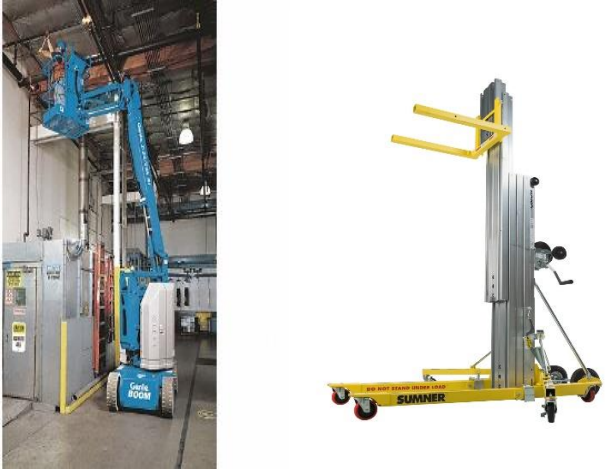


OH Schit...

Date: 5/26/2022
Project: UPF

Region: V Division/ TN
Incident Title: Dropped Support
Near Miss

Summary	Picture
<p>Two Apollo employees were tasked to place a 10ft section of tube steel (weighing 210 lbs.) onto steel building trusses for it to be tack welded into position for installation.</p> <p>One employee planned to utilize a panel cradle attachment on an aerial lift to lift the tube steel material into place. Once they were in the air, they attempted to transfer the material from the aerial lift to a fully extended duct jack. After this transfer had begun the crew quickly realized that they needed another clamp to secure the tube steel.</p> <p>The individual on the ground let go of the duct jack to get another clamp, once this positive control was lost the duct jack shifted, causing the piece to fall approximately 23 feet to the floor below.</p>	
What Went Right?	What Went Wrong?
<ul style="list-style-type: none"> • The area was barricaded and the material fell within the drop zone that was barricaded off. • The employee on the ground just left the area, ultimately being safe from the overhead fall. • The individuals immediately stopped work and informed supervision of the incident. • Individuals were forthcoming and honest during the investigation. 	<ul style="list-style-type: none"> • Working without Authority • No management oversight • No planning for this task (STARTR CARD) • Duct Jack wheels were not locked and only one outrigger was deployed • The material was not tethered during the transition. • Change in process. Similar work had been completed twice before using rigging and a chain fall. The crew decided to try a new method in an attempt to save time. • The employee on the ground was exposed to an overhead hazard due to the fact the material was not secured 100%.
Would of, Could of, Should of	
<ul style="list-style-type: none"> • Management should have been involved in the planning process. Especially if there was a change. • A planning session needed to occur before attempting this task. • Rigging should have been utilized to complete this task. • The ground individual should have exercised their stop work authority when they were concerned about the process. 	

