Butte Priority Soils Side Dump Rollover

Investigation Lessons Learned Summary

Incident: Side Dump Rollover
Type of Incident: Near Miss/HSE Opportunity
Business Unit: Remediation Management
Location of Incident: Butte, Montana USA
Tr@ction No: 2013-IR-4567740
Date of Incident: November 6, 2013

Brief Account of Incident: While dumping a load of material, a side dump truck and trailer rolled over onto the passenger side of the equipment. No injuries occurred during the incident. The planned dump site was adjacent to a paved road. Due to limited entry/egress to the site, the first three side dump loads were planned to be dumped from the pavement and used to build an access road into the site where future loads would be dumped. After arriving at the site, the Side Dump Operator (SDO) conferred with the spotter who was also tasked with operating a skid-steer on the site to refine the placement of fill after it was delivered. The SDO then proceeded to drive the passenger side of his tractor-trailer onto the shoulder of the road as the spotter finished moving the traffic cones placed by the edge of the road. This was the SDO's first load of the day, but the second delivered to the site that morning; another SDO had delivered the first load to the site about thirty minutes earlier. As the SDO dumped the load of material, the truck and trailer started to become unstable. The SDO immediately tried to reverse the load and bring the trailer back down; however, the truck and trailer both rolled over onto the passenger side.

What Went Wrong: The truck was not positioned with all wheels on the pavement prior to dumping as identified in the pre-job meeting. A communication misinterpretation between the spotter and the SDO contributed to the load being dumped in the incorrect location.

What Went Well: Proper case management was conducted to ensure that the SDO was given appropriate medical care. In this case, the SDO was immediately transported to the Occupational Health Clinic identified in the HASP. The appropriate verbal notifications were also made in a timely manner within the SDO's company and within RM.

Lessons Learned: Guidance and/or procedures for spotter roles and responsibilities did not exist, and therefore were not understood. Communication between the driver and spotter was not effective. Stop work was not employed although questionable conditions were present. Verbal identification and communication of the hazards were performed; however, written documentation was lacking.

What Improvements Will Be Made: To ensure dumping from level terrain, the supplier practice for daily toolbox meetings will be modified to include a check of proper vehicle placement for each designated dump site including communication of the dump location and truck position.

Spotter's roles, responsibilities and training will be identified and documented in a new spotting SOP scheduled to be developed and implemented in 1Q2014. Instances when a spotter should be used to mitigate a hazard will be included in the SOP.

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