

**Fatal 5 – Employee sustains face injuries whilst assisting in the movement of a suspended load with a telehandler.**

## **WHAT HAPPENED**

The motor on a mobile screen on a wharf was leaking hydraulic oil. The wharf foreman was asked to remove the motor prior to the attendance of contractors, to allow them to fit another motor from consignment stock; a task that had been carried out on previous occasions.

The foreman had been advised to get assistance from a site operative. The weight of the motor was supported by a telehandler. The incident occurred when the final bolt was released from the motor. As the motor was pulled back, it snagged on the torque plate brace. The operative tried to release the snag and the motor freed and then, because it was attached to strops suspended from the telehandler, it rotated anti clockwise hitting the operative's safety helmet, which pushed into his forehead causing a laceration. The motor continued to rotate, with the torque plate striking the right-hand side of the operative's nose. He was taken to hospital where he required 3 stitches.

Image of motor in position



Image of motor suspended



## KEY FINDINGS

**Safe Systems** - There was no specific Risk Assessment, Method Statement (RAMS) or Lifting Plan for the activity.

**Lifting** - There were lifting certificates for the strop and telehandler.

**Isolations** - Manager in charge isolation padlocks and tags were in place on the mobile screen isolator.

**Take 5** - Undertaken before commencing the activity by both the foreman and operative.

**Communication** - The two staff were communicating through the open telehandler window.

**Personal Protective Equipment (PPE)** - Both of them were wearing full PPE.

## LEARNING POINTS / ACTIONS TAKEN

## HOW COULD THEY HAVE BEEN AVOIDED

- Specific RAMS and Lift Plan should have been in place to identify the most appropriate method of work, and ensure when the task didn't go to plan, it was stopped allowing the RAMS and Take 5 to be reviewed.
- The weight of the motor was being supported by a strop wrapped around the motor attached to the telehandler. The foreman operating the telehandler and operative were communicating through an open window. Use of a Hiab may have improved communication and allowed the person guiding the lift to stand on the work platform; alternatively, use of a pull lift would have provided greater control of the tension placed on the motor.
- Rather than attempting to release the motor by hand, use of a guide rope would have avoided the need to be "in the line of fire".

## KEY REVIEW POINTS

- **Safe Systems** – Is there sufficient planning of activities, with RAMS, lifting plans, etc. in place before work starts?
- **Management of Change** – If a task isn't going to plan, do we stop and reassess the method of work?
- **Competence** – Is everyone involved in lifting operations competent for the work? The Operative had only been in position for 6 months.
- **Tools / Equipment** – Do we always use the right tools / equipment for the task?

---

LOCATION:	WHARF	ALERT STATUS:	Normal
ACTIVITY:	LIFTING	DATE ISSUED:	29/11/2023 10:15:26
SUB ACTIVITY:	NO SUB ACTIVITY AVAILABLE	INCIDENT No:	03677