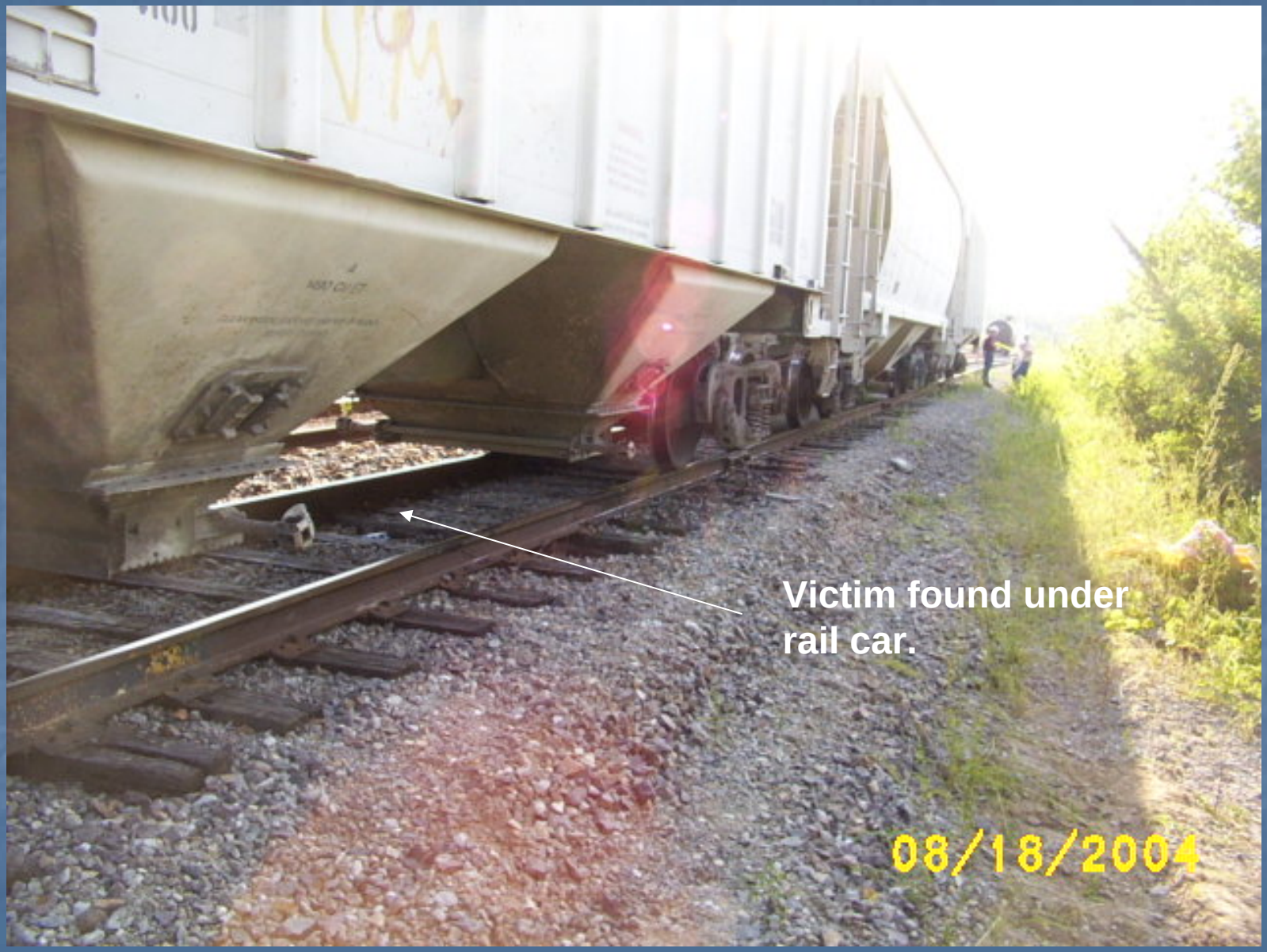
MNM Fatal 2004-15

- Powered Haulage
- August 18, 2004 (Missouri)
- Cement Operation
- Deck Hand Helper
- 50 years old
- 9 years experience

Overview

- The victim was helping the locomotive operator reposition rail cars in the plant rail yard when he was struck by moving railcars.

