



FUELS INDUSTRY
Association of South Africa

LEARNING FROM INCIDENT (LFI)

Fall from Height

19th January 2024

2024



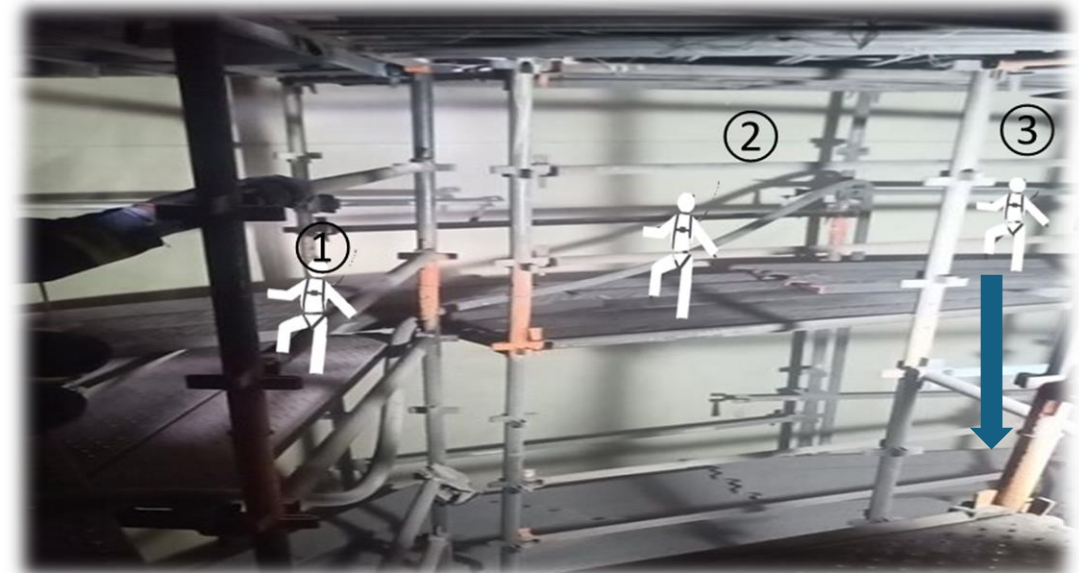
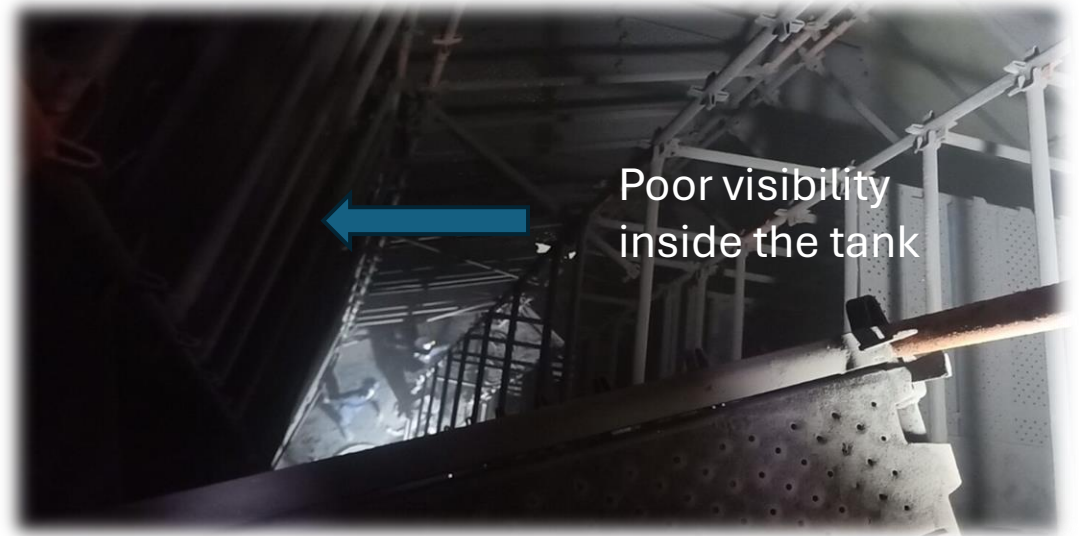
INCIDENT DESCRIPTION

