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Federal Mine Safety and Health Review Commission
Office of Administrative Law Judges

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), PETITIONER	CIVIL PENALTY PROCEEDING Docket No. CENT 87-2-M A.C. No. 29-00159-05516
v.	Tyrone Mine & Mill
PHELPS DODGE CORPORATION ÄTYRONE BRANCH, RESPONDENT	

DECISION APPROVING SETTLEMENT

ORDER TO PAY

Before: Judge Merlin

This is a civil penalty proceeding arising under the Federal Mine Safety and Health Act of 1977 (Act). 30 U.S.C. 801 et seq. The Secretary of Labor, charged the operator, Phelps Dodge Corporation, with a violation of 30 C.F.R. 56.16001. The violation was issued as a result of an accident in which one man was killed and another seriously injured.

On April 27, 1987, the parties submitted a motion to approve a settlement in the amount of $192 which was the originally assessed amount.

On May 6, 1987, I issued an order disapproving the recommended settlement, explaining why the recommendations of the parties could not be accepted. 9 FMSHRC 920 (May 1986).

On June 2, 1987, at the request of counsel, a telephone conference call was held. Counsel advised that they had attempted to address the concerns expressed in the disapproval of settlement and requested permission to submit a revised settlement motion. I granted the request.

On June 19, 1987, the parties submitted the revised motion seeking approval of a settlement in the amount of $3,840.

Thereafter, on June 25, 1987, pursuant to counsels' request, another telephone conference call was held to discuss the revised motion. I advised that most of the proposed findings and conclusions were acceptable, but stated that based upon MSHA's Accident Investigation Report, and other materials of record, a finding of "low negligence" was not acceptable. Counsel

requested permission to submit another settlement motion, which request was granted.

On July 7, 1987, a third motion was submitted which proposed a settlement of $5,000. After a review of this motion, I am satisfied that the recommended findings and conclusions set forth therein are in accordance with the record and that the settlement amount satisfies the requirements of the Act.

The subject Citation, No. 26620005, dated January 8, 1986 describes the condition as follows:

> Two employees of an independent contractor were seriously injured on November 25, 1985, and one died on December 19, 1985, when a bundle of three, 12 inch by 45 feet long pipe that were banded together slid from a stack and pinned the victims between pipe on the ground they were attempting to put a choker on, and the falling bundle. The pipe had been stacked about one week prior to the accident by an employee of the production-operator in a manner that contributed to a fall of material hazard in that the south stack of five bundles of pipe had three pipe in the bottom bundle, three pipe in the next bundle and four pipe in the top three bundles, resulting in a total height of approximately 5 1/2 feet. The top bundle of four pipe in the south stack apparently slid to the north and pushed the three pipe off the north pile onto the victims.

The mandatory standard, 30 C.F.R. 56.16001, requires that:

> Supplies shall not be stacked or stored in a manner which creates tripping or fall-of-material hazards.

The MSHA Accident Investigation Report sets forth these facts: Phelps Dodge Corporation contracted with Hamilton Western Construction Company, Inc., to install a 6,000ÄfootÄlong 12Äinch dewatering pipeline. This arrangement required that Hamilton Western lay the pipeline in accordance with a provided design while Phelps Dodge was to provide, among other items, the plastic pipe specified. Phelps Dodge purchased the required pipe which was delivered to the mine-site by common carrier. As in previous deliveries, the pipe was received by Phelps Dodge warehousing personnel who unloaded the pipe with a Phelps Dodge forklift. The pipe was unloaded and stacked at a predetermined location ahead of the approaching pipeline construction. The pipe in question was delivered and unloaded on November 12, 1985, thirteen days before the accident. A total of 49 pipes was de

