MAI-2017-03

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

REPORT OF INVESTIGATION

Surface Nonmetal Mine
(Crushed Stone)

Fatal Powered Haulage Accident
March 27, 2017

Bonito Pit
Black Rock Services
Los Lunas, New Mexico
Mine ID 29-02450

Accident Investigators

Darwin L Bratcher
Mine Safety and Health Supervisor

James Coats
Mine Safety and Health Inspector

Andrew Tabor
Mine Safety and Health Inspector

Originating Office

Mine Safety and Health Administration
South Central District
1100 Commerce Street RM 462
Dallas, TX 75242
Michael Davis, District Manager

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OVERVIEW

Steve Justice, plant operator, age 53, was fatally injured on March 27, 2017. Justice was outside of the operator's cab of his personal service truck near a generator trailer when the service truck rolled forward and pinned him between the truck and the trailer.

The accident occurred because management's policies and controls were inadequate to ensure proper parking procedures were followed.

GENERAL INFORMATION

Bonito Pit, a surface open pit crushed stone mine, is owned and operated by Black Rock Services, and is located in Los Lunas, Valencia County, New Mexico. The principal operating official is Robert Caldwell, owner. The mine employs seven miners and operates one ten-hour shift, five days a week.

Rock is removed from the pit by front end loaders and transported to the crushing plant. The front end loader then feeds the material into the plant for processing. The finished material is used in the company's hot mix plant.

The Mine Safety and Health Administration's (MSHA) last regular inspection at Bonito Pit was January 30, 2017.

DESCRIPTION OF ACCIDENT

Steve Justice had been residing in a travel trailer on the mine site for two weeks prior to the accident. He finished his regular shift on Friday, March 24, 2017, at 4:00 p.m. and returned to his trailer. David Evans, electrician, shut down the generators and took his hourly readings at 4:15 p.m. Based on the investigation, Justice turned on the generator to get gas for his vehicle and left the generator running sometime between 4:15 p.m. and 7:40 p.m. At approximately 7:40 p.m., Sundance T. Harvill, security guard, arrived at the plant and noticed the plant light was on. Harvill proceeded to the generator trailer and turned off the plant light. Harvill then proceeded to Justice's trailer and found him sitting in his truck. Harvill asked Justice if he wanted him to turn off the small generator. Justice told him he would take care of it. Harvill then traveled to his parking area for the rest of his shift. Harvill left the mine at his usual time, approximately 4:45 a.m., on Saturday, March 25, 2017.

On Sunday, March 26, 2017, Harvill returned to work. Harvill traveled to the plant at his normal time of 7:00 p.m. and went to Justice's trailer. But, Justice's truck was not there. Harvill proceeded to his parking area for the remainder of his shift. Harvill left at his normal time the following morning at 4:45 a.m.

On Monday, March 27, 2017, Michael Chavez, front end loader operator, arrived at the mine site at 5:45 a.m. Chavez started the office generator and proceeded to his loader. Chavez noticed Justice's truck near the generator trailer but continued to service his loader. After completing the service of his loader and another loader, Chavez approached Justice's truck and noticed the driver's side door had been left open. He found Justice pinned between the truck and generator trailer. Phillip Castillo, front end loader operator, arrived at the accident scene and Chavez informed him about the victim. Chavez called Eric Martinez, pit foreman, and told him to call 911. Emergency medical crews and law enforcement arrived at approximately 6:15 a.m. and the victim was pronounced dead a short time later. Official cause of death was traumatic asphyxia.

INVESTIGATION OF THE ACCIDENT

The MSHA Albuquerque Field Office received a call at 8:10 a.m. on March 27, 2017, from Kayla Kersey, Black Rock Services. Kersey did not mention the accident and only asked that Mark Williams, MSHA's Albuquerque field office supervisor, call her back. Williams called Kersey back at 9:30 a.m. and was made aware of the accident and an investigation was started. An order was issued under the provisions of Section 103(k) of the Mine Act to insure the safety of the miners and to protect the accident scene.

