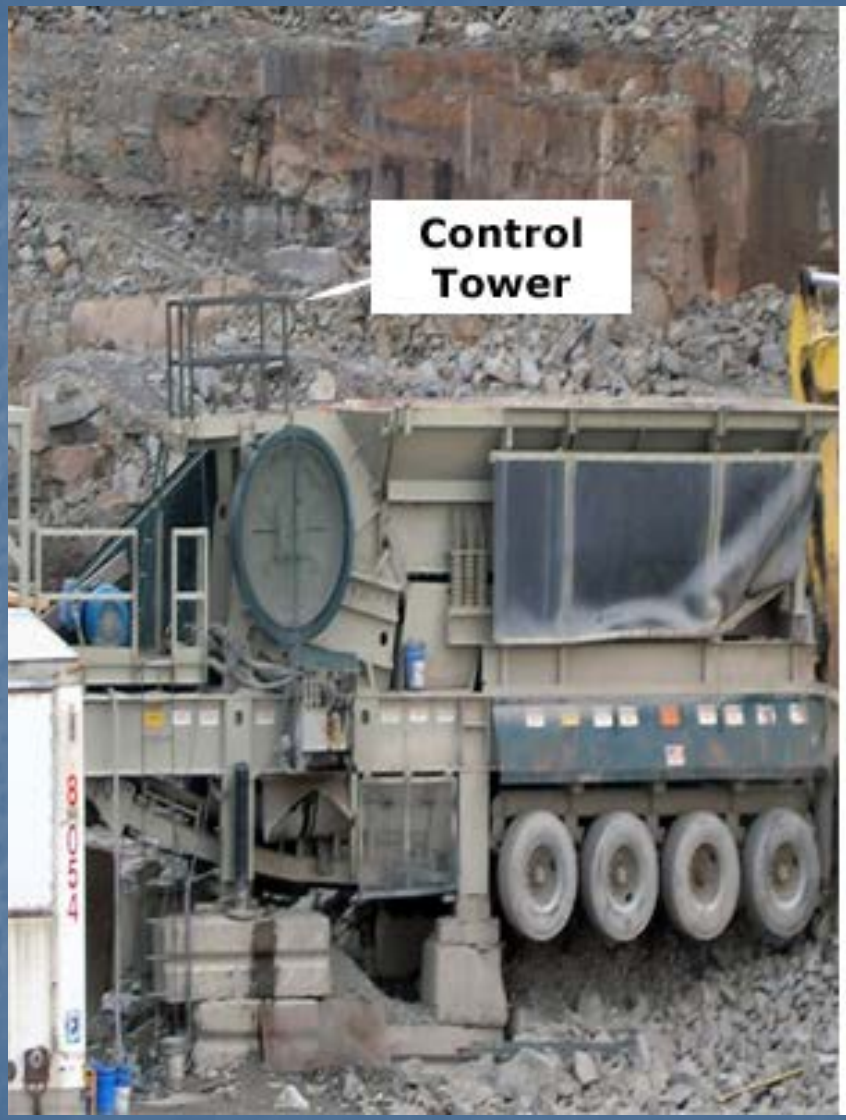
MNM Fatal 2011-16

- Machinery Accident
- December 15, 2011 (Pennsylvania)
- Crushed Stone Operation
- Crusher Feed Controller
- 22 years old
- 14 weeks of experience

Overview

The victim was killed when he fell into an operating jaw crusher. He was last seen standing on the viewing platform. He apparently climbed over the railing of the platform to access the vibratory feeder to clear jammed material close to the opening of the crushing chamber.

