

Incident Details

What Happened?

On 28 December 2014, a High Potential Near Miss occurred when a forklift operator was attempting to erect a 10.5 meter steel column weighing 1.5 tons using a forklift. A General Foreman received a phone call to reinstate the Project fence line. These instructions came from the senior construction manager. The General Foreman went to the site and inspected the work area, he then called for a fork lift and assembled his crew. The fork lift drug the column out to a clear area and started to maneuver the column into place. The column was shifted on the fork lift in a horizontal position and eventually aligned with the base plate. At this time the General Foreman decided that a mobile crane was required to complete the job, told the crew to wait and left to make arrangements for the crane. The forklift operator then decided to attempt erecting the column. The forklift lifted the column once then set it down then lifted it a second time to about a 45 degree angle at which time the column slipped off the forklift and fell on the consultant site office that was fortunately not occupied at the time.

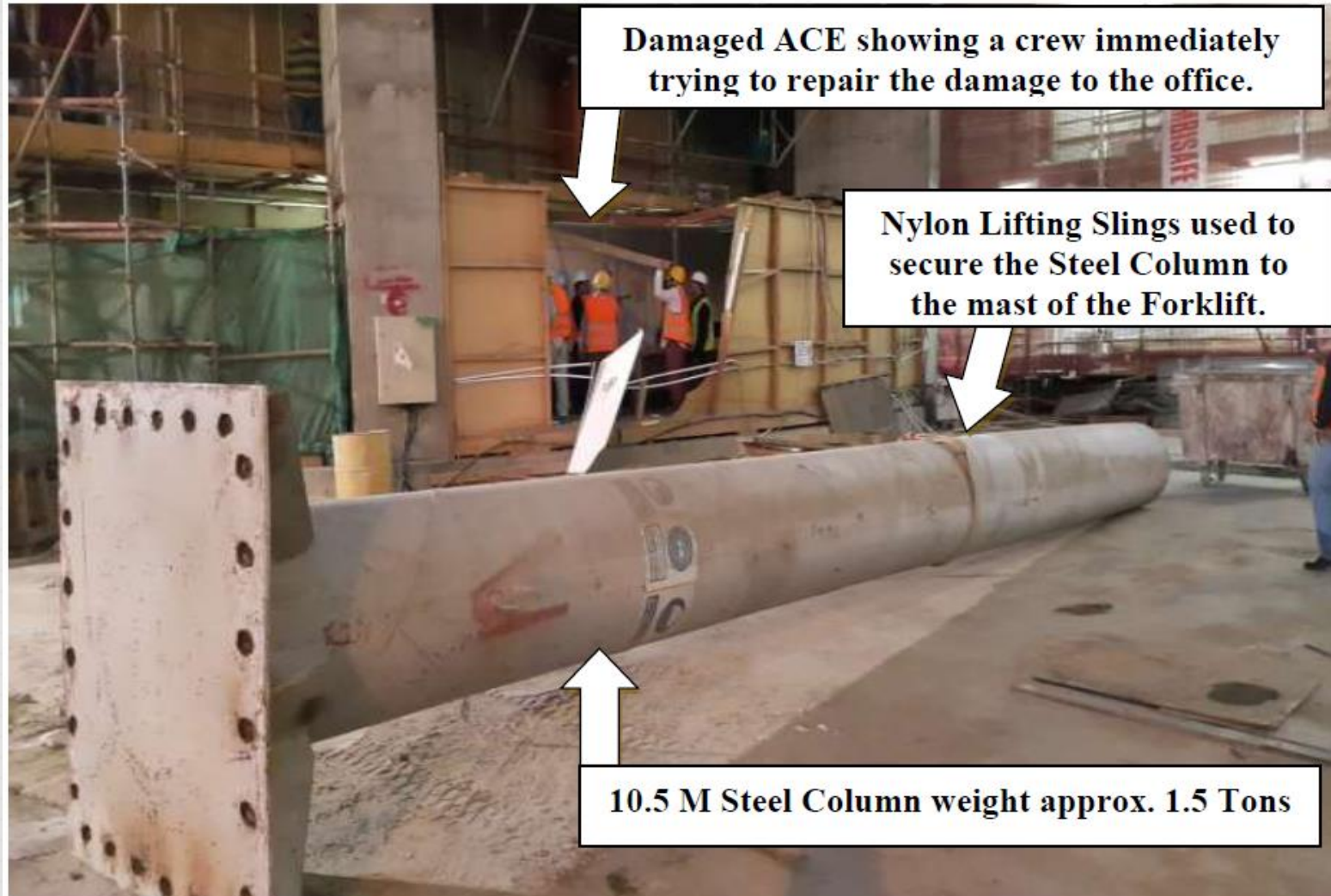
Root Causes

1. Procedure - FEL (Front End Loading) procedure was not followed, the work was not planned nor a mobile crane arranged. "No Risk Assessment/Method Statement/Job Safety Analysis/Job Safety Task Instructions/Toolbox talks).
2. Work Direction – No JSTI perform by the task supervisor to identify task hazards.
3. Work Direction – Task Supervisor failed to give proper instruction when he stopped the task to request a crane.
4. Training – Task Supervisor was not trained on the required JSTI process/procedure.

