REMEDIATION MANAGEMENT
HSSE SHARED LEARNING
Shoulder Injury from Slip on Slope

Shared Learning: Shoulder Injury from Slip on Slope
Business Unit: Ops US Other Refining Non Mining E&P Chemical Lubs
Location of Technology Application: Retail Stations, Terminals, Bulk Plants, and Refineries

Brief Account of Shared Learning: An employee was traversing a sloped area on an angle (his left foot was higher in elevation than his right foot) when he slipped and fell landing on his left shoulder.

The sloped area is associated with the West Surge Pond which is used to store wastewater diverted to the site from the City of Wood River Publically Operated Treatment Works (POTW). URS was in the process of draining the West Surge Pond so a land survey could be conducted to verify the storage capacity of the pond. The pond is drained by placing a portable pump at the lowest elevation area in the pond, and the water is then pumped out of the surge pond, over the pond wall, and to the East Surge Pond. Prior to the date of the incident, the pumps had been turned on daily for approximately three to four hours per day for the previous two weeks.

On the day of the incident, the employee was making his daily rounds to check on various areas of the site. When he came upon the West Surge Pond, he noticed that the hose associated with the dewatering activities was not discharging water. The employee determined that the pump had not been turned on yet that morning and decided to turn the pump on while he was there. In order to turn the pump on, he decided to descend the slope to reach the pump even though the pump could likely have been reached via driving a vehicle to the pump location. The slope was muddy due to rain that had fallen in the past 36 hours. He was walking down the slope to check on the pump when he fell.

Slope where injury occurred

Actual Outcome:
A changed condition (rain caused slippery conditions on a slope) was not recognized and therefore not properly risk assessed, resulting in a slip resulting in an OSHA recordable.

What Went Wrong:
Employee failed to evaluate the risk of traversing on the slope with changed conditions within the assessment tool (WRAT) or TSEA, so proper engineering or administrative control mitigation factors were not identified. The training materials on work risk assessing were not recalled by the employee.

What Went Well:
Proper case management was conducted to ensure that all possible care was given to employee prior to final diagnosis.

What Improvements Were Made (Lessons Learned):
An inventory of sloped areas has been created and an administrative control has been implemented to cease work on slopes. The inventory will be used to identify needs for engineering controls (i.e., stairs, drive paths, etc.) Reinforcement training will be conducted on Work Risk Assessing, focusing on recognizing changing conditions.

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