

MNMM Fatal 2006-02

- Machinery
- January 27, 2006 (Oregon)
- Crushed Stone Operation
- Heavy Equipment Operator
- 60 years old
- 10 years mining experience

Overview

The victim was fatally injured when the dozer he was operating backed over the edge of a highwall and fell approximately 50 feet. The dozer landed in mud and water which had accumulated on the level below.



Root Causes

- Standards and controls were inadequate and failed to require auxiliary lighting to be installed when work was performed near elevated areas during darkness.
- Controls were inadequate and did not ensure the operator of the dozer wore his seat belt when operating the equipment.

Best Practices

- Stop, Look, Analyze, and Manage (SLAM) each task to identify all potential hazards before performing work.
- Maintain and wear seat belts when operating machinery.
- Always keep the blade between yourself and the edge of the highwall when operating a dozer on the highwall bench.

Best Practices

- Operate equipment so that control is maintained.
- Reduce the throttle position and know how to immediately stop the dozer when working near the edge of the highwall.
- Provide adequate illumination when work is performed during non-daylight hours.