Direct Causes

1. Wrong equipment used (a forklift was used instead of a crane)
2. Lack of communication where the task supervisor failed to give proper instruction when he stopped the task and left to request a crane
3. Lack of competent supervision (supervisor is not trained)
4. Inadequate HSE Training
5. Poor decision making and judgment – disregarding safety rules
6. Inadequate Hazard Identification (operator, employees and supervisor failed to recognize the unsafe act)
7. In a hurry to complete a task.

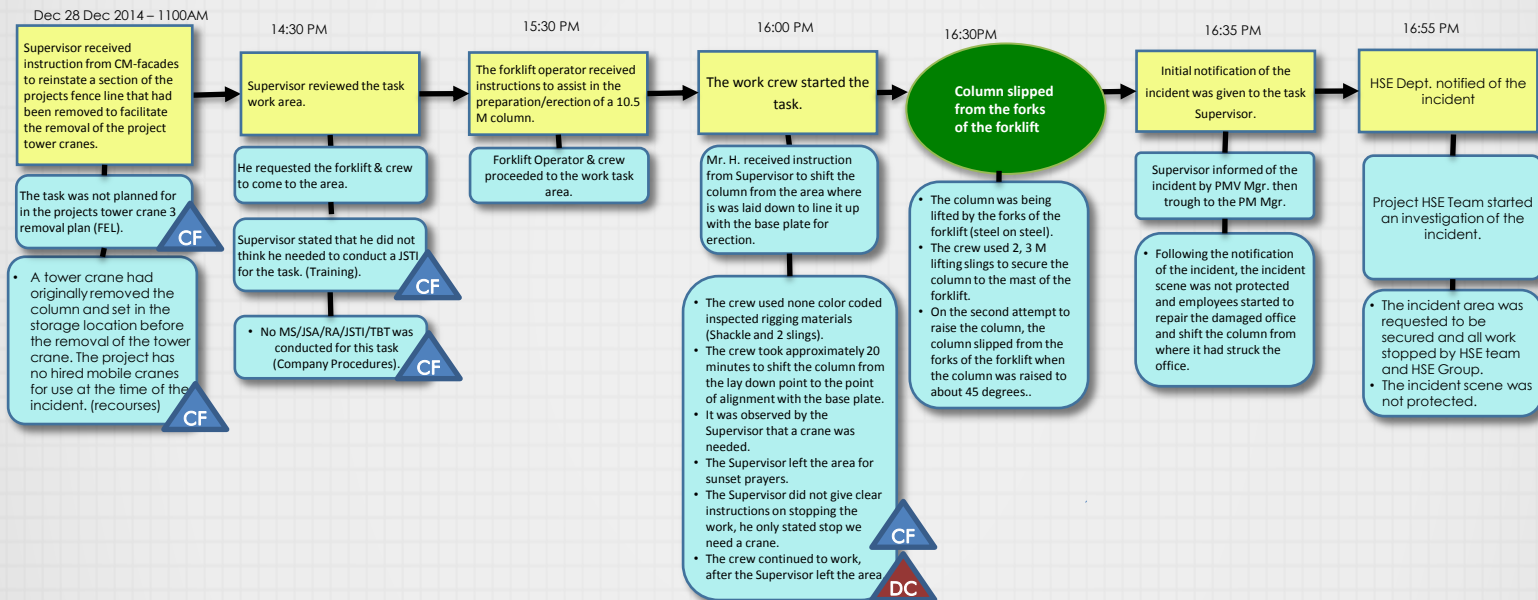
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TAP Root Cause Analysis



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Corrective Actions

1. Job Safety Task Instructions should be prepared by a competent supervisor and delivered to the work crew before every task
2. Ensure adequate & competent supervision is in place at all time
3. Analyze and select the proper equipment for the task
4. Ensure adequate hazard awareness & identification training is provided
5. Ensure that the Risk Assessment & Method Statements are in place
6. Training & empowerment of the Project employees to STOP unsafe acts
7. Implement the Step Back 5x5 last minute safety check system
8. Disciplinary action for violators of lifesaving rules & safety procedures

Lessons Learned

1. Never conduct an unplanned task
2. Always ensure the use of proper equipment for the task
3. All site supervisors must be highly competent, able to recognize unsafe acts and be present at all times
4. Site Supervisors must make sure that crew members understood his instructions
5. Select the proper equipment for the work before work begins