MNM Fatal 2014-20

- Fall of Person
- October 10, 2014 (Pennsylvania)
- Cement Operation
- Truck Driver
- 66 years old
- 11 years of experience

Overview

The victim was killed at a cement operation. He was standing inside a loading rack safety cage attempting to close the center hatch on top of a bulk tanker truck. He was unable to close the hatch due to the position of the truck's trailer. The fill port on the trailer was not centered within the confines of the safety cage. Consequently, he had to raise the safety cage to access the hatch. After the victim raised the safety cage, he tripped and fell through the opening, between the raised safety cage and the rounded side of the tanker truck, approximately 11 feet to the ground below.

The accident occurred due to mine management's failure to establish procedures to ensure that truck drivers properly align the bulk tanker trucks under the loading rack at close hatch station No. 1 in order to safely close the hatch on the trucks. In addition, contract management failed to have policies in place to ensure that truck drivers used fall protection where there was a danger of falling from performing work on top of bulk tanker trucks at the plant.

Root Causes

Root Cause: Mine management failed to establish procedures to ensure that truck drivers properly align the bulk tanker trucks under the G4 SafeRack system at close hatch station No. 1 in order to safely close the hatch on the trucks.

Corrective Action: To ensure proper alignment of bulk tanker trucks, mine management installed cement barriers and painted delineating lines along the roadway leading to close hatch station No. 1. In addition, overhead cameras have been installed at close hatch stations No. 1 and No. 2, complete with video display monitors, to enable truck drivers to view the top hatch and properly position their trucks under the G4 SafeRack system. Multilingual warning signs have also been posted at the scale house and bulk load out station exits to warn truck drivers of the hazards associated with misalignment of bulk tanker trucks.

Root Causes

Root Cause: Contract management failed to establish policies requiring their truck drivers to wear fall protection when there was a danger of falling from performing work on top of bulk tanker trucks at the plant.

Corrective Action: Contract management established a written policy and safe work procedures, including the use of fall protection when there is a danger of falling from performing work on top of bulk tanker trucks at the plant. All contract truck drivers were trained in these new policies and procedures.

Best Practices

- Establish traffic patterns to ensure safe alignment of vehicles with access equipment.
- Identify and control all hazards associated with the work to be performed and use methods to properly protect persons.
- Ensure that persons are trained, including task-training, to address the hazards associated with the work being performed.
- Always use fall protection when working where a fall hazard exists.
- Always be aware of your surroundings and any hazards that may be present.