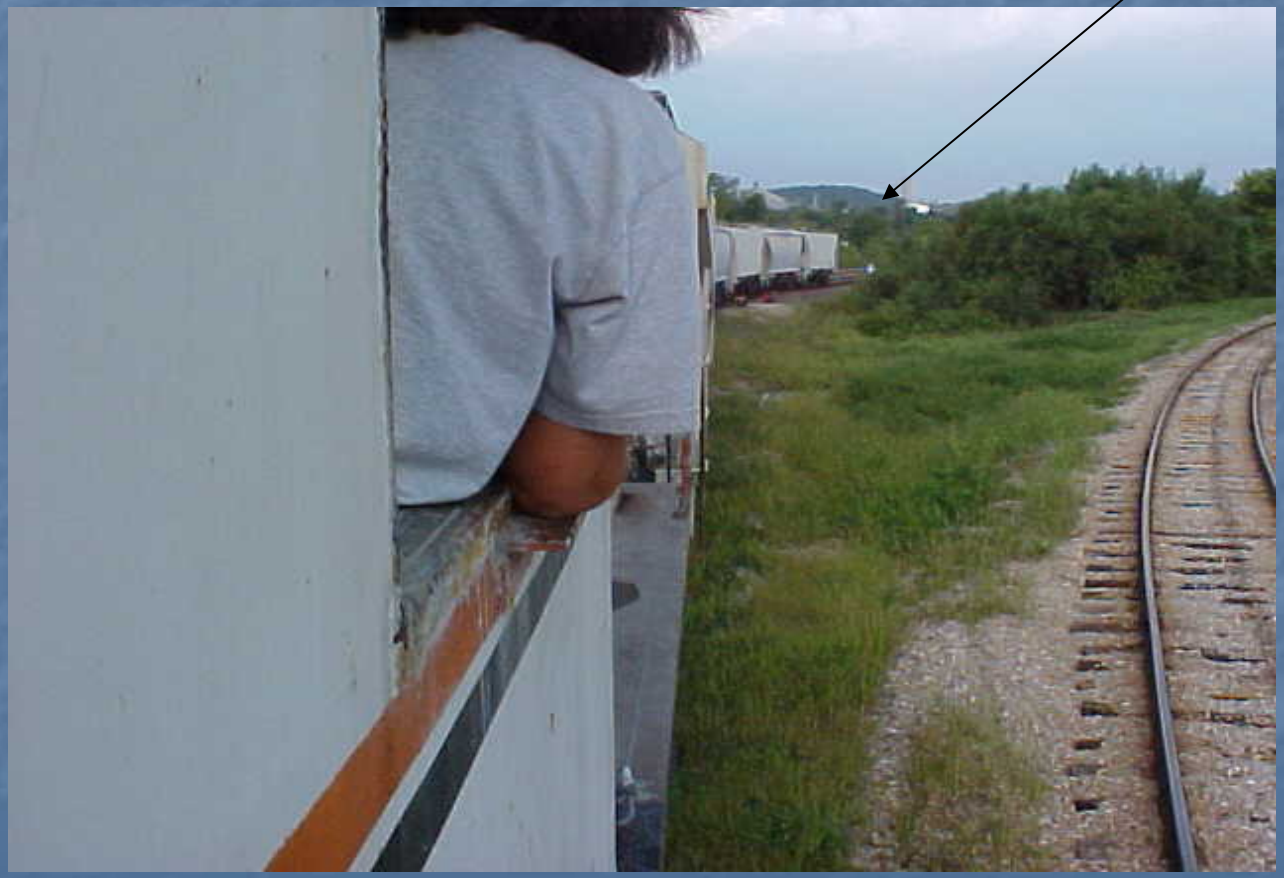

Victim found under
rail car.
08/18/2004

Front view of rail car involved in the accident

Why Did Accident Occur?

- Safe work procedures had not been established to guide miners who were assigned to move railcars. The locomotive operator and the victim did not maintain visual contact or have some system to communicate with each other.

View from operator's compartment



Causal Factors

- Management policies, standards, and controls were inadequate and failed to implement safe work procedures to ensure that miners were protected from hazards when working near moving railcars. Personnel assigned to this task were not monitored periodically to ensure safe procedures were followed.

Causal Factors

- Neither visual contact nor communication was maintained between employees who were moving railcars. The locomotive operator continued to push the railcars onto the inbound track even though the victim was no longer in view.

Best Practices

- Miners need to discuss the job tasks and identify any potential hazards (conduct a risk analysis) before beginning any work. Identify safe work procedures and take action to eliminate any hazards.
- Train all personnel assigned to operate mobile equipment regarding the safe work procedures and the hazards associated with the job tasks.

Best Practices

- Position yourself in a safe location where you are not exposed to hazards.
- Utilize radios to communicate when visual contact can not be maintained.
- Monitor personnel routinely to determine that safe work procedures are followed.