

MNM Fatal 2014-09

- Fall of Person
- February 27, 2014 (Iowa)
- Underground Limestone Mine
- Contract Mechanic
- 27 years old
- 3 years of experience

Overview

The victim was seriously injured at this mine on February 27, 2014. He was repairing a hydraulic pump on a scaler when he fell from an attached platform approximately five feet to the ground. He was airlifted to a hospital where he died on February 28, 2014.

The accident occurred due to management's failure to ensure the platform walkway on the scaler was free of slip, trip, and fall hazards. Johnston was not effectively protected from these hazards while working from the upper elevated work platform on the scaler.

The scaler had a multi-level platform system. The lower platform was originally constructed and installed by the manufacturer. The upper platform, constructed by the mine operator in June 2013, was affixed to the scaler at the engine compartment. The upper platform was framed in 2-inch wide angle iron and filled with grating for a walking surface. However, the grating wasn't flush with the top edges of the framing, leaving an approximate 1³/₄-inch high tripping hazard at the access point. This access point was not provided with a railing, barrier, or cover to prevent a person from a slip, trip, or fall hazard.

While outside handrails were provided on both platforms, they were not adequate in preventing a person from falling over the railing where the upper platform transitioned via a step to the lower platform. The handrail height, as a person was positioned at the step, was approximately 32 inches high.



Root Cause

ROOT CAUSE: Mine management failed to ensure that persons could safely work on the upper platform on the scaler. When the upper platform was constructed, mine management did not ensure that the grating was flush with the top edges of the framing, leaving an approximate 1¾-inch high tripping hazard at the access point that was not provided with a railing, barrier, or cover to prevent a person from a slip, trip, or fall hazard.

Additionally, outside handrails were provided on both platforms but were not adequate in preventing a person from falling where the upper platform transitioned via a step to the lower platform. The handrail height, as a person was positioned at the step, was approximately 32 inches high.

CORRECTIVE ACTION: Mine management modified the angle iron to eliminate the tripping hazard at the access point to the upper platform. Additionally, a chain was placed across the opening access as a barrier to prevent persons from falling from the upper platform. The railing on the platform was also modified by adding an additional section at the transition points between the upper and lower platforms.

Best Practices

- Ensure that persons are trained, including task-training, to understand the hazards associated with the work being performed.
- Establish and discuss safe work procedures before beginning work. Identify and control all hazards associated with the work to be performed and use methods to properly protect persons.
- Conduct work place examinations before beginning any work.
- Do not place yourself in a position that will expose you to hazards while performing a task.
- Ensure effective gates, safety chains, or railings are used and properly maintained where openings may exist that could pose a hazard.