Overview

During works to re-configure scaffolding arrangements, an operative was removing a scaffold tube which then moved and trapped two of their fingers. As a result of the injury, the tip of the ring finger on their left hand had to be surgically amputated and a metal rod inserted into the middle finger.

At the time the scaffolder was adjusting the tube and in undoing the coupler, the right-hand end of the tube dropped causing the opposite end of the tube to move upwards, trapping their fingers between the tube and the structure above.

Advice & Guidance

The investigation identified that an overall set of RAMS had been created for the task, but when the addition of a hop up was identified, the RAMS were not further reviewed for additional control measures.

It was also highlighted that the floor of the working area had significant debris from Hydro Demolition works, which may have contributed to the incident.

Actions

- Brief scaffolding and site teams on the details of this incident & lessons learnt.
- Ensure the scaffolders are instructed to review their structures, and consider how tubes may move when clips are released.
- Consider reviewing scaffolding already on site which use girder clamps and so could create a pinch point.
- Ensure the working area is clear of debris or underfoot hazards.
- If the task being completed is likely to change, a review of the new working method should be completed to reassess the risks and ensure sufficient controls are in place and understood.
- Ensure that when one element of work has been completed, there is a clear process of hand over before another phase of operation begins. In this case, the Hydro Demolition works to the scaffolder team.

For further information please contact the National Health and Safety Team via nh&st@highwaysengland.co.uk

HEi061