livered packaged in seven 3Äpipe and seven 4Äpipe bundles. The pile nearest the pipeline contained three 4Äpipe bundles overlain by two 3Äpipe bundles (north stack). Abutting this pile on the south was a 22Äpipe pile consisting of two 3Äpipe bundles on top of which were stacked four 4Äpipe bundles (south stack). This pile was inherently unstable since the base bundles were 12 3/4 inches narrower than the width of 16 pipe lengths it supported. During preceding pipe-laying activity, pipe bundles were reportedly stacked only 2 or 3 units high (approximately 43.5 inches). On this occasion, however, the bundles were stacked 6Ähigh (87 inches). The crew, therefore, was faced with a significantly different set of physical conditions. The pipeline construction crew consisted of a crane operator and two laborers. They had previously received their work assignment and proceeded to the jobsite without their supervisor's presence. The crane operator moved a cherry picker into hoisting position as the first laborer readied the fusion equipment. The crane operator began cutting the steel-securing bands of the top 3Äpipe bundle of the south stack nearest the crane. He cut 5 of the 6 bands and, positioning himself in the clear, cut the last band. This allowed the 3Äpipes to fall to the ground on the south side of the steel service pipeline. He then obtained hoisting slings while the second laborer positioned a dozer to drag fused lengths of pipe away from the fusion machine. As the crane operator was attaching the hoisting sling to the first pipe on the ground, the remaining 3Äpipe bundle of the north stack slid to the ground landing on top of him and pinning the second laborer's right leg against the steel service pipeline. Apparently at the same time the top 4Äpipe bundle of the south stack also slid off to the north and across the pipe bundle lying atop the crane operator. Twenty-four days later the crane operator died of his injuries. The second laborer suffered a broken leg.

The Accident Investigation Report described the cause of the accident in this manner:

> The direct cause of this accident was the failure to recognize the instability of the irregularly stacked pipe bundles.
>
> Possibly contributing to this accident was the fact that the crew members were not accustomed to working with pipe piled higher than 2 or 3 bundles. In this accident the bundles were stacked 6Ähigh. The light rainfall of the past night may have created even greater pile instability; wet plastic pipe presents a very slippery surface.

The most recent settlement motion analyzes the cause of the accident as follows:

> Both the citation and the investigation report identify as a cause of the accident the manner in which the pipes were stacked. While these statements were made, the only apparent problem with the stacking of the pipe was that the south stack of pipes consisted of two 3Äpipe bundles on top of which were stacked four 4Äpipe bundles. The apparent problem was mitigated by the established and usual procedure of Hamilton in removing the top bundle of pipe from the stacks first. By removing the highest bundle first any problem with undercutting the support of bundles at a higher elevation would be eliminated. Hamilton's employees failed to follow this procedure when they removed the fifth bundle from the north stack before they removed the sixth bundle from the south stack. Had Hamilton's employees followed this procedure the hazardous condition would have been minimized and in all likelihood eliminated. The apparent problem with the stacking of the pipe was further mitigated by the fact that there was no shifting of the pipe between the second row (3Äpipe bundle) and the third row (4Äpipe bundle) of the south stack. Rather the movement of pipe occurred between the fifth and sixth stacked bundles and then the fourth and fifth stacked bundles of the south stack. The apparent problem with the stacking of the pipe was effected by considerable mitigating circumstances.

During the first conference call I inquired about the liability, if any, of the independent contractor. The settlement motion advises in this respect:

> Hamilton, the independent contractor, was not issued a citation even though the accident would not have occurred had its employees removed the top or sixth bundle from the south stack before removing the fifth bundle from the north stack in accordance with the usual procedure. However, the Mine Safety and Health Administration was unable to determine that the contractor Hamilton violated any mandatory standard applicable to the conditions.

The fact that the independent contractor was not cited does not, of course, increase the operator's liability with respect to the acts for which it is responsible. Nor does it affect

a determination as to what constitutes an appropriate penalty in this proceeding. However, in light of the inability to cite the independent contractor in this case, the Secretary may wish to re-examine the relevant mandatory standards.

I find that the accident had multiple causes, one of which was the way the operator stacked the pipes. Another was, as the parties represent, the way in which the independent contractor removed the pipes. Based upon the record and in light of the representations of the parties, I conclude that the occurrence was extremely serious and the operator was negligent. In addition, the operator's size is large; its history of violations is small; imposition of the recommended penalty will not affect ability to continue in business; and there was good faith abatement.

In light of the foregoing, the recommended settlement is APPROVED and the operator is, if it has not done so already, ORDERED TO PAY $5,000 within 30 days of the date of this decision.

Paul Merlin
Chief Administrative Law Judge