MSHA's accident investigation team traveled to the mine, conducted a physical inspection of the accident scene, conducted interviews, and reviewed documents and work procedures relevant to the accident. MSHA conducted the investigation with the assistance of mine management and mine employees. The investigation was completed on April 18, 2017.

DISCUSSION

Location of the Accident

The accident occurred at the generator trailer located on the north side of the crushing plant. The victim's truck was facing south towards the generator trailer. The ground in the area generally sloped north away from the generator trailer, for the exception of the area located approximately 72" from the generator trailer, where the ground was identified to slope south toward the generator trailer at an approximately 16 degrees.

Weather

The weather was not a factor in this accident.

Truck Information

The vehicle involved in the accident was a one-ton, Dodge Ram 3500, service truck. The victim had left the truck in a forward gear, according to the police report, without setting the park brake and chocking the wheels against movement. The truck rolled forward pinning the victim between the truck and trailer. The truck had run out of fuel by the time the accident scene was discovered.

Training and Experience

Justice had more than 30 years of mining experience. A representative of MSHA's Educational Field and Small Mines Services reviewed the Part 46 training records for Justice. The records documented that he had received all of the required training.

ROOT CAUSE ANALYSIS

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

Root Cause: Management's policies and work practices were inadequate and failed to ensure parking procedures were followed when leaving mobile equipment unattended.

Corrective Action: Management has developed Standard Operating Procedures (SOP) on parking procedures for unattended mobile equipment. Mine management has provided training to all employees on the new SOP and will be including it in their Site-Specific Hazard Awareness Program to address all other vehicular traffic on the mine site.

CONCLUSION

Based on the investigation and statements gathered during interviews, the investigation team concluded that sometime after 7:40 pm on Friday, March 24, 2017, Justice drove to the generator trailer, exited the cab with the truck running and in gear, and walked between the truck and trailer with his back to the truck. Due to the slope of the ground in the area, the truck rolled forward and pinned Justice between the truck and the trailer resulting in his death.

ENFORCEMENT ACTIONS

Issued to Black Rock Services

Order No. 8972423 was issued on March 27, 2017, under the provisions of Section 103(k) of the Mine Act. This citation was issued as Non-Significant and Substantial.

A fatal accident occurred at this operation on March 27, 2017 when a miner was observed pinned between the Ram 3500 pickup and the generator trailer. This order is issued to assure the safety of all persons at this operation. It prohibits all activity at the generator trailer area until MSHA has determined it 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.

Citation No. 8959590 was issued on April 10, 2017, under provisions of Section 104(a) of the Mine Act for a violation of 56.14207. This citation was issued as Significant and Substantial.

A fatal accident occurred on March 27, 2017 when the operator of a 2012 Dodge Ram 3500 flatbed truck left the cab of his truck to stand between the front of the truck and the generator trailer. The victim had left the truck in a forward gear without setting the park brake and chocking the wheels against movement. The truck rolled forward pinning the victim between the truck and trailer.

Citation No. 8959591 was issued on April 10, 2017, under provisions of Section 104(a) of the Mine Act for violation of 50.10a. This citation was issued as Non-Significant and Substantial.

A fatal accident occurred at this mine at 5:45 a.m. on March 27, 2017. The mine operator failed to notify MSHA within 15 minutes after discovering the miner had suffered fatal injuries. MSHA was notified at 9:20 a.m. on March 27, 2017

Approved: _____ *Date:* _____

Michael A. Davis
District Manager

Investigation Participants

Black Rock Services

Robert Caldwell	Owner
Eric Martinez	Pit Foreman
Michael Chavez	Front End Loader Operator
Phillip Castillo	Front End Loader Operator
Dave Evans	Electrician
Sundance T. Harvill	Security Guard
Jose Gonzales	Water Truck Driver

State of New Mexico

Randy Logsdon	State Mine Inspector

Mine Safety and Health Administration

Darwin L. Bratcher	Supervisory Mine Safety and Health Inspector
James Coats	Mine Safety and Health Inspector
Andrew Tabor	Mine Safety and Health Inspector
Steve M. Powroznik	MSHA/EFSMS