

Incident Learning: Medical Treatment

BRIEF DESCRIPTION OF INCIDENT

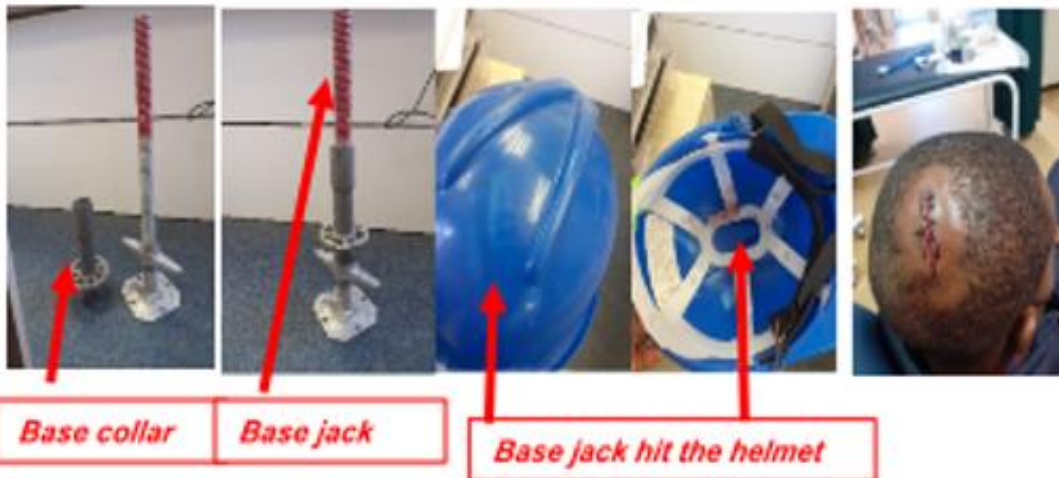
1. A scaffolding crew were busy dismantling a scaffold at a tank, and were bringing the scaffold material down to the ground by passing the components from hand to hand, down the levels of the scaffolding. A worker at the 1st platform (top) was passing a scaffold base jack, with a collar attached to it, to the worker on the 2nd platform. The receiving worker gripped the collar ONLY and the base jack slipped through the collar and fell towards the ground. At the same time, a worker on the 3rd platform ~6m below, was handing other material to a worker on the ground level. The scaffold base jack struck the worker on the 1st platform on his helmet. The inner of the helmet subsequently causing him to sustain a laceration to his head, from the plastic inner component of the helmet.

2. The injured person was taken to the clinic for medical attention, where he received stitches – no signs of concussion. He has since recovered fully and is working as normal.

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BRIEF DESCRIPTION OF INCIDENT

3. SKETCH/PHOTOGRAPH:



4. SUMMARY OF MAIN CAUSES

- The employee handed the base jack with the base collar connected. The components are 2 separate components and are not secured to each other posing a risk of falling.
- Poor Situational Awareness and Hazard Identification.
- The employee on the 1st platform was unaware that he had positioned himself in the line of fire by extending himself over the handrail to pass the brace to the employee on the ground level.

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LEARNINGS FOR IMPLEMENTATION

5. INVESTIGATION FOLLOW ACTIONS:

- An inspection of the area was carried out.
- A stand down was conducted with all employees to create awareness and share immediate learnings. Practical example of the base jack and base collar was shown to employees to drive the message to all.
- Further investigation is in progress.

6. LESSONS LEARNT

- Always assess for the risks before conducting the work and put mitigations in place.
- Never put yourself in the line of fire
- Ensure that every 2m a platform is erected to stand on when passing material.
- Ensure good communication between passer and receiver
- Base jack and base collar are 2 components and must be passed separately
- Always apply the 4 WHAT principle whenever executing all tasks, (what can go wrong, what can cause it to go wrong, what can be done to prevent it from going wrong, what can be done to minimize the negative consequences if it does go wrong).

Incident Learning: First Aid Case 1



BRIEF DESCRIPTION OF INCIDENT

1. Mechanical Fitters were stripping and removing filters on the boiler feed water utility system. A fitter had removed the covers and then decided to place them on the grass area adjacent to where he was working. As he stepped of the concrete plinth onto a lower concrete step, his ankle twisted on the uneven surface.
2. The injured person was taken to the clinic for medical attention, where he received treatment for a soft tissue injury. Hew returned to work the next day with a slight limp and slight swelling. He has since recovered fully.

Incident Learning: First Aid Case 1

LEARNINGS FOR IMPLEMENTATION

3. SKETCH/PHOTOGRAPH:



4. SUMMARY OF MAIN CAUSE

- Mechanical fitter stepped between the concrete step and the scaffolding.

5. INVESTIGATION FOLLOW UP ACTIONS:

- Uneven surfaces had not been identified.
- Employee not aware of his surroundings.

6. LESSONS LEARNT

- Uneven surfaces to be identified and mitigated accordingly. The LMRA discussion to involve entire team and signed as proof of communication.
- Employee to be made aware of there surrounding via the LMRA/RAMS and Toolbox talk discussions.

Incident Learning: First Aid Case 2



BRIEF DESCRIPTION OF INCIDENT

1. Two contractors were offloading cable trays from a vehicle and loading them onto an A-frame storage rack. When the last tray was placed on the storage rack, the shelf collapsed and falling material caused the 2nd shelf to collapse under the additional load. The workers were caught in the line of fire from the falling material and sustained bruises to their shins.
2. They were taken to the clinic for medical attention, where they were treated for bruises and lacerations. They have since recovered fully and are working as normal.

Incident Learning: First Aid Case 2

LEARNINGS FOR IMPLEMENTATION

3. SKETCH/PHOTOGRAPH:



Employees were standing at each end as they loaded cable rack

4. SUMMARY OF MAIN CAUSES

- Load was not evenly distributed between two shelves.
- A-Frame was rusted at weld points compromising integrity of shelving
- Employees were inadvertently placed in the line of fire when shelf collapsed as there was no room to move out of the drop zone &
- Indirectly linked to space constraints and how items were stored
- A-Frame rack was overloaded with materials resulting in supporting arms breaking off.
- A-Frame rack was not designed to support heavy weight – no SWL

5. INVESTIGATION FOLLOW-UP ACTIONS:

Internal investigation underway:

- In the interim all angle iron and cable racking will be stored at floor level, within a designated area which has been allocated .
- A-Frames will be reviewed and will not be used in the interim.
- Appointment of an adequately trained stacking and storage supervisor to monitor all loading and offloading activities in non-process areas.
- Layout of laydown area to be reviewed and all excess/ unused materials to be removed in order to create more storage space.
- Laydown area execution pack to be revised, current, fit for purpose and include all activities.
- LMRA refresher training for all employees who are responsible for conducting LMRA's
- 5 Leadership behaviour refresher training to be held with all supervision and foreman staff.
- Line of fire awareness campaign to be roll out with the team.
- Inspection of all storage shelves to ensure they are not overloaded, safe stacked and adequate to withstand weight of materials.

6. LESSONS LEARNT

- Robust inspection system of all equipment that is exposed to weather also considering wear and tear over time.
- Risk recognition i.e. integrity of the support brackets; LMRA that was reviewed did not highlight this risk which was deemed routine
- Visible field supervision in execution of all tasks to visually assess weight when stacking material.
- Prior to offloading mechanical items first identify location of final resting place and determine if suitable for offloaded items