REMEDIATION MANAGEMENT
HSSE
Lessons Learned One-Pager

Type of Incident: Medical Treatment Shoulder Injury
Business Unit: Remediation Management – US Mining
Location of Incident: Yerington Mine Site, Yerington, NV
Date/Time: October 16, 2013, 08:00 am

Brief Account of Incident: While walking through a congested work area, a Site O&M Technician tripped and fell to the floor, receiving a contusion and shoulder strain injury. The injured party (IP) was gathering fire extinguishers to bring to a centralized area for annual inspection. One fire extinguisher was located in the corner of a building near the closed roll-up door. When he arrived at the location, he discovered that a drilling subcontractor had recently filled the area with well construction supplies resulting in restricted access to the fire extinguisher. The IP made the decision to attempt to walk across the congested area by stepping on a cardboard box which collapsed or shifted, lost his balance and fell forwards to ground level, striking his shoulder on a nearby steel pipe.

Outcome: A medical incident intervention case was initiated immediately following the injury and the IP received first aid consultation from a nurse. Based on the described injuries, it was determined that medical evaluation by a physician was not required at the time, but the IP should take over-the-counter pain reliever and apply ice to the injured shoulder. The condition and recovery of the IP was monitored during the following days and it was apparent that the bruising was healing; however, he was still experiencing significant restriction in the range of motion of his arm and shoulder. The decision was made to send the IP to an occupational physician for further evaluation. X-rays confirmed that there was no damage to the bones, however the physician recommended a course of physical therapy to help the IP recover range of motion. Physical therapy is defined as medical treatment under OSHA recordkeeping requirements and the injury was reclassified as OSHA recordable.

What Went Well:
The incident was promptly reported by the IP which allowed implementation of medical case management procedures. The case management process provided an appropriate initial assessment but, through continued monitoring of the IP, the recommendation was modified and additional treatment was sought when it was apparent the IP was not healing quickly.

What Went Wrong:
The IP did not use his Stop Work authority to modify his work task when he identified a housekeeping and tripping hazard. Rather than find an alternate safe walking route or delay the task until the area could be cleaned up, he made the decision to walk through an area with insufficient walking surface. Poor housekeeping or staging of supplies was identified as the root cause that created the tripping hazard in the first place. The subcontractor had staged material in a way that did not provide sufficient walking access through the area and blocked access to the fire extinguisher in that part of the building. At the time they were placing materials in this area, access was through the open roll-up door and from their perspective there was not an obvious access issue.

Immediate Causes:
8.1 –Workplace layout/congestion. Materials had recently been stored in this area and designated aisle space was not provided.
4.1 – Lack of focus or inattention, distracted by other concerns. The worker felt a sense of urgency (self imposed) to complete the task because another person was waiting for him to bring the fire extinguishers.

System Cause:
22.2 – Development of standards, practices & procedures not effective. Informal procedures had been developed designating areas available for storage of sensitive materials inside the building. Implementation of these procedures was ineffective because the subcontractor had stored some materials inside which could have been stored outside resulting in unnecessary congestion.
22.3 – Communications between different organizations not effective. Specific limitations of material storage requirements (i.e. aisle space, access to fire extinguishers, etc.) were not discussed as part of the procedure. The drilling subcontractor was allowed to stage their supplies with little/no communication with Site field staff.

Corrective actions:
- A housekeeping plan was immediately implemented and communicated, including developing improved communications methods for establishing subcontractor storage activities at the start of each project and assigning continued monitoring to the Project Field Manager.
- Enhance the safety observation program to complete more frequent safety observations with the goal of coaching workers to improve their recognition of hazards and things they can do to reduce the risks and make safer choices.
- Implement additional safety awareness tools to remind workers of the expectation of their active involvement in the safety program, their responsibility to stop work or make corrections when they see a potentially unsafe situation.

Lessons Learned:
1. Do not allow a sense of urgency to override the recognition of hazardous conditions or the correction of those hazards. This was a good opportunity to use Stop Work Authority.
2. Develop a material storage strategy with affected Site workers and subcontractors at the start of new projects and be sure to evaluate effectiveness and compliance as the project work continues.

If you have any questions, please contact Jack Oman, Remediation Management OPM at (714) 228-6774.