# Mosaic Esterhazy K3 – North Shaft Plank Incident

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# Mosaic Esterhazy K3 – North Shaft Plank Incident

Agenda

- Incident Overview
- Shaft Layout and Cage Slinging Bail Design
- Incident Investigation Findings
- Corrective Actions
- Key Messages
- Questions

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# Mosaic Esterhazy K3 – North Shaft Plank Incident Incident Review

**Mosaic Corporate Final Incident Notification**

**Date/Time of Incident**: July 20th, 2019

**Description of Event:**

- North Shaft crew was setting up to lower material within the Blair Cage Slinging Bail
- Control room supervisor noticed that the crew had placed a shaft plank across the full diameter of the shaft
  - Notified the hoist operator to immediately shutdown the Koepe (production) hoist that was currently in automatic mode.

- During the investigation of this incident, other safety infractions were discovered through the use of the camera system.
  - Violation of Mosaic's cardinal rule ( working at heights )
  - As a result of the potential, the incident was rated as a PSI.

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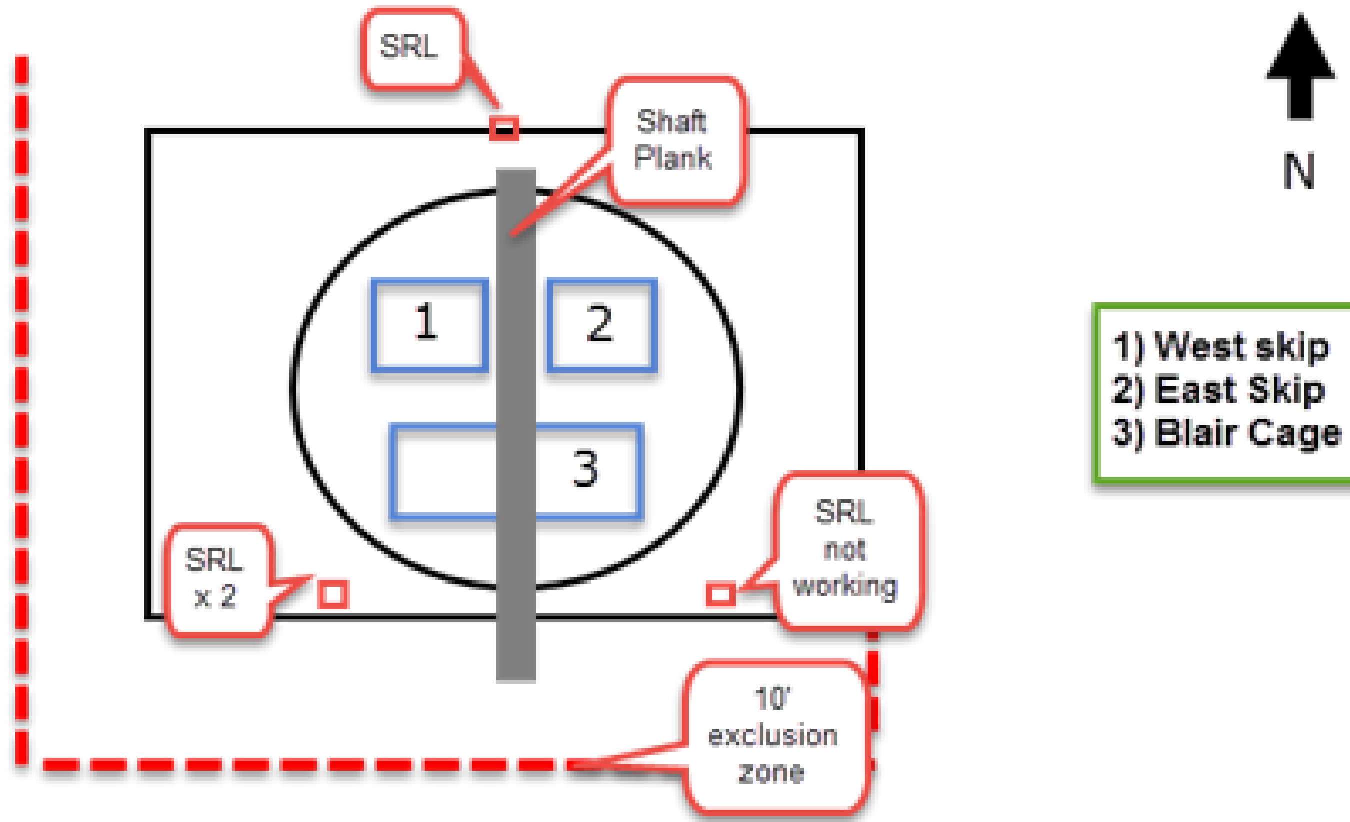
## Shaft Layout and Cage Slinging Bail Design



