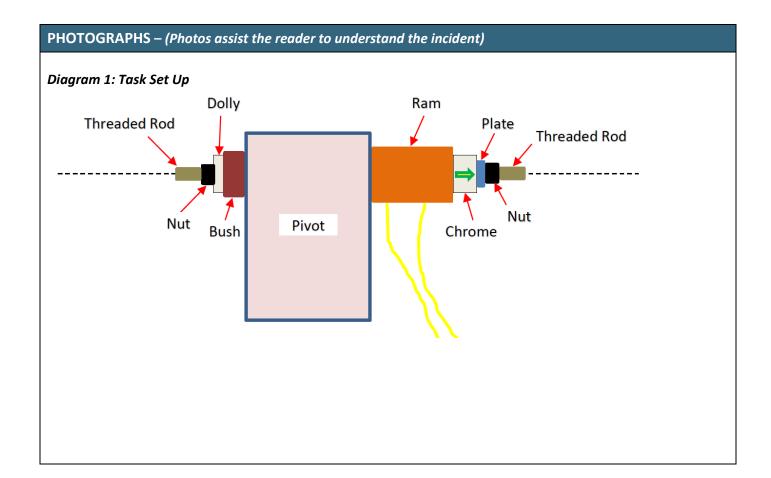
HSEC FINAL INCIDENT ALERT

INCIDENT DETAILS —Thread Rod Failed on Cap Press

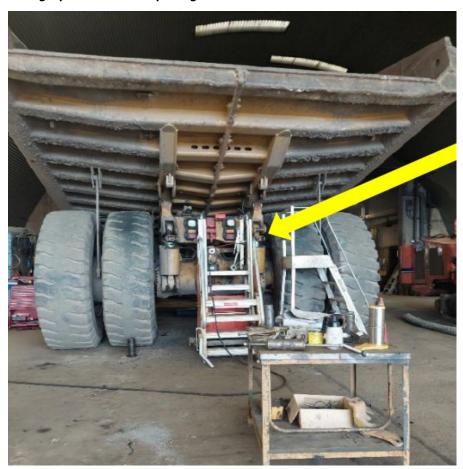
Date	11-April-2022	Time	10:00
Location on Site	Contractor Workshop	Energy Type	Kinetic
Employee /Contractor/Public	Contractor	Consequence Category (HS/ENV/FIN/COMM/LEG/RUP)	HS and Financial
Potential Severity (1-5)	HS- 3	Actual Severity (1-5)	5

INCIDENT DESCRIPTION – Provide a short description of the events (Who, What, Where, When- DO NOT USE NAMES)

- A hydraulic porta pack was being used to pull a strut pin bush into position on a 777 truck, deck pivot.
- This routine task is completed by inserting a threaded rod of about 25 mm diameter and 600 mm length through the bush with nuts securing it at each end.
- During the task, the rod has failed adjacent to one of the nuts and the rod has been propelled across the workshop about 5 m distance and 3 m above floor level.
- The rod has penetrated the cab window of a Pantera drill parked adjacent and came to rest on the operator's seat.



Photograph 1: Task Set Up – Right Hand Side Pivot



Photograph 2: Power Pack



Photographs 3 and 4: Line of Flight And Impact Point On Unoccupied Drill Rig



Photographs 5 and 6: Part of Rod And Nut, Left With An Impression Of Centre Plate Dolly as Indicated





BASIC/ROOT CAUSE

• Failure to identify the change in the task from routine to non-routine which resulted in a failure to use correct tooling, or the correct procedure for the task as per the OEM.

CONTRIBUTING FACTORS

Absent or Failed Defences

• Less than adequate risk assessment of task. This highlights that when a task changes in the workshop, this was not considered 'non-routine' therefore triggering additional supervision or risk management.

Individual or Team Actions

- Less than adequate assessment of fit for purpose tooling (dolly, rod, hydraulic ram)
- Failure to notify the Supervisor when a change to equipment and the task was identified

Task or Environmental Conditions

- Use of incorrectly rated puller rod (mild steel)
- The use of stepped task-specific dollies (which would have prevented misalignment of the dolly that caused the dead-ending against the pivot/chassis), were not available in the Contractor's workshop
- Less than adequate barricading to prevent other persons entering the work area
- The parked drill rig was in the firing line

Organisational Factors

inspection

Less than adequate workshop supervision.

• Contractor workshop activities have not been included under the site (CMS)- Contractor Management Standards responsibilities.

ACTIONS AND RECOMMENDATIONS		
1	All Contractors to complete the site Hazard Identification and Risk management Training	
2	Correct dolly for this task to be made available at the contractor workshop when this work is being conducted.	
3	Conduct a meeting with contractor's management, RE improvements and help required to assist their supervisor around all risk management controls and organisation of job tasking.	
4	Implement formal systems to audit and review contractor workshop activities, including: • implement documented monthly meetings with Contractor Workshop Manager and Supervisor with specific focus on risk controls.	
	 Mobile Plant management to implement workshop inspections and review of contractors workshop activities twice weekly. Review this investigation in detail with Mobile Plant staff, as well as sub- contractors. 	
5	Remove non-rated puller rods from general access: Purchase additional rated rods locate non-rated rods in controlled environment check storage as part of workshop	

SIGNIFICANT LEARNINGS

There are significant potential financial and people risks associated with less than adequate identification of hazards in a task, or when a task changes. When a change does occur, appropriate actions must be taken to by the worker and the Supervisor, to ensure that controls are implemented to ensure the health and safety of workers and to prevent equipment damage.

Appropriate Contractor Management responsibilities include ensuring that contractors (and sub-contractors) are provided with competent supervision, hazard identification/risk management skills, fit for purpose tooling and approved procedures.

This Alert is forwarded in the interests of ensuring that similar accidents do not reoccur in the future.

This Alert is to be placed on all safety notice boards and discussed at Pre-shift Information Sessions and other Safety Communication Forums.