



SEP 16 2013

MEMORANDUM FOR NEAL H. MERRIFIELD

Administrator for Metal and
Nonmetal Mine Safety and Health

FROM:

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SUBJECT: Fatality Review Committee Decision on Chargeability

Case No.: 2012-M-30 [REDACTED]

Deceased: [REDACTED]

Date of Incident: October 03, 2012

Date of Death: October 03, 2012

Operator: Pacific Northwest
Aggregates, Inc.

Mine: Avery Pit

Decision: Not chargeable

In a unanimous decision, the Fatality Review Committee has determined that the death of [REDACTED] should not be charged to the mining industry. [REDACTED], [REDACTED] was discovered unconscious and pulseless in the road grader he was operating which was stuck on a pile of rocks. The engine was running and the rear wheels were spinning. Co-workers began CPR but he was pronounced dead on the scene by the coroner.

The State of Washington death certificate indicated that [REDACTED] died from electrocution in that the "left hand contacted electrical source." The autopsy report listed the cause of death as "cardiac effects of electrocution." The autopsy report also listed hypertensive heart disease as a significant finding, and the manner of death as "accident."

The MSHA investigation included two on-site assessments by electrical engineers from the MSHA Mine Electrical Systems Division. The road grader, electrical installations, and a portable welder were all inspected for deficiencies that could have caused an immediate fatal injury to the victim. The investigators did not find any exposed power lines, cables, or electrical connections on the road grader or any other area checked at the mine site that was capable of electrocuting [REDACTED]. Early in the investigation, MSHA learned that the coroner's initial ruling was that the victim received a fatal electrical shock. The MSHA investigators returned to the accident scene to try to determine if any electrical hazards were present at the time of the death. The investigators found through interviews that the victim had been welding for 3 days at the plant and the burns may have been consistent with welding activity. The victim had burns on the palms of both hands, the back of his left hand and on his left forearm. MSHA investigators checked the batteries in the road grader and no defects were found. The investigators determined that when [REDACTED] was found, his left hand had been laying on a rheostat controller on the heater in the grader. The heater was capable of producing heat up to about 300 degrees Fahrenheit which may have contributed to the burn marks found. MSHA's report concludes that there were no source of electrical power that could cause an electrocution in the area where [REDACTED] was found.

Reviewing the investigators' negative findings and in consultation with the physician assigned as a member of MSHA's Fatality Review Committee, the investigation team and other MSHA employees participated in discussions to share all of the known information with the physician. Based on the investigators' negative findings from the accident scene and interviews, and after consultation with the physician from the MSHA fatality review committee, the conclusion of the MSHA accident investigation team was that the victim did not die as a result of an electrical accident.

Based on this evidence, the members of MSHA's Fatality Review Committee concluded that [REDACTED] died due to natural causes and that his death should not be charged to the mining industry.

cc: Joseph A. Main
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