Fatal 6 - Conveyor LTI - Laceration to arm

WHAT HAPPENED

Day before Incident:

Due to the conveyor running off track, material spilt off the belt at the head and tail drum causing the belt to cut out. As this occurred at the end of the day, production ceased with the intention of addressing the issue the following day.

Day of Incident:

Due to the incident the previous day, the conveyor was not operated although the primary section of the plant was put into production. For the first hour all employees started cleaning up the spillage and thereafter cleaning was completed by various personnel in between other duties. During this time, no guards were removed and no isolations were in place. By midday the only spillage left was that tight to the conveyor and inside the guards.

After lunch the injured party (IP) had time to continue the spillage clearance. The IP isolated the conveyor and the conveyor anti-run back initiated before removing the guard around the tail drum allowing access to the tail drum. He then proceeded to clear the material with a bar and his hand from between the bottom of the tail drum and the conveyor. The conveyor belt suddenly moved forward (uphill) as the last remaining spillage was cleared nipping the IP's hand between the bottom of the tail drum and the return belt. The return belt had to be cut to release the IPs hand who received a cut to the elbow area of the right arm requiring surgery to clean and stitch.

The Panel of Learning agreed the following Root causes

- No risk assessment undertaken
- IP eagerness to start the task

Other contributory factors

- No Formal SWP in place
- Failure to wear the correct PPE – Although this would not have prevented the incident, the POL agreed the severity of the Injury would have been reduced

LEARNING POINTS / ACTIONS TAKEN

Highlighted from the Panel of Learning;

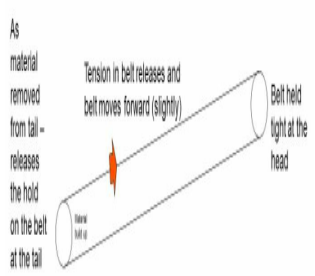
Risk Assessment: Had a discussion taken place before the event a different approach may have been taken

S**tored Energy:** The isolation of the conveyor had taken place and the direction movement of the belt may not have been foreseeable,

It was agreed to produce a training document to highlight all risks (including all types of stored energy)

PPE: Correct use for different situations (Produce CREW training to demonstrate why we need to use and the consequences of not using correctly)

(Safequarry editor's note: A similar incident is detailed in Safequarry - 'Arm trapped in conveyor' to view put trapped in key word search)



LOCATION:	**QUARRY**	**ALERT STATUS:**	**Normal**
ACTIVITY:	**MAINTENANCE & HOUSEKEEPING**	**DATE ISSUED:**	**25/11/2019 09:36:43**
SUB ACTIVITY:	**N/A**	**INCIDENT No:**	**01535**