

Case 530. 30-year-old male crane service technician died when struck by and caught in between a steel girder and the motor housing/brake cover of an overhead crane.

A 30-year-old male crane service technician died when struck by and caught in between a steel girder and the motor housing/brake cover of an overhead crane. The firm for whom the decedent worked had been contracted to perform annual inspections on Firm 1's overhead cranes. The decedent was a member of a two-person crew. There were two overhead cranes located in a bay at Firm 1; a larger capacity crane (Crane 1) located above a smaller capacity crane (Crane 2). The decedent was performing maintenance on Crane 2. Crane 1 was operational on runways which ran east-west, Crane 2 had been locked out. The decedent had been performing work under Crane 2 in an elevated aerial lift basket, but out of the travel path of Crane 1 which was operated by a Firm 1 employee. Unknown to the Firm 1 employee, the decedent, who was facing east towards the motor housing/brake, was raising the aerial lift basket to perform work. The basket was raised into the travel path of Crane 1 just as the girder of Crane 1 traveled overhead. The eastern most girder on Crane 2 struck the decedent as it traveled overhead, causing the decedent's head to be pinned in the 2- to 3-inch space between Crane 2's motor housing and Crane 1's steel girder.

MIOSHA General Industry Safety and Health Division issued the following Serious and Other-than-Serious citations at the conclusion of its investigation.

Serious: 408.11843(4): GI PART 18, OVERHEAD AND GANTRY CRANES: A crane shall be equipped with a main switch which can be locked out. An employer shall establish a written lockout procedure which shall be used in connection with R 408.11872 and R 408.11875. Lockout shall conform to the requirements prescribed in General Industry Safety Standard Part 85 "The Control of Hazardous Energy Sources, (Lockout/Tagout)," as referenced in R 408.11807.

The following energy control deficiencies were found for the Crane 2 and Crane 1 overhead cranes:

- a. Energy control procedures were not utilized when an employee moved the overhead Crane 1 in close proximity of a third-party contractor performing preventative maintenance to the overhead Crane 2. On *Date* 2019 the third-party contractor sustained fatal injuries while performing maintenance to the overhead Crane 2.
- b. The employer or contractor did not inform each other of their respective lockout procedures while maintenance was performed on the employer's Crane 2 by a contractor. The contractor received a fatal injury on *Date* 2019 after being struck in the head by the adjacent Crane 1 which was being operated by the host employer in the same bay that the Crane 2 was being serviced. Lockout procedures were not coordinated in order to isolate the hazardous energy from the movement of Crane 1 prior to service being performed. *NOTE: MIFACE removed the brand names of the cranes and the dates referenced in the citation.*

Serious: 408.15839(1): GI PART 51, AERIAL WORK PLATFORMS: The aerial work platform shall be used only in accordance with the manufacturers or owners operating instructions and safety rules.

An operator of the JLG 450AJ did not operate the aerial work platform in accordance with the manufacture's operating instructions. The operator was operating the JLG 450AJ aerial work platform

within close proximity of an adjacent overhead crane. The aerial work platform operator was struck in the head and killed on *Date* 2019. (*MIFACE removed the specific incident date.*)

Other-than-Serious: 408.15815(6): GI PART 58, AERIAL WORK PLATFORMS: A permit to operate an aerial work platform is valid only when performing work for the employer who issued the permit. A permit shall be issued for a period of not more than 3 years.

Employees were not provided permits from their employer prior to operating the JLG 450AJ aerial work platform on *Date* 2019 and *Date* 2019. The employee was operating the JLG 450AJ aerial work platform within close proximity of an adjacent overhead crane which fatally struck him in the head on *Date* 2019. (*MIFACE removed the specific incident dates.*)