

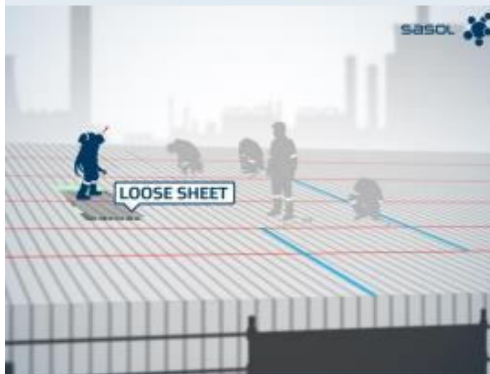
SASOL – LEARNING - FATALITY

- On 14 April 2023, while replacing roof sheets on the Polypropylene bagging warehouse, a service provider team was adjusting the sheeting to rectify misalignment. Secured and partially secured roof sheeting in the team's work area had been loosened as part of rectifying the sheeting's misalignment. In the process of walking to his work area, the now-deceased stepped onto an unsecured roof sheet and fell approximately 8 meters onto the concrete floor below. Because he was not tied on to a lifeline or transfer line, his fall to ground was not arrested. As a result of the fall, the person succumbed to his injuries

SASOL – LEARNING - FATALITY



The now-deceased person stepped onto the roof from the access scaffold and started walking on the roof without hooking the lanyard onto the life line or transfer line.



He proceeded to walk on the loose roof sheeting to his work area.



A loose roof sheet tilted inwards and he fell through the roof to the cement floor below.

SASOL – LEARNING – FATALITY: Causes

Direct causes:

1. The deceased did not hook his lanyards onto the lifelines and/or transfer lines.
2. The deceased fell when he stepped onto a roof sheet that was unsecured, which then tilted and gave way.

Underlying causes:

1. The deceased made a personal choice to walk untied on an unsecured roof, probably due to perceiving it as a low-risk task.
2. The service provider's work method changes (loosening and realignment of roof sheets) were considered as part of their initial scope; and therefore, the pre task risk assessment (PTRA) was not updated.
3. The service provider's work methods and fall protection plans were generic and not site specific.
4. The service provider did not adhere to the requirements to install safety nets and the use of a full-time safety monitor (spotter) as stipulated in their method statement, their working at heights procedure and the potential deviation analysis (PDA) conducted for the work. The service provider claimed that it had received exemption from Sasol, however, no proof was found of this exemption.
5. Working on roofs prevents continuous and easy visibility of working practices. The access scaffold, in this case, was orange-tagged due to modifications required for loading and off-loading of roof sheeting, which contributed to limited assurance being provided (orange-tagged scaffolding can only be accessed by appropriately trained people, as it requires 100% tie-on when being used).
6. The PDA was conducted without the involvement of a roof work subject matter expert. The agreed PDA next steps were partially signed-off.

SASOL – LEARNING – FATALITY: Causes

Underlying causes (cont.)

7. Critical control management, application of life saving rules and implementation of assurance processes associated with working at heights, in this case, were found to be inadequate.
8. Secunda Operations' primary focus is on risks associated with operating plants and shutdown / maintenance activities. Peripheral areas do not receive the same focus and attention.
9. The Sasol service provider safety accreditation system does not include an in-depth analysis of the service provider's deviation management system:
 - Collective view of deviations and incidents recorded by the service provider was not considered; and
 - Collective view of sanctions applied by the service provider for deviations associated with working at heights was not available.

SASOL – LEARNING – FATALITY: Causes

Root causes:

1. Inadequate assessment by the service provider of risks associated with the changes to the execution method of roof sheet installation, necessitated by the misalignment issues.
2. The service provider management failed in ensuring effective procedures, supervision, adherence to safe work practices, and assurances.
3. The active management and oversight of the safety assurance processes, specifically relating to key undesirable events (KUEs) were inadequate.
4. Roles, responsibilities and interface management between multiple stakeholders on the Secunda site regarding the management and execution of small projects (Tier 5) posed challenges

SASOL – LEARNING – FATALITY: Detailed learnings for action

1. Controls and assurances required for roof work and use of lifelines
 - Implement effective engineering solution(s) that will ensure team members cannot access certain working areas (like roofs) without being hooked on and they remain hooked on to prevent falling from heights.
 - Ensure the following documents and or processes:
 - Site specific method statement and fall protection plan
 - Pre-task risk assessment
 - Potential deviation analyses (PDA), involving a roof work specialist and considering previous learnings of similar incidents
 - A competent person must evaluate the suitability of anchor points, lifeline configuration and equipment used specific for the task.
 - Consider safety nets in fall protection and rescue plans, where practical.
2. Adequate assessment of changes to working methods, the associated risks and required assurance
 - Reconfirm with all service providers that changes to work methods require work to be stopped and reassessed.

SASOL – LEARNING – FATALITY: Detailed learnings for action

3. Risk management and effective assurances to ensure safe work practices
 - Reconfirm that all Sasol KUEs have been assessed for applicability in each operating platform and used as an input to assess the risks and identify the preventative and corrective critical controls.
 - Improve system to ensure that line management awareness of high-risk activities within their area of responsibility and implement the necessary first-line assurance protocols.
 - Prevent over reliance on service providers to provide assurance for safe work execution.
 - Establish a post-PDA second level of assurance process for high-risk activities involving KUEs.
 - Guard against complacency of employees when executing routine high-risk activities.
4. Sasol service provider safety management system
 - Ensure service providers' management of life saving rule deviations are aligned with Sasol procedures.
 - Ensure visibility of service providers' identification, management and loop closure of deviations.

SASOL – LEARNING – FATALITY: Detailed learnings for action

5. Implementation of the high severity incident (HSI) prevention programme
 - Ensure learnings from high severity incidents are available on a central database for all relevant stakeholders, including service providers.
 - Simplify life-saving rules, agree with site OMEs and service providers and ensure consistent application.
6. Effective internal communication, and clear roles and responsibilities
 - Reconfirm and communicate roles and responsibilities for the management of service providers where multiple Sasol stakeholders are involved.

SASOL – LEARNING – FATALITY: Identification of standard or good practice related to the incident

- Emergency protocols were initiated correctly and efficiently.
- Employees who were working with the deceased expressed gratitude for the counselling sessions which were arranged by Sasol and the care they have received from the service provider management.

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END