MNM Fatal 2009-13

Machinery Accident
July 2, 2009 (Pennsylvania)
Dimension Stone Operation
Mine Owner
52 years old
34 years of experience

Overview

The victim was working alone and was cutting stone on top of a bench using a walk-behind concrete saw. Apparently, he was operating the saw near the edge of the bench when he tripped and fell. The victim and the saw went over the 9-foot ledge and the saw fell on him.

The accident occurred because management failed to ensure that a berm or barrier was installed along the highwall edge to prevent a fall of person or machinery from the bench.



Root Cause

<u>Root Cause:</u> No procedures were in place for persons to safely operate a walk behind concrete saw on an elevated bench where there was a hazard of falling. No berms or guardrails were provided and maintained along the edge of the bench where a nine foot drop off existed.

<u>Corrective Action:</u> The victim was a sole proprietor and; therefore, the business terminated at the time of his death. Consequently, no corrective action was taken.

Best Practices

- Identify all hazards and use appropriate controls to protect persons.
- Ensure that operators are in a safe position and have control of their equipment at all times.
- Keep workplaces free of tripping hazards.
- Use barricades or railings at edges of drop-offs where persons are in danger of falling.
- Equip walk behind masonry saws with devices to stop the engine if the operator can not maintain control of the equipment.
- Design bench top stone cutting patterns so the saw operator is not positioned between the saw and the drop off edge.