

MNM Fatal 2011-10

- Fall of Person Accident
- September 23, 2011 (New York)
- Sand & Gravel Operation
- Plant Operator
- 32 years old
- 10 years of experience

Overview

The victim was killed when he fell from a screen deck work platform 56 feet to the ground below. He was standing on two steel clamping bars that had been placed between the midrail of the protective rail surrounding the screen deck work platform and the screen structure to create a step. He stood on the step to reposition a screen. He was positioned above the confines of the protective railing when he slipped and fell.

The accident occurred because management policies, procedures, and controls did not ensure that persons could safely perform maintenance on the secondary screen tower. Routine maintenance required that the screens be replaced periodically. The height of the opening for the screen being replaced was 64 inches from the work platform, making it difficult for persons to gain the leverage necessary to safely remove the screen. No procedures had been established to ensure that persons could safely reach the elevated screen from the provided work platform. To gain the needed leverage on the screen, the victim had to be positioned above the protective railing on the screen deck work platform. He was not wearing a safety belt and line where there was a danger of falling. The victim's fall protection was attached to a man lift that had been used earlier to lift the screens to the elevated platform.



(Accident scene re-constructed)

Root Cause

Root Cause: The accident occurred because management policies, procedures, and controls did not ensure that persons could safely perform maintenance on the secondary screen tower. The victim was having difficulty gaining the leverage necessary to remove the screen. To gain the needed leverage on the screen, he had to be positioned above the protective railing on the screen deck work platform. He was positioned above the protective railing on the screen deck work platform and was not wearing a safety belt and line where there was a danger of falling.

Corrective Action: Management established a written Job Safety Analysis (JSA) for the task of changing screens and trained all persons regarding these safe procedures. The mine operator also trained all persons in the use of fall protection where there is a danger of falling.

Best Practices

- Establish and discuss safe work procedures. Before starting any work, identify and control all hazards.
- Train all persons to recognize and understand safe job procedures, including the purpose of fall protection barriers and the proper use of fall protection.
- Always use fall protection when working where a fall hazard exists.