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INCIDENT ALERT

LOCATION:	CONCRETE PRODUCTS	ALERT STATUS:	Normal
ACTIVITY:	MAINTENANCE & HOUSEKEEPING	DATE ISSUED:	15/11/2010
SUB ACTIVITY:	N/A	INCIDENT No:	00274

TITLE

Failure to isolate results in injury & dismissal

ACCIDENT / INCIDENT DETAILS

A Fitter suffered a crushed finger when a silo gate suddenly snapped shut, trapping his finger tip against the structure. The incident investigation revealed the Batcher had asked the Fitter to help clear a blockage in the neck of a silo.

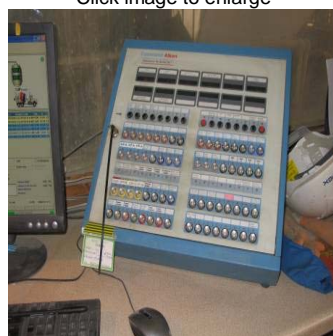
The Fitter climbed on top of the cement weigh hopper and, whilst the Plant Supervisor held down the button on the control panel, he attempted to insert a block of wood into the discharge gate to jam it open.

Due to a false scale reading the Batcher believed the blockage had been cleared and took his finger off the button causing the gate to suddenly close and trap the Fitter's finger. There was significant potential for very serious injury with this incident.

(see additional pdf)

ACCIDENT / INCIDENT IMAGES

[Click image to enlarge](#)



Control Panel

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Silo Gate

LEARNING POINTS / ACTIONS TAKEN

Despite receiving full training and safe systems being in place, which the employees had followed before, there was no detailed discussion between them as to how this blockage would be cleared:

Communication – Even though the Operations Supervisor was on site he was not informed of the breakdown situation or the remedial actions being undertaken. Are personnel aware that whenever out of the ordinary situations develop they should always inform their line manager?

Risk Assessment – No pre-job risk assessment was completed. All staff must complete a pre-job risk assessment before undertaking any non routine activity. If the this highlights any significant risk then the activity must not progress without reference to the line manager.

Permit – No Permit to Work was completed. When a Fitter is working on any equipment then the appropriate paperwork must be in place. A Permit to Work would have ensured that the task was discussed and a common understanding agreed, between the Batcher and Fitter, prior to the work commencing.

Isolation – The correct Lock Off & Isolation procedures were not followed. Both employees had received full Lock Off & Isolation training and had used the system correctly in the past. In this instance however neither had locked off the silo discharge gate and removed the stored energy. Are employees and contractors regularly trained and reminded of Lock Off & Isolation procedures? Do Managers and Supervisors check awareness of this fundamental system and are all forms of stored energy isolated?

Safe System of Work – A safe procedure to clear blockages in this silo had been developed but was not followed. This silo was prone to blockages, particularly if it was not used for an extended period.

To ensure any blockage could be safely cleared a Roding Port had been installed above the discharge gate; thereby eliminating the need for staff to work on any moving equipment.

Where there are Safe Systems of Work, do employees and contractors always follow the correct procedure? Are checks made to ensure

short cuts aren't taken and procedures are followed? Are appropriate Safe Systems / Procedures developed and implemented to cover maintenance works, including the unblocking of silos?

Sadly, having carefully reviewed the particular circumstances of this incident, the employees involved were dismissed; both had worked for the company for over 20 years.

LEARNING POINTS / ACTIONS IMAGES

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