



HAND INJURY- SPRAIN/STRAIN- DURING CLEAN UP



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BACKGROUND

Two employees were tasked with cleaning up around a metal storage rack. The task included placing (2) - 20 foot 2" x 2" sticks of square metal tubing onto the storage rack. Using proper team lifting techniques, the employees successfully placed the square tubing onto the rack. The next 20-foot 2"x 2" stick of metal was a solid core and much heavier. The weight of this stick was too heavy for the employees to handle safely. One employee lost control of their end, and it fell to the ground. The resulting jar from the metal striking the ground caused the second employee's wrist to twist, resulting in a sprain/strain injury.

HAZARDOUS CONDITIONS

Conditions that contributed to this injury were the excessive weight of the square tubing on the rack. The employees were responsible for initially placing two hollow 20-foot tubes on the rack. Once that was complete, the employees attempted to place a solid 20-foot 2"x2" solid core tube on the rack, which was significantly heavier than the initial tubing. The employees were also working in inclement weather, including rain and cold temperatures, which could cause them to hurry and not take into account the differences in weight between the materials being handled.

UNSAFE ACTS

One of the unsafe acts that led to this event was the failure to use a lifting device to handle the material properly. Company Policy states that personnel cannot lift more than 50 pounds manually, and each square tubing (hollow and solid) was above the 50-pound lifting limit. Employees are also required to complete a pre-task assessment for the project but, in this case, failed to do so.

RECOMMENDATIONS FOR CORRECTION

This is a prime example of where a pre-task hazard assessment could have prevented the injury. A forklift was available and located less than thirty yards from where the incident occurred, and both employees were trained and certified to operate a forklift.

It should be noted that the employees were utilizing proper lifting mechanics. Still, they failed to recognize the weight of the material being handled and the availability of a lifting device (forklift).



The square tubing was lying here before the employees moved them on to the rack.



The hollow square tubing the employees placed on the rack.



The solid square tubing that was involved in the incident.



This Safety Alert analyzes an injury in accordance with the chain of events represented by the five dominoes above. Pioneer industry safety experts H.W. Heinrich and Alfred Lateiner developed this accident analysis system to provide a graphic sense of how injuries can be avoided. Their methodology has been accepted by safety professionals worldwide.

Safety Meeting Report

Topic(s) Discussed:

Comments / Recommendations:

Date:

Company:

Names of Employees Attending:

Meeting Conducted by:

Please follow equipment manufacturers' recommendations for safe operation and maintenance procedures.

signature