

Naval Facilities Engineering Command

# Abstract of an Accident

03-01

**Accident Type:** Struck By/Crushing  
**Injury:** Fatality  
**Type of Work:** Removing Concrete Support Forms From Beneath Pier  
**Equipment:** Material Float, Come-a-long and Dinghy

**DESCRIPTION OF THE ACCIDENT:**

A contractor carpenter/dock-worker sustained severe head injuries while removing concrete forms from the underside of a pier. Two workers had just finished lowering 2 steel beams onto a steel float (5 feet by 20 feet) in the water. The beams were not centered on the float and caused it to list. One of the workers, contrary to the established work procedures, climbed out of the work dinghy onto the float to tie down the beam. While the worker was securing the beam, the float flipped over and landed over top of him. The second worker entered the water and pulled out the injured worker. The injured employee sustained critical head injuries and was airlifted to the hospital where he died.



Outer float at accident site.



Inner capsized material float.



Concrete support steel beams ready for retrieval.



Close up of steel beams with lifting washer and nut.

**DIRECT CAUSE:**

- ◆ Instability of material float.
- ◆ Employee walking on loaded unstable material float.

**INDIRECT CAUSE:**

- ◆ Loading of steel beams off center on material float.
- ◆ Lack of job/site specific Activity Hazard Analysis (AHA).
- ◆ Lack of stability calculations for material float.
- ◆ Failure to follow work practices or procedures for loading steel beams on material barge.

**LESSONS LEARNED:**

- ◆ AHA must be site specific for each definable feature of work.
- ◆ AHA must address all control measures to be followed.
- ◆ Employees must follow set work procedures identified.

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