

## **Construction Focus Four: Caught-In or -Between Hazards Student Handouts**

- Fatal Facts Accident Summary #5
- Fatal Facts Accident Summary #13
- Fatal Facts Accident Summary #15
- Fatal Facts Accident Summary #18
- Fatal Facts Accident Summary #22
- Fatal Facts Accident Summary #31
- Fatal Facts Accident Summary #38
- Fatal Facts Accident Summary #50
- Fatal Facts Accident Summary #61
- Fatal Facts Accident Summary #73

Blank Page

# ACCIDENT REPORT FATAL FACTS

## ACCIDENT SUMMARY No. 5

|  |                          |  |
|--|--------------------------|--|
| Accident Type:                                       | Caught in or Between     |  |
| Weather Conditions:                                  | Clear                    |  |
| Type of Company:                                     | Street Paving Contractor |  |
| Size of Work Crew:                                   | 1                        |  |
| Union or Non-union:                                  | Non-Union                |  |
| Worksite Inspections Conducted (1926.20(b)(2)):      | Yes                      |  |
| Designated Competent Person on Site (1926.20(b)(2)): | Yes                      |  |
| Employer Safety Health Program:                      | Yes                      |  |
| Training and Education for Employees (1926.21(b)):   | Yes                      |  |
| Craft of Deceased Employee(s):                       | Ironworker               |  |
| Age & Sex:   | 22-Male                  |  |
| Time on the Job:                                     | 1 day                    |  |
| Time on Task:  | 3 Hours                  |  |

### BRIEF DESCRIPTION OF ACCIDENT

A laborer was steam cleaning a scraper. The bowl apron had been left in the raised position. The hydraulically controlled apron had not been blocked to prevent it from accidentally falling. The apron did fall unexpectedly and the employee was caught between the apron and the cutting edge of the scraper bowl. The apron weighted approximately 2500 pounds.

### ACCIDENT PREVENTION RECOMMENDATIONS

---



---



---



---



---



---



---



---



---



---

# ACCIDENT REPORT FATAL FACTS

## ACCIDENT SUMMARY No. 13

|  |                                       |  |
|--|---------------------------------------|--|
| <b>Accident Type:</b>                        | Collapse of Shoring                   |  |
| <b>Weather Conditions:</b>                   | Clear                                 |  |
| <b>Type of Operation:</b>                    | Boring and Pipe Jacking<br>Excavation |  |
| <b>Size of Work Crew:</b>                    | 4                                     |  |
| <b>Collective Bargaining</b>                 | Yes                                   |  |
| <b>Competent Safety Monitor on Site:</b>     | Yes                                   |  |
| <b>Safety and Health Program in Effect:</b>  | No                                    |  |
| <b>Was the Worksite Inspected Regularly:</b> | Yes                                   |  |
| <b>Training and Education Provided:</b>      | Yes                                   |  |
| <b>Employee Job Title:</b>                   | Pipe Welder                           |  |
| <b>Age &amp; Sex:</b>                        | 62-Male                               |  |
| <b>Experience at this Type of Work:</b>      | 18 years                              |  |
| <b>Time on Project:</b>                      | 2½                                    |  |

### BRIEF DESCRIPTION OF ACCIDENT

Four employees were boring a hole and pushing a 20-inch pipe casing under a road. The employees were in an excavation approximately 9 feet wide, 32 feet long and 7 feet deep. Steel plates 8' x 15' x ¾", being used as shoring, were placed vertically against the north and south walls of the excavation at approximately a 30 degree angle. There were no horizontal braces between the steel plates. The steel plate on the south wall tipped over, pinning an employee (who was killed) between the steel plate and the pipe casing. At the time the plate tipped over, a backhoe was being operated adjacent to the excavation.

### ACCIDENT PREVENTION RECOMMENDATIONS

---



---



---



---



---



---



---



---



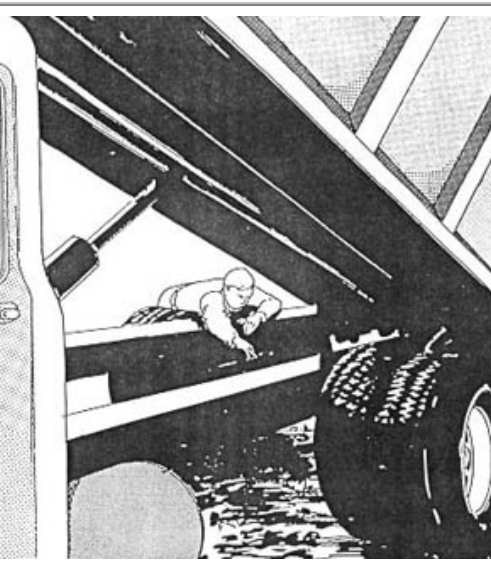
---



---

# ACCIDENT REPORT FATAL FACTS

## ACCIDENT SUMMARY No. 15

|  |                            |  |
|--|----------------------------|--|
| <b>Accident Type:</b>                        | Crushed by Dump Truck Body |  |
| <b>Weather Conditions:</b>                   | Clear, Warm                |  |
| <b>Type of Operation:</b>                    | General Contractor         |  |
| <b>Size of Work Crew:</b>                    | N/A                        |  |
| <b>Collective Bargaining</b>                 | Yes                        |  |
| <b>Competent Safety Monitor on Site:</b>     | Yes                        |  |
| <b>Safety and Health Program in Effect:</b>  | Yes                        |  |
| <b>Was the Worksite Inspected Regularly:</b> | Yes                        |  |
| <b>Training and Education Provided:</b>      | No                         |  |
| <b>Employee Job Title:</b>                   | Truck Driver               |  |
| <b>Age &amp; Sex:</b>                        | 25-Male                    |  |
| <b>Experience at this Type of Work:</b>      | 2 Months                   |  |
| <b>Time on Project:</b>                      | 2 Weeks at Site            |  |

### BRIEF DESCRIPTION OF ACCIDENT

A truck driver was crushed and killed between the frame and dump box of a dump truck. Apparently a safety "over-travel" cable attached between the truck frame and the dump box malfunctioned by catching on a protruding nut of an air brake cylinder. This prevented the dump box from being fully raised, halting its progress at a point where about 20 inches of space remained between it and the truck frame. The employee, apparently assuming that releasing the cable would allow the dump box to continue up-ward, reached between the rear dual wheels and over the frame, and disengaged the cable with his right hand. The dump box then dropped suddenly, crushing his head. The employee had not received training or instruction in proper operating procedures and was not made aware of all potential hazards in his work.

### ACCIDENT PREVENTION RECOMMENDATIONS

---



---



---



---



---



---



---



---



---



---