Date	19 th January 2024 at 09h00
Location	Chemicals Facility
Activity	Conducting housekeeping on scaffold (blowing-off grit) at an elevated platform inside of tank.
17 Jan 2024	(Two days before) Penalties effected to the principal contractor for project delays.
18 Jan 2024 13:00	(Day before) Subcontractor supervisor starts planning for the next day's activities (paint work to commence next day). To prevent the hose and vacuum cables from getting tangled during operation, the supervisors decides that the ledgers must be removed from the scaffold to increase ease of movement. He communicates this with his team.
19 Jan 2024	07:40 Scaffold inspected by the supervisor, task observation completed, toolbox talk, and gas test conducted. The supervisor reminds team of the risks verbally (i.e. ledgers removed). PTW is issued.
	08:33 3 subcontractor workers enter the tank to resume with housekeeping activities.
	08:40 On 7 th platform, the 3 workers set up such that one worker controls the light, second worker supports the hose, and the third worker was blowing sand-grit off the platform.
	08:50 Once completed on 7 th platform, the 1 st and 2 nd workers walked to platform 6, whilst the IP was holding and directing the light for them. Once on lower level, the IP handed over the light to worker 1 on 6 th platform and thereafter walks to the 6 th platform in the dark.
	08:53 When IP gets to 6 th platform, he unhooks his lanyard, and walks towards the section where he tries to re-hook his lanyard to the ledger. However, the ledger in this area had been previously removed to prevent the hose from getting tangled. This is when the worker falls.
	08:55 Worker 3 (worker blowing the sand grit) feels the scaffold shaking and suspects something is wrong. When they look for the worker who was holding the light (worker 1), they realize he had fallen to the ground.
	09:00 Incident is reported and: <ul style="list-style-type: none"> The Emergency Response Plan process was triggered. The IP was mobilized out of the tank and first aid administered. The IP was transferred to the nearest hospital for further medical assessment
Classification	LTI



INCIDENT DESCRIPTION

- Three workers were conducting housekeeping on platform 7 of 8 inside of the tank.
- Conditions inside the tank; relatively dark, dusty and with poor visibility.
- Once platform 7 sweeping was completed, worker No. 1 (operating the hose) and worker No.2 (supporting the hose) moved to the level below (platform 6) whilst IP was holding the light for them until they both were at platform 6.
- When workers No. 1 and 2 reached platform 6, IP handed over the light to the hose operator (Worker No. 1) from the 7th platform.
- Worker No. 1, took the light from IP and tied it to the scaffold ledger and then continued with task.
- IP goes down to platform 6 (**no one was directing the light for IP**), gets to platform 6, unhooks his lanyard, and tries to re-hook it to the missing ledger (previously removed to prevent the hose from getting tangled) then he falls to the bottom of tank (approximately 10 meters).
- Workers 1 and 2 felt the scaffold shake, then realized Worker No.3 had fallen.





INCIDENT ROOT CAUSE

Immediate Cause Finding / Gap	Comments
<p>1. The scaffold platform was unsafe to be used because the ledgers had been removed by the supervisor, (who was also the scaffold inspector)</p>	<p>a) Review roles and responsibilities and ensure there is independence to avoid conflicting interest between inspector and supervisor, consider an independent scaffold contractor / inspector.</p> <p>b) Initiate Performance management for supervisor for violating the HSE procedures (Personal Optimising violation)</p>
<p>2. The worker did not secure the harness leading him to fall from a height.</p>	<p>a) Review lighting requirements and make specific recommendations for confined space entry, consider the use of lights in hard hat, and possibly the housekeeping process that affects visibility.</p> <p>b) Consider consequence management for IP for not hooking lanyard on harness (Personal Optimising violation)</p>
Underlying Cause Finding / Gap	Recommendation
<p>1. Improper management of subcontractor resulted in subcontractor deviation from HSE plan.</p>	<p>a) Contract User to ensure there is detailed HSE project implementation and interphase plan in place inclusive of clear roles and responsibilities amongst relevant HSE, HSEBP, Contractor HSE, in the implementation of the approved HSE Plan.</p> <p>b) Reinforce compliance to HSE requirements particularly inspections by safety agents, Approving authority, and site management in confined spaces.</p>
<p>2. Inability to perform assigned tasks safely is a lapse in the safety system of work.</p>	<p>a) To reinforce compliance to safe systems of work requirements through training and audits to ensure sites are conducting joint site visit and verification of controls prior to approval of PTW by RA/AA.</p>



INCIDENT LEARNINGS

- Sub-contractor management. Focus on sub-contractor as stringently as focus on Principle contractors.
- Reinforce – joint site visits (PTW approver and contractor) to identify potential risks especially confined space activities.
- Ensure independence of contractor supervisor and scaffolding inspector – conflicting interests. This must not be the same person.
- Review Emergency response measures between contractor and site ERP.



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Thank You

2024