# Critical Incident Notification

## Operator falls into an Aggregate bin

A potentially serious incident has occurred at a London Concrete plant in the United Kingdom. This is an opportunity to reflect on this incident and take any relevant necessary actions to help prevent another accident, if possible.

**Date of incident:** 2016-01-21

**Country:** United Kingdom

**Site:** Tolworth – London Concrete (UK Concrete)

| | | |
|---|---|---|
| x Employee | ■ Contractor | ☐ Third Party / Member of the Public |
| ■ On-Site | ☐ Off-Site | ■ Transport |

## What we know so far:

The batcher fell into one of the overhead aggregate bins when he stepped on the metal grated flooring after resetting a trip switch.

On Thursday 21st January Tolworth concrete plant broke down at 7:30am. The small shuttle belt above the aggregate bins tripped out whilst the main feed belt continued running. This caused the material to block on the belt until the main belt also tripped out. The batcher completed the isolation procedure before going up stairs to remove the guard to gain access to the shuttle belt. Once the material had been cleared off the belt he then reset the trip switch and started to make his way out of the guarded area. As he stepped onto one section of the grated floor it gave way causing him & the section of floor to fall into the aggregate bin. As the bin was full he only fell waist height in on to the aggregate within the bin. If the bin had been empty the operative could have fallen 8m causing a serious injury or death.

## Initial Investigation Findings:

- The batcher was trained in the isolation procedures & these had been followed correctly.
- Both aggregate belts were not interlinked so when the shuttle belt stops the main belt stops.
- External & Internal structural inspections had been undertaken but had not highlighted this defect.
- The floor section was only resting on two supporting beams at one corner and would appear to be have been damaged.
- There should have been four clips interlocking the floor to either the support beams or adjacent floor.
- The floor appeared to be installed like this when the plant was erected in 2008.
- The floor is the guarded area was not part of an inspection regime.


Aggregate Industries, Old Hall Farm, Copt Oak, Markfield, Leicestershire, LE67 9PJ
Phone 01530510066, info@lafargeholcim.com, www.lafargeholcim.com

LafargeHolcim

# Critical Incident Notification

Operator falls into an Aggregate bin

## Immediate actions taken by country leadership:

- All flooring including behind guarded areas needs to be inspected e.g. level 1 structural survey to ensure all access points are identified this task is undertaken by a competent person to undertake and visual inspection. Any areas of concern should be subject to a further investigation by a competent structural engineer as appropriate.
- Hatches should be in a good condition and secured in place when not in use by clamps or bolts.
- A sign needs to be installed on the inspection hatch to highlight it to people entering this area.
- All feed conveyor system should be inspected and where conveyors are not interlinked in sequence to prevent spillages remedial work should be undertaken.
- Ensure that after access into bins / silos has been completed covers / lids are replaced and secured as required.

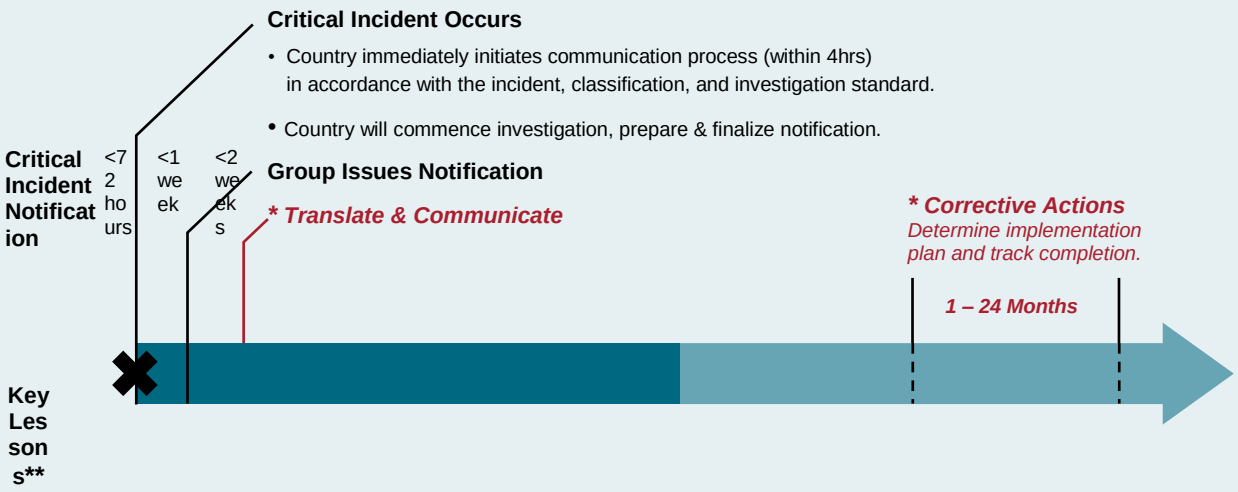
**The above actions MUST be reviewed and actions taken as necessary at all sites. Confirmation that the review has been undertaken and details of any subsequent action taken to prevent a reoccurrence MUST be communicated to your business Director in writing by Friday 26th February 2016.**

How the floor was originally.


New section of floor.

# Critical Incident Notification

Operator falls into an Aggregate bin




**Group Issues Key Lessons****

***Step 1** Translate

***Step 2** Organize EXCO level review

- *Assess, analyze, and determine applicability, feasibility & forward actions*

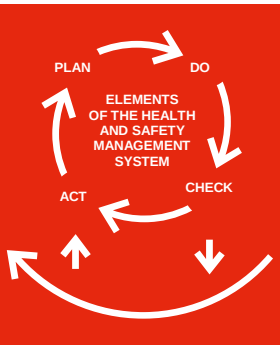
***Step 3** Share/cascade key lessons & country action plan in accordance with country communication guidelines.*

** Indicates country action.*

** Key lessons are not always issued.
They depend on local legal & global applicability.

## Communication Principles

- Determine a country-wide process for distribution of this document, including appropriate corrective actions for all levels of the organization.
- Communication should include discussions in team meetings, toolbox talks, posting on notification boards, e-mail distribution, and developing and sharing relevant action plans




## Important Actions

- Perform a gap analysis based on the information in this document.
- Establish the action plan, including objectives and processes necessary to ensure that a similar incident will not occur at your sites.
- Implement the action plan, execute the process, close the gaps.
- Collect data to track implementation until completion