SafetyToolboxTopics

www.SafetyToolboxTopics.com

Preventable Accidents

Print



The following are true stories. What could have been done differently to prevent each accident from occuring?

Employee was riding a pallet on the forks of an industrial truck when his foot was caught between the

pallet and stationary object. Employee died of a reported embolism at a medical facility.

At approximately 9:00 a.m. on June 5, 2007, Employee #1 was working in and around a 5.5-ft deep trench in type "C" soil. Employee #1 had not had any training on working in or around trenches, and could not answer any questions about soil types or when trench protection is needed. The trench collapsed, causing Employee #1 to suffer a broken collar bone. Employee #1 was hospitalized.

Employee was operating a backhoe at a gravel pit to load gravel into the bed of a dump truck. Employee exited the backhoe that was still running and got beneath the front bucket of the backhoe. The bucket fell, crushing the employee.

On June 11, 2007, Employee #1 and a coworker were unloading material from the bed of a truck. As Employee #1 opened the passenger-side door of the truck, a steel T-handle three roller fell from the cab. Employee #1 attempted to intercept the roller by catching it with his right pinky finger. However, his right hand became caught between the back end of the truck and the roller, causing the amputation of his right pinky finger.

Employee was working at a network junction box. He was pinned between his work van and the junction box after the vehicle rolled forward.

On June 9, 2007, Employee #1 was working in an excavation that was 6-feet deep. While standing on a storm drain pipe that measured 24 inches in diameter, the excavation collapsed. Employee #1 was trapped in the excavation and died.

At approximately 3:00 p.m. on September 3, 2003, Employee #1 with South Bay Pipeline was working on an underground pipeline installation project in Moreno Valley, CA. While helping to guide an 8-ft by 12-ft side plate of a box trench shield onto 3-ft spreaders that were being positioned by a Hitachi Model EX 200 Excavator, he placed his right forearm and hand under the plate. His forearm became crushed between the bottom of the shield plate and a 4-in. steel spreader. Employee #1 was hospitalized at Loma Linda University Medical Center for surgery to reattach his partially severed arm.

Employee #1 was working in an excavation while hydro testing a 24-in. gas pipe line. It is believed that Employee #1 slipped on the gas pipe line, hit the valve that releases the air pressure mixed with water causing the bull plug to dislodge and strike Employee #1 in the forehead. There were no witnesses to the accident. A work crew of 19 employees was hand digging an approximately .25 mile long excavation along the edge of a road. The excavation ranged from 28 in. to 32 in. deep. While digging, Employee #1 struck a gas line using a shovel and pickaxe. This gas line had not been marked and no one knew that it was there. The old gas line was marked and was located about two feet away from the new one that was struck. No one was injured.

At 8:50 a.m. on August 19, 1999, Employee #1 was assisting in laying a natural gas pipeline. As Employee #1 approached the sling that was suspended from the Caterpillar Side-Boom Pipe Layer, Model 527G, the boom fell crushing Employee #1. The equipment operator was lowering the boom with a sling over a natural gas pipeline. Employee #1 was asked to connect the sling to the attachments on the pipe. As Employee #1 stepped under the boom frame it dropped to the ground with Employee #1 under it. This action resulted in fatal injuries to Employee #1.

At about 2:30 p.m, Employee #1 was standing on a ladder cutting pipeline with an acetylene torch. Employee #1 was Vice President of the company which had been contracted to remove pipelines due to earthquake damage at the Northridge, CA, facility. Employee #1 had cut the #3 pipeline; when he cut the #2 pipe, residual petroleum distillate from the #3 pipe caught fire. Employee #1 sustained 2nd-degree burns on his face, arms, and stomach.

The employer was laying a 10 in. gas pipeline for a distance of 235 miles, replacing a line that had been installed in 1929. The stringing crew was unable to place pipe joints beside the trench in one area because the pipelaying machine was too big to get around some trees. The pipe bending crew had a smaller pipelayer (Caterpillar, model 561D, side-boom pipelayer) that they used to place the pipe on each side of the trees. Employee #1, a laborer on the crew, was hooking and unhooking the pipe joints being moved. The crew had placed a joint on one side of the trees and the operator backed around the tree with the side boom in a vertical position. Employee #1 was walking alongside the pipelayer. The operator started lowering the side boom, which struck Employee #1. He was knocked against a pipe joint and suffered fatal internal injuries.

This toolbox topic was reviewed by _	
on	with the following employees: