

CSI Country Wide Case Study Safety Strategy Discussion

Construction Safety Investigator



Instructions

The objective of this tool is to provide field supervisors with information to proactively engage workers and discuss safety related concerns that they may encounter. Safety discussions should not be limited to the subject above and should pertain to the activities that workers will be involved in that may have the potential for safety related exposures.

Case Day:

June 2010

Accident Type:

Fall Accident - Side Loading Equipment

Relevant laws, rules and codes may include:

29CFR 1926.20(a)(1), 1926.21(b)(2), 1926.500, 1926.502(e)(1) - (10)

Case:

A lather was seriously injured when the positioning device he was using failed.

Accident Detail:

While climbing up a rebar wall cage to finish tying rebar in preparation for the forms to be installed, a lather lost his footing and slipped. When this occurred, the pelican hook used in the positioning device failed and the lather fell 15 feet to the concrete slab below, severely injuring his neck and back.

Reconstructive Safety Evaluation:

- What are some of the possible causes of the accident being discussed?
- What actions could have been taken that might have prevented this accident from occurring?

Accident Scene Conclusion:

The investigation revealed that the safety latch on the positioning device's pelican hook had pulled through the throat of the hook. Other positioning device rigs inspected also showed that they, too, had signs of the safety latches being bent as a result side loading. Side loading occurs if a worker positions the hook in a way that places stress on the side of rather than the throat of the hook. If this stress exceeds the capability of the safety latch, when the base of the main gate is bent far enough, it can be pulled out of the nose of the hook.