The accident occurred due to management's failure to establish policies and procedures ensuring the safety of persons working near the jaw crusher. The jaw crusher was not de-energized, locked and tagged out, and blocked against motion prior to persons performing work around the feed opening. Procedures were not established to ensure that persons could safely access the feeder from the viewing platform or ground level. To access to the feeder, the victim had to climb out from the protective railing system, on the provided platform, and cross the jaw feed opening to reach the feeder deck. Additionally, he had only 14 weeks of experience and did not receive training in accordance with 30 CFR Part 46.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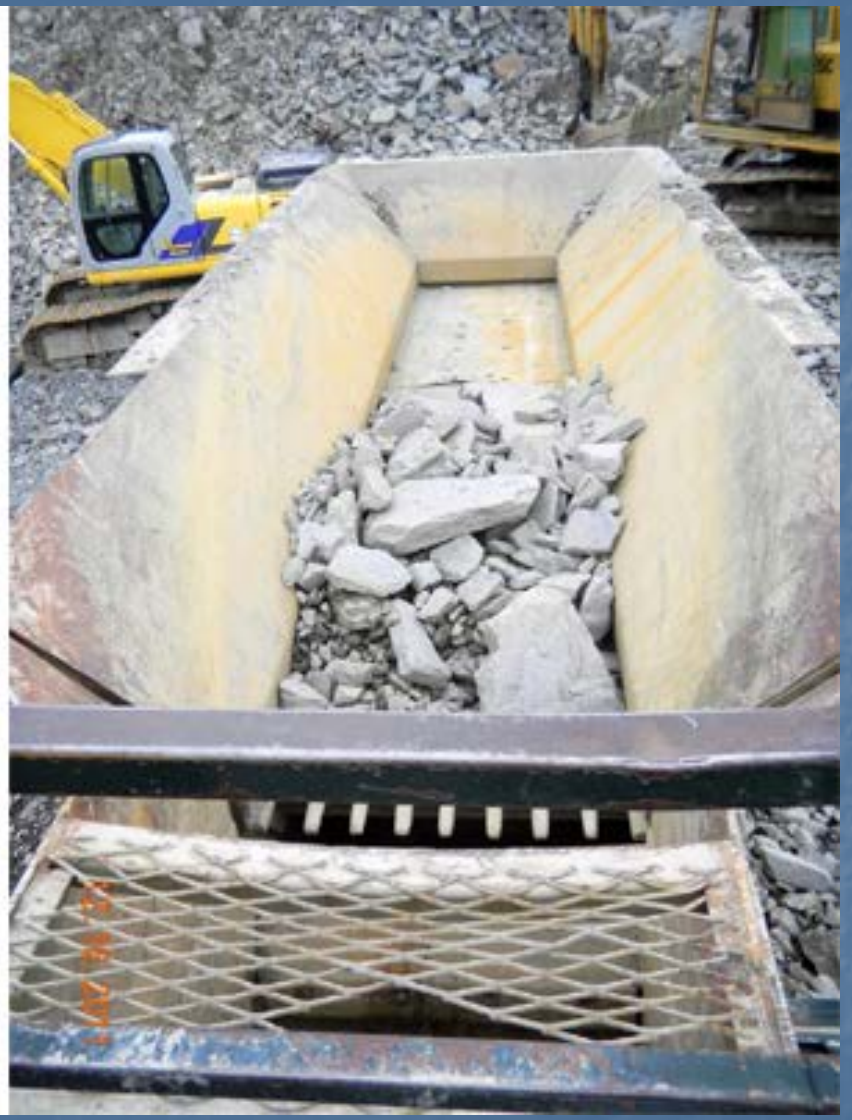

Root Causes

Root Cause: *A risk assessment was not conducted to identify potential hazards and establish safe procedures prior to performing inspection, maintenance, or tasks such as clearing jammed material on the jaw crusher.*

Corrective Action: Management implemented a policy requiring risk assessments/JSAs to be conducted prior to performing maintenance or other tasks on the crushing plant. The policy requires persons to identify potentially hazardous conditions. Procedures will be established to safely complete the task.

Root Cause: Management failed to ensure policies and procedures were in place to safely perform maintenance or other tasks on the jaw crusher. The victim left the confines of the protective railing system on the platform to access the areas adjacent to the jaw feed opening. Safe access was not provided or maintained to safely access the area.

Corrective Action: Management established written policies, procedures, and controls to ensure that:

1. Crushing plants will be de-energized, locked and tagged out, and blocked against hazardous motion before work begins. The procedures address the hazards associated with the work to be performed.
2. A safe means of access will be provided to the feeder deck using a secured external ladder.

Root Cause: Management failed to provide adequate New Miner *and Task Training to the victim regarding tasks such as clearing a jammed crusher.*

Corrective Action: Management established a written plan for proper New Miner and Task Training. This training includes procedures ensuring persons can safely perform crusher inspection, maintenance, or other tasks. The proper documentation of the training will be provided.

Best Practices

- Always use fall protection when working where a fall hazard exists.
- Establish policies and procedures for safely clearing plugged material in a jaw crusher.
- Ensure that persons are task trained and understand the hazards associated with the work being performed.
- Deenergize and Lock-out/tag-out all power sources before working on crushers.
- Do not place yourself in a position that will expose you to hazards.
- Monitor personnel routinely to determine that safe work procedures are followed.