SAFETY ALERT
Shared Learning's

INCIDENT TITLE:

Mt Millar Lift Near Miss

TIME AND DATE OF INCIDENT:

14 September 2018

INCIDENT DETAIL :

On 14 September 2018, two technicians ascended a tower via the lift. The first technician had exited the lift and made their way up to the nacelle. The second technician then exited the lift, shut the door and moved towards the ladder to attach their slider. Before reaching the ladder, the lift started to descend behind them as the lift was being operated from the bottom floor. The second technician reacted well by quickly attaching his slider to the ladder and manoeuvring away from the lift to avoid entanglement.

There are no barriers and space is limited around the lift well on the upper lift landing platform. There are known hazards of entanglement and exposure to an unguarded edge. The existing control, which was not completed on this day, was for those at the top and bottom of the tower to communicate before driving the lift down from the 'operator station controls' to ensure that everyone has ascended clear of the moving lift.

INITIAL RESPONSE AND INVESTIGATION OUTCOMES :

During the investigation it was discovered that the 'operator station controls' at the lower lift landing platform were in fact emergency controls and not intended for general use. The glass covers had been bypassed as per the photo. It is believed that all covers were originally removed around 2007 shortly after commissioning to increase the efficiency of transporting personnel due to the inherent limitations of the original lift design. This practice has then been inherited by new personnel over the years and become standard procedure.

Other notable findings:

- There is no formalised lift training program or competency assessment framework in place;
- A second bypass of a safety system was also standard practice – use of the emergency door release key to access intermediate tower platforms (limit switches are only fitted for the upper and lower lift landing platforms);
- Various independent inspectors have certified the lifts as safe to use without picking up on the bypassed safety systems; and
- Daily work planning and risk assessment processes are in need of improvement.

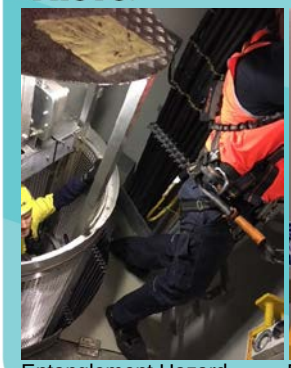
LEARNINGS AND RECOMMENDATIONS FROM THIS INCIDENT:

The adoption of and continued use of operating the lifts via the emergency controls resulted in a situation that was not error-tolerant. If the lift was operated in accordance with the operating manual and within its original design limitations, this event would not have occurred.

Corrective actions include:

- Reinstallation of the glass panels on the emergency controls to ensure the lifts are only driven by those inside as per the operating manual;
- Cease use of emergency door release keys to access intermediate platforms;
- A full review of the lift design to determine possible engineering improvements;
- Review of safety signage within the lifts and other relevant locations;
- Contacting the lift and turbine manufacturers to obtain any updated operating manuals and training procedures;
- Development of a formalised lift training framework;
- Working with the independent inspectors to improve their inspection criteria; and
- Updating the daily lift inspection checklist.

PHOTO:



Entanglement Hazard

Bypassed emergency controls

The Corporate Safety and Health Team are currently working on systems to support the above learnings.
If interested in viewing the full investigation report for this incident, it can be found in:

Safety Manager Event ID 939024

meridian