H&S ALERT

Trustpower Limited April 11 2017

What Happened?

While working on a Generator overhaul some components had to be mounted on the turbine pit wall. This was done after the guide vanes had been tested for correct functionality. At this point the guide vane hydraulic system was charged and energised. It was observed that staff were placing body parts in the travel path of the guide vane actuation components.

Impact

Should the guide vanes been inadvertently actuated whilst body parts were in the travel path the person or persons could have suffered a very serious, if not life threatening, injury.

Causes

Incorrect Work Control Procedure being used when persons work on, or in close proximity to, equipment with a potential or kinetic energy source.

No recorded tailgate or toolbox session prior to commencing work on the day the incident occurred. Resulted in poor or lack of communication amongst the work group of the risks involved and safety measures that should have been put in place to isolate the risk.

Potential Cause

Work group being physically and mentally fatigued after an extended 6 month maintenance shutdown that required extended hours being worked.

Lessons Learnt

The importance of selecting the correct Work Control Procedure. Completing and recording daily tailgate / toolbox sessions. Communicating, acknowledging, recording and mitigating all known and potential hazards. Including fatigue.

Comments

Staff to be coached and refreshed in the importance of selecting the correct Work Control Procedure. Completing and recording daily tailgate / tool sessions. Communicating, acknowledging, recording and mitigating all known and potential hazards. Including fatigue.

Photo Caption

If it's not safe then find a better way...

someone expects you home today!