

Crushed by trolley system of crane – Inspection # 1043283

A **64 year old male** employee was fatally injured when he was struck in the head by the trolley system of an overhead crane. The crane, utilized to move aluminum coils into storage, is normally operated in automatic mode and controlled from a central control room. Due to new renovations of the coil storage area, the TR3-4 crane was not successfully programmed to operate in automatic mode. On the day of the accident, the victim was operating the TR3-4 crane in maintenance or manual mode. The victim was standing on an elevated platform or “open cab” connected to the crane. When the trolley is in the east most position, a metal bracket on the trolley, containing sensors that read load reflectors, passes the guardrail posts on the open cab within two inches. This hazard had been noted by the employer and “caution pinch point” stickers were placed on the guardrail posts notifying crane operators of the potential pinch point hazard. An employee on the ground was assisting the victim to place the coils on the storage racks through the use of hand signals, and verbal communication. The control panel on the open cab limited the victim’s line of sight, and he moved his head to the north side to look over the platform’s guardrail system. In this position, his head and shoulders were in front of the trolley system. The victim was crushed between the open cab frame, and the bracket on the trolley of the crane.

Citation(s) as Originally Issued

A complete inspection was conducted at the accident scene. Some of the items cited may not directly relate to the fatality.

Citation 1 Item 1

TCA 50-3-105(1)	Each employer did not furnish to each of its employees conditions of employment and a place of employment free from recognized hazards that are causing or are likely to cause death or serious injury or harm to its employees. In that the crane operator was not protected from being struck by the crane’s trolley when manually operating the Hitachi 30 ton crane located in the east bay of building 816.
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Citation 2 Item 1

29 CFR 1910.157(e)(2)	Portable fire extinguishers were not visually inspected at least monthly. In that two fire extinguishers located in the control room of the Hitachi 30 ton crane TR3-4 had not been inspected.
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Citation 2 Item 2

29 CFR 1910.23(a)(2)	Ladder way floor opening(s) or platform(s) were not guarded by a standard railing with standard toe board(s) on all exposed sides (except at the entrance to opening) with passage through the railing either provided with a swinging gate or so offset what a person could walk directly into the opening. In that the fixed ladder located on the west side of the Hitachi 30 ton crane TR3-3 did not have a swing gate installed.
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Photo 1 of 2 – This photo is a view of the platform where the open cab and panel are located for the crane.

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Photo 2 of 2 – This photo shows the where the victim was looking down into the storage area and the bracket on the trolley system.