

SAFETY ALERT

Shared Learning's

INCIDENT TITLE:

Shackle Pin Dropped From Height

TIME AND DATE OF INCIDENT:

Thursday 11th September 2014 1452hrs

INCIDENT DETAIL :

There was a significant near miss recorded on a Suzlon site in South Australia earlier this week where a technician who was setting up the "Sky Climber" (for blade inspections and repair works) dropped the pin out of the shackle after cutting the hole in the fibre glass from 80 metres. The pin landed within 1 m of the Service Technician at the base of the turbine. No injuries were recorded but clearly a near miss with fatal consequences.

Please toolbox this at both sites as a clear reminder on why we must remain diligent in respect of setting up exclusion zones and tethering all tools and equipment or safely storing them whilst working at heights.

LEARNINGS AND RECOMMENDATIONS FROM THIS INCIDENT:

The Key findings were;

- No tool lanyards were available or being used
- The take 5 principle did not occur to ensure the shackle pin was secured before cutting the hole.
- No drop zone was established around the turbine
- The hazard was not identified or the risk
- Control measures were not adequate to control the risk
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Recommendations from this incident are;

- Review General Health and Safety documentation around sky climber work.
- If tools and equipment are to be used where there is any risk of falling they must be tethered off or stored in a safe manner.
- Ensure all hazards associated with the tasks are identified and clear controls are in place on the daily Hazard Identification Form
- Ensure there is an adequate drop zone in place before commencing work at height
- Risk assessment refresher training

INITIAL RESPONSE AND INVESTIGATION OUTCOMES :

As a direct result of this incident a wind technician/contractor was lucky to come away with no injuries.

In general a number of procedures and education programmes were not in place. These are mainly in relation to, hazard identification and tethering of equipment when working at height. Also playing a significant outcome in the event was the incorrect risk assessment used in looking at the probability and consequence of cutting a hole into the nacelle whilst unsecured equipment had the potential to fall.

PHOTO:

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 Id Number . If you do not have access to Safety manager contact a member of Meridian's CSH team.



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