.

TRAINING AND EXPERIENCE

Glenn Dibble had 1½ years of mining experience as a truck driver, all at this mine. A representative of MSHA's Educational Field Services reviewed the mine operator's Part 46 training records for G. Dibble. Although the records documented that G. Dibble had received all required training, including task training and annual refresher training, he did not receive task training addressing safe work procedures for accessing overhead areas and the potential hazards associated with the task.

ROOT CAUSE ANALYSIS

The investigators conducted a root cause analysis and identified the following root causes and the corresponding corrective actions implemented to prevent a recurrence:

Root Cause: Management failed to provide a safe means of access for miners retrieving stored materials from the overhead rafters in the bag storage building.

Corrective Action: All materials were removed from the overhead rafters and stored in a safe manner. In addition, management established written policies and safe work procedures, including the use of ladders for any work being performed overhead. Miners were trained in the new policies and procedures.

Root Cause: Management failed to provide the victim, an over-the-road truck driver, sufficient task training addressing safe access and safe work procedures while performing additional duties at the mine.

Corrective Action: Management has revised their Part 46 training plan to include task training for over-the-road truckers who may perform additional duties at the mine. All truck drivers were trained in accordance with the revised plan.

CONCLUSION

The accident occurred due to management's failure to establish and implement procedures for persons to safely access materials stored in the bag storage building. Additionally, G. Dibble did not receive task training addressing safe work procedures for accessing overhead areas and the potential hazards associated with the task.

ENFORCEMENT ACTIONS

Issued to Gardenscape of New York

Order No. 8802348 – Issued on August 26, 2014, under the provisions of Section 103(j) of the Mine Act. An Authorized Representative modified this order to Section 103(k) of the Mine Act upon arrival at the mine site:

> *A fatal accident occurred at this operation on August 25, 2014. On August 26, 2014 the miner was discovered at approximately 0602 in the storage garage. This order is issued to assure the safety of all persons in this area of the mine. It prohibits all activity at the storage garage at the east end until MSHA has determined that is safe to resume normal mining operations in the area. The mine operator shall obtain prior approval from an authorized representative for all actions to recover and/or restore operations to the affected area.*

The order was terminated September 3, 2014, when conditions that contributed to the accident no longer existed.

Citation No. 8802373 – Issued under the provisions of 104(a) of the Mine Act for a violation of 30 CFR 56.11001:

> *A fatal accident occurred at the mine on August 25, 2014. A miner (victim) had climbed on top of loaded pallets in the bag storage building to access wooden planks stored in the rafters. The planks were intended to be used to unblock a cone crusher. The miner fell approximately eight feet to the ground below. A safe means of access was not provided and used to retrieve materials stored in the bag storage building.*

Citation No. 8802374 – Issued under the provisions of 104(a) of the Mine Act for violation of 30 CFR 46.7(a):

> *A fatal accident occurred at the mine on August 25, 2014. A miner (victim) was accessing an elevated work area to get planks down from the rafters of the bag storage building. The miner was not properly tasked trained on safe access and working from elevated heights. The miner climbed on top of loaded pallets and fell approximately eight feet to the ground below.*

Approved: Donald J. Foster Date: 11-20-2014

Donald J. Foster, Jr.
District Manager

LIST OF APPENDICES

APPENDIX A

PERSONS PARTICIPATING IN THE INVESTIGATION

Gardenscape of New York

Kevin Dibble	Plant Manager
Fred Simmons	Safety Representative

New York State Police

Rachelle L. Foster	Investigator

Allen-Denesha Funeral Home

Donna L. Whitelaw	M.S. Ed., L.F.D.

Mine Safety and Health Administration

Matthew H. Mattison	Mine Safety and Health Inspector
Brian T. Righi	Mine Safety and Health Inspector
Blane Shrewsberry	Mine Safety and Health Specialist (Training)

APPENDIX B

VICTIM INFORMATION

Accident Investigation Data - Victim Information
Event Number: 6 6 8 2 5 3 2

U.S. Department of Labor
Mine Safety and Health Administration

Victim Information: 1

1. Name of Injured/Ill Employee: *Glenn F. Dibble*
2. Sex: *M*
3. Victim's Age: *54*
4. Degree of Injury: *01 Fatal*
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death: *a. Date: 08/25/2014* *b.Time: 15:15*
6. Date and Time Started: *a. Date: 08/25/2014* *b.Time: 7:30*
7. Regular Job Title: *176 Over the road truck driver*
8. Work Activity when Injured: *039 Retrieving wooden planks*
9. Was this work activity part of regular job? Yes: No: X
10. Experience

	Years	Weeks	Days
a. This Work Activity:	1	23	3
b. Regular Job Title:	1	23	3
c. This Mine:	1	23	3
d. Total Mining:	1	23	3

11. What Directly Inflicted Injury or Illness? *114 Victim fell from stacked loaded pallets*
12. Nature of Injury or Illness: *220 Spinal Cord Severe Compression*
13. Training Deficiencies: Hazard: X; New/Newly-Employed Experienced Miner:; Annual:; Task: X
14. Company of Employment (If different from production operator): *Operator*; Independent Contractor ID: (if applicable)
15. On-site Emergency Medical Treatment: Not Applicable:; First-Aid:; CPR:; EMT:; Medical Professional:; None: X
16. Part 50 Document Control Number: (form 7000-1)
17. Union Affiliation of Victim: *9999 None (No Union Affiliation)*

APPENDIX C

ACCIDENT SCENE PHOTOS

Figure 1 – Bag Storage Building showing stacked pallets where victim had been kneeling (prior to the accident).

Figure 2 - Distance from top of stacked pallets to rafters.

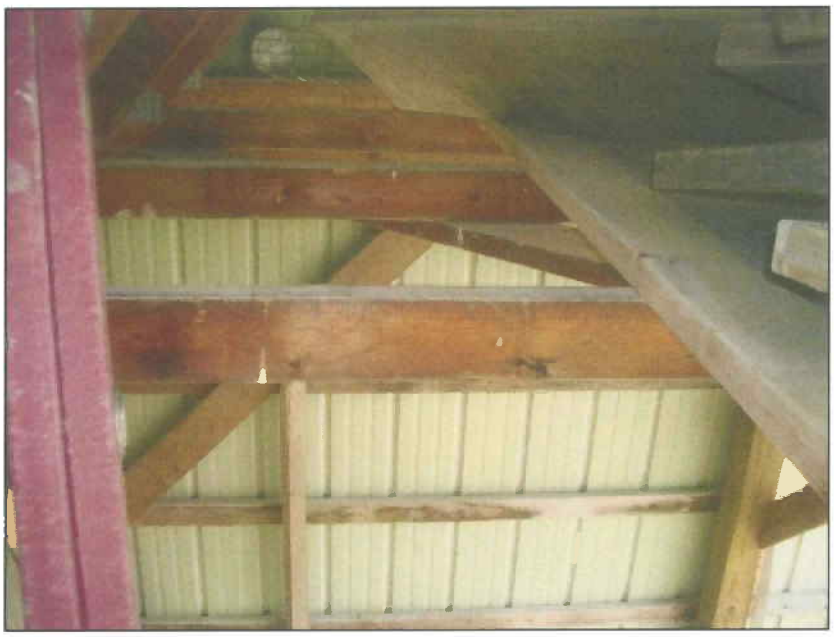

Figure 3 - View of rafters where wooden planks were stored.
(Note: limited dust where planks had been removed by the victim)