WHAT HAPPENED

Whilst attempting to remove the belts from a dryer belt drive a plant operative's finger became trapped between one of the drive belts and the driven pulley, resulting in the amputation of one of his finger tips.

It was established that whilst the drive motor had been properly isolated, one of the adjusters for the drive was seized so the operative had tried to lever the belts over the edge of the pulley using a short pry bar whilst pulling the belts round by hand, rather than releasing the tension in the belts first.

There have been several similar incidents to this in the past, all resulting in serious injury.



Drive belt that was being worked on

LEARNING POINTS / ACTIONS TAKEN

There was a safe system of work in place for the changing of the drive belts but the injured person was not aware of this. The operatives had imposed unnecessary pressure upon themselves to get the plant running as soon as possible. The operatives had not received any training in the changing of drive belts.

- Are Safe Systems of Work up to date, detailing how tasks are to be performed?

- Are all operatives trained in relevant safe systems of work, with their understanding of the required procedures being verified?

- Do only authorised personnel undertake maintenance activities?

- Is Pre-Job risk assessment carried out prior to all non-routine activities?

- Do operatives appreciate that they must not cut corners when they feel under pressure?

I- s effective supervision and monitoring in place to ensure safe systems of work are followed?

LOCATION:	
ACTIVITY:	
SUB ACTIVITY:	

READYMIX OR MORTAR PLANT MAINTENANCE & HOUSEKEEPING N/A ALERT STATUS: DATE ISSUED: INCIDENT No: Normal 09/02/2012 00325