



# Office of Environment, Safety and Health Just-In-Time Report

2006-01

**Improper Material Handling Results in Near Misses**

June 2006

## Events

**Site/Facility: Kansas City Plant, Main Building**

**Employee Pinned by Load Falling from Walkie Stacker**

**Reference: ORPS Report NA--KCSO-AS-KCP-2006-0004**

On April 26, 2006, an employee was struck and pinned against a freight elevator gate by a 670-pound trim fixture that had fallen off a skid as the fixture was being transported on a Walkie Stacker from the attic to the ground floor. Luckily, the employee was not injured. A one-week safety stand-down was held following the event.

Important Point:	<ul style="list-style-type: none"><li>• <b>The persons operating the Walkie Stacker were trained on use of the equipment.</b></li></ul>
Contributor:	<ul style="list-style-type: none"><li>• <b>The fixture was not secured to the Walkie Stacker</b></li></ul>

**Site/Facility: Paducah Gaseous Diffusion Plant, C-402 Lime House**

**Near Miss Results When Heat Exchanger Falls from Personnel Lift during D&D Operations**

**Reference: ORPS Report EM--PPPO-PRS-PGDENVRES-2006-0002**

On May 2, 2006, two workers lost control of a 150-pound heat exchanger that they were trying to unload from a personnel lift, and the unit fell approximately 2 feet onto a concrete floor. The mechanics inappropriately used the lift to lower the heat exchanger from an elevated position, (carrying the exchanger on the safety railing of the lift) because a forklift could not be positioned as planned. There were no personnel injuries; however, coworkers were exposed to potentially contaminated lime dust after dust dispersed from the unit when it fell.

Important Point:	<ul style="list-style-type: none"><li>• <b>Both the Front Line Manager and the assigned safety professional authorized use of the personnel lift for the job.</b></li></ul>
Contributor:	<ul style="list-style-type: none"><li>• <b>The forklift to be used for the job would not fit through the doorway of the facility.</b></li></ul>

**Site/Facility: Argonne National Laboratory East, Sector 30, Building 400**

**Crate Falls from Pallet Jack**

**Reference: ORPS Report SC--ASO-ANLE-ANLEPFS-2006-0002**

On May 5, 2006, an experimental device packaged in a wooden crate rolled off of a manual pallet jack and fell approximately 8 inches onto a concrete floor during a move. The riggers were using a forklift and the pallet jack positioned at the ends of the 12-foot-long crate. The crate rolled off the pallet jack when the forklift was moved. There were no injuries.



Important Point:	<ul style="list-style-type: none"> <li>The device had been moved successfully without incident previously using a different method.</li> </ul>
Contributor:	<ul style="list-style-type: none"> <li>The forklift tines were adjustable. The tines on the manual pallet jack were fixed.</li> </ul>

**Site/Facility:** Pantex Plant, Zone 4

**Employee Knocked Down by Forklift**

**Reference:** ORPS Report NA--PS-BWXP-PANTEX-2006-0045

On May 8, 2006, an employee was struck and knocked to the floor by a forklift that was transporting a 6-foot long x 3-foot diameter container. The employee was not injured. The forklift operator did not see the employee due to the large load on the forklift.

Important Point:	<ul style="list-style-type: none"> <li>The forklift operator's field of vision was obscured by the load.</li> </ul>
Contributor:	<ul style="list-style-type: none"> <li>The spotter assigned to the job saw the employee and warned the forklift operator, who was unable to stop in time.</li> </ul>

### Important Considerations for Material Handling (Lessons Learned)

- Is the equipment in use designed and rated for the load being moved?
- Are items secured to prevent movement during transit?
- Are employees trained to operate material-handling equipment?
- Are trained spotters assigned when the equipment operator's vision is obscured? Are spotters positioned such that they can observe the entire work zone?
- Is the number of spotters assigned adequate to detect all hazards and communicate these to the equipment operator?
- Have steps been taken to ensure continuous communications between spotters and equipment operators?
- Have unanalyzed hazards been introduced by deviating from the original plan?

