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

REPORT OF INVESTIGATION

Surface Nonmetal Mine
Dimension Stone

Fatal Powered Haulage Accident

April 11, 2006

1845 Texas Stone Products, Inc.
Texas Stone Products, Inc.
Lometa, Lampasas County, Texas
Mine I.D. No. 41-03518

Investigators

Daniel J. Haupt
Supervisory Special Investigator

Jerry Y. Anguiano
Mine Safety and Health Inspector

Originating Office
Mine Safety and Health Administration
South Central District
1100 Commerce St., Room 462
Dallas, TX 75242-0499

Edward E. Lopez, District Manager

OVERVIEW

Alberto Hernandez, production worker, age 22, was fatally injured on April 11, 2006, when a skid steer loader backed over him. The victim was tightening field fence wire with pliers to secure stone to a pallet, when the skid steer loader backed over him.

The accident occurred because operating procedures were inadequate and did not ensure that pallets were placed away from the established haulage roadway so miners could safely work on them. A risk assessment to identify and eliminate all possible hazards was not conducted before starting the task.

GENERAL INFORMATION

1845 Texas Stone Products, Inc., a surface mine and mill, owned and operated by 1845 Texas Stone Products, Inc., was located about 10 miles south of Lometa, Lampasas County, Texas. The principal operating official was William B. Davis, president. The mine operated one 10-hour shift, 5 days a week. Total employment was 42 persons.

Sandstone was mined from the quarry using front-end loaders and a track backhoe. Portions of the mined stone were sized with hammers in the quarry, loaded in metal boxes, and transport by front-end loader to the shipping storage area. The larger stones were transported to the mill rock saws for sizing. These stones were further sized with hammers and/or rock choppers and palletized for shipment. The finished products were sold to customers as dimension stone.

The last regular inspection at this operation was completed on March 2, 2006.

DESCRIPTION OF THE ACCIDENT

On the day of the accident, Alberto Hernandez (victim) reported for work at 7:00 a.m., his normal starting time. He and Arturo Mayo, production worker, continued the process of palletizing sawn patio stones, a task they had started the previous day.

In the morning, Alberto Hernandez and Mayo palletized three pallets of stone. They placed the pallets adjacent to the stone storage area and stacked the sawn stones on the pallets, trimming the stones to fit within the 40 - 48 inch area dimensions of the pallets. Two piles of excess trimmed material were piled on the ground opposite the side of the pallet from the storage area. Twelve layers of stone were stacked on the pallets. Field fence, that had 4 inch by 12 inch openings, was wrapped around the stones. The ends of the fence were twisted together to secure it.

At noon, Alberto Hernandez and Mayo took their lunch break and then returned to the mill area to continue palletizing the patio stone. Mayo took a pallet and laid it on the

ground between the piles of trimmed stone and the stone storage area. Alberto Hernandez moved the pallet to the other side of the trim piles adjacent to the haulage roadway to the 72-inch rock saw. A few patio stones from the storage area and the remaining stones from the two trim piles were stacked on the pallet. They wrapped the field fence around the stones and secured the ends. Mayo took the remaining roll of field fence to the storage area by the rock chopper.

Pedro Gonzales, 72-inch saw operator, signaled to Juan Hernandez, operator, who was operating the skid steer loader, to pick up a sawn end piece of reject stone. Juan Hernandez traveled by the palletizing operation and picked up the reject stone with the loader's forks. He then backed the loader out of the area.

At approximately 2:10 p.m., Alberto Hernandez was tightening the fence wire on the side of the pallet adjacent to the haulage roadway. Mayo, who had returned to the work area, was picking up the remaining trim pieces to move them to the storage area. He heard a cracking sound, looked to his left, and saw the right rear wheel of the skid steer loader on the victim's chest. Mayo yelled to the operator, who pulled forward.

Mine personnel administered first aid until local emergency medical personnel arrived a short time later. The victim stopped breathing and all attempts to resuscitate him failed. He was pronounced dead at the scene by the county justice of peace. Death was attributed to blunt force injuries.

INVESTIGATION OF THE ACCIDENT

MSHA was notified at 5:40 p.m. on April 11, 2006, by a telephone call from Christopher (Shawn) Webb, general manager, to Ralph Rodriquez, supervisory mine safety and health inspector. 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 miners. MSHA's accident investigation team traveled to the mine, made 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 and the employees.

DISCUSSION

Location of the Accident

The accident occurred outside of the mill building near the sawn patio stone storage area. The ground was generally flat with dry conditions. Visibility was good with clear skies.

Skid Steer Loader

The skid steer loader involved in the accident was a Case, Model 95XT, manufactured in 1999. A four-cycle 74 horsepower diesel engine powered the loader. The power train was a hydrostatic type drive with 2 speed motor planetary reduction and sprocket chain to drive all four wheels. The right and left hand control levers were the travel/steering and lift/tilt controls. Tires were non-pneumatic size 33 X 6 X 11. The brakes were dry disc, spring applied, and hydraulic release. The loader was equipped with a backup alarm. The basic machine operating weight with the pallet fork attachment was 9,336 pounds.

All safety devices and controls were tested and found to be functional. When tested the back-up alarm was clearly heard above the surrounding noise.

Training and Experience

Alberto Hernandez had 39 weeks mining experience, all at this mine. He had received training in accordance with 30 CFR, Part 46.

ROOT CAUSE ANALYSIS

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

Root Cause: Operating procedures were inadequate and did not ensure that pallets were placed away from the established haulage roadway so miners could safely work on them. A risk assessment to identify and eliminate all possible hazards was not conducted before starting the task.

Corrective Action: Procedures should be implemented to ensure that pallets are placed away from the established haulage roadway so miners can safely work on them. A risk assessment to identify and eliminate all possible hazards should be conducted before starting the task.

CONCLUSION

The accident occurred because operating procedures were inadequate and did not ensure that pallets were placed away from the established haulage roadway so miners could safely work on them. A risk assessment to identify and eliminate all possible

hazards was not conducted before starting the task.

ENFORCEMENT ACTIONS

Order No. 6258238 was issued on April 11, 2006 under provisions of Section 103(k) of the Mine Act:

A fatal accident occurred at this operation on April 11, 2006, when a miner was run over by a Case 95XT skid steer loader, while twisting fence wire on a pallet of patio rock. This order was issued to assure the safety of all persons at this operation. It prohibits all activity around the skid steer loader and adjacent pallet of sawn patio stone until MSHA has determined that it is safe to resume normal operations. The mine operator shall obtain prior approval from an authorized representative for all actions to recover and /or restore operations to the affected area.

This order was terminated April 13, 2006. The equipment and the area were found to be safe and normal mining operation could resume.

Approved by: Date:

Edward E. Lopez
District Manager

APPENDIX A

PERSONS PARTICIPATING IN THE INVESTIGATION

1845 Texas Stone Products, Inc.

William B. Davis	president
Christopher S. Webb	general manager
Matthew W. Simmons	supervisor

McCathern Mooty LLP

Jennette E. DePonte	attorney

Trans Con Investigations LP

Edward Brady	investigator

Mine Safety and Health Administration

Daniel J. Haupt	supervisory special investigator
Jerry Y. Anguiano	mine safety and health inspector