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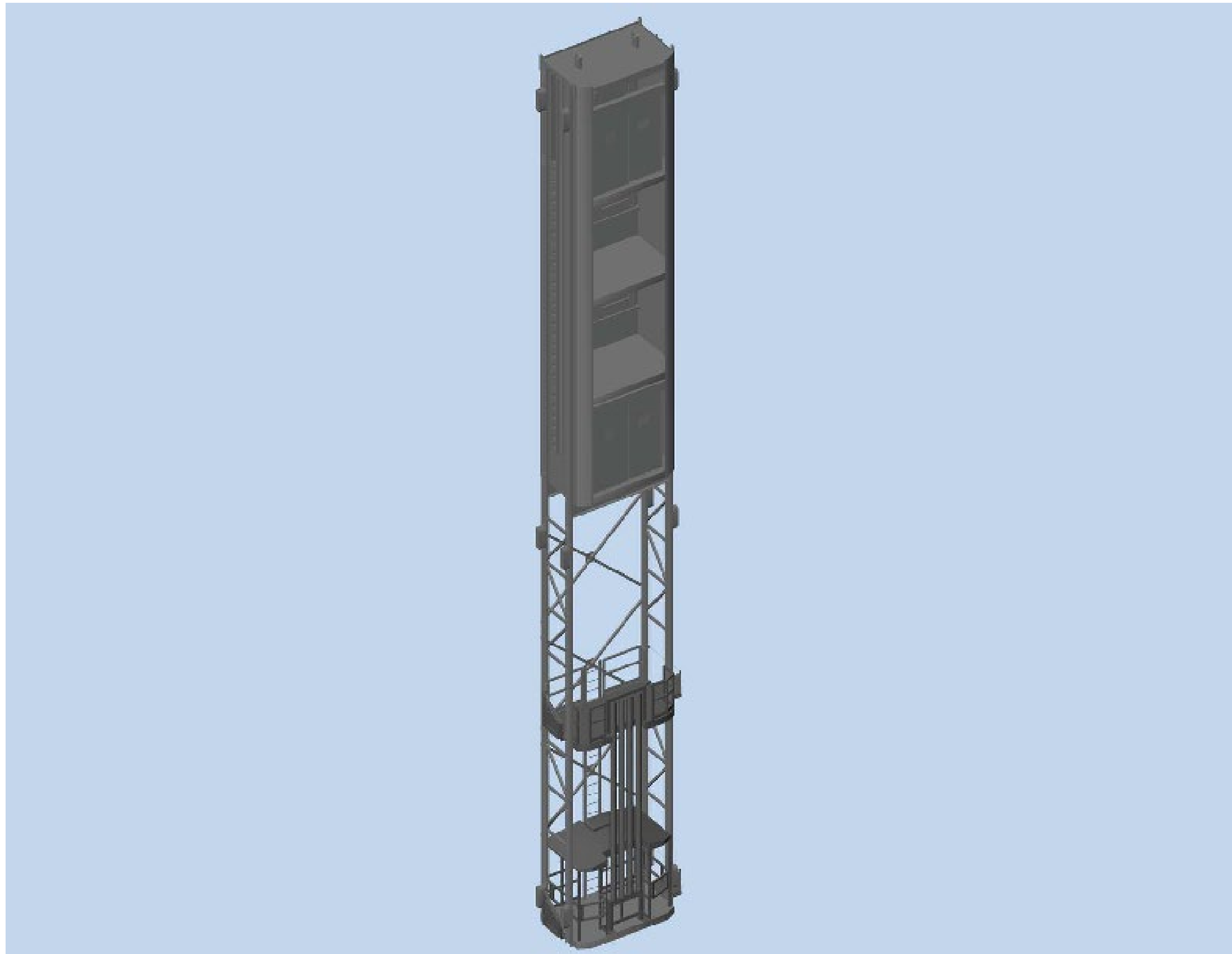
Shaft Layout and Cage Slinging Bail Design (Continued)



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Incident Investigation Findings

- Lifting/ lowering plan called for a three point lift
  - Installed lifting ring- could only accommodate two slings, not three
  - Required the crew to deviate from the plan and change the lifting ring and sling arrangement
- Access to the top of the slinging bale requires use of a shaft plank
  - Crew was unaware that the Koepe (production) hoist was in automatic
  - Crew performed separate FLRA
  - Unaware of the risk, until dust collector was heard starting operation

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Incident Investigation Findings (Continued)

- Failure to follow procedure
  - Failure to complete “Personnel Working in Shaft Permit”
  - Majority of crew was unaware a permit was required
    - 3 of 5 workers had not reviewed the policy
  - Hoist operator was new to role
  - Reliance on supervisor to complete permit

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Incident Investigation Findings (Continued)

- Insufficient or Inadequate Supervision
  - Working supervisor was at the mining level
  - Control/ Site Supervisor unfamiliar with task
  - Expectations were unclear on the Control/ Site Supervisor
  - “Lead hand” on surface was expected to supervise

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Corrective Actions

- Formal Review Conducted
  - Lowering SOP
  - Working in Shaft SOP
- Group FLRA's Mandatory
- Implemented Non-Working Supervisor
- Access to Lowering Information
- Engineering Controls
  - Electronic Gate Lock Installed with Flashing Light

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Key Message

- Don’t rely on administrative controls
- Ensure clarity on roles and responsibilities
  - Supervisors must supervise
- Communicate the importance of timely reporting
  - Over reporting vs under reporting
- Proper investigations can uncover larger/ hidden issues

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