SAFETY ALERT
Shared Learning's

INCIDENT TITLE:

Electric motor dropped on hand

TIME AND DATE OF INCIDENT:

Friday 8th May 2015 1400hrs

INCIDENT DETAIL :

The work party had concluded a fault finding task on a turbine and this confirmed that the 69kg motor in the nacelle required replacing.

The work party went back to the service building to collect the appropriate tools and parts. However a suitable lifting eye could not be found to lift the motor. A decision was made to instead use lifting strops.

The correct documentation for this task was not available. A request was made to the documentation team to approve an Approved Written Procedure (AWP) as soon as possible.

The work party then returned to the turbine without the correct paper work. Two techs ascended the turbine while one stayed at the bottom to attach the load to the crane. The motor was craned to the top of the turbine using a lifting bag.

While removing the motor from the lifting bag in the nacelle the motor rolled and dropped, a distance of 150mm, onto one of the technicians hands.

INITIAL RESPONSE AND INVESTIGATION OUTCOMES :

The injured party made her way down the turbine to find the first aid kit had no ice pac in it. Approximately 15 minutes from the injury an ice pac was applied. The injured technician was then evacuated via an emergency access road not normally used to find one of the gates was locked. By this stage the ice pac was no longer any use and no more were available. The technician arrived at the medical 2 hours after the event with swelling on her hand.
The job did not have a Work Instruction or Method Statement identifying the new hazards available prior to the job commencing. There were guidelines in place for this type of occasion following the documentation decision tree which was not followed correctly.

The correct lifting eye was not available and this was not communicated to the Maintenance Team Lead. The decision to use the lift strops was made by the work party

LEARNINGS AND RECOMMENDATIONS FROM THIS INCIDENT:

The Key findings were;

- There was no other planned work, providing an alternative job for that day.
- No lifting eye bolt available to lift the motor.
- Document decision tree was not followed.
- The fault finding AWP was not closed off at the right time.
- The resource issue of the unavailable lifting eye was not communicated to the manager.
- Manual handling equipment error. Manual handling training was only completed 6 months ago.
- There had been no work instruction developed although there have been prior examples of this type of task being recently completed.
- Work party choose to complete the task a different way using equipment that was not the preferred option.
- No first aid kit with ice pac was up in nacelle with the work party and vehicle first aid kit had no ice pac in it.

Recommendations from this incident are;

- Documentation process explained/refreshed to all.
- Lifting eye for hydraulic motor to be available at Te Uku Wind Farm
- Van Houte land owner to ensure his gate is not locked for use in an emergency.
- Used first aid kit to be restocked.
- Ensure there is an ice pack in the vehicle first aid kits and enough spare gel ice packs in the service building freezer.

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 467373. If you do not have access to Safety manager contact a member of Meridian's CSH team.

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