StanleyBlack&Decker

Incident Investigation Analysis

Define

Facility Name: **EMAS Lewesk Champion**
Incident Date: **09th May 2016**
Shift**: Days**
Incident Type: **First Aid Case**
Incident Cause: **Human Error**
Lost Work Days: **0**

Description of Incident

On the 9th May, 2016 approximately at 0800hrs, while performing automatic welding on the 44” pipe joint, the approximately 15kg Automatic Welding Bug detached from its Band's lowest point, slightly contacting the right hand and thigh of a welder before landing on the pipe tunnel grating. At this time the Station 2 Welder and his Welder Helper setup the Auto Welding Bug on the Pipe Band. The Bug has 2 band locks one top one bottom. The Welder locked the top and the Welder Helper locked the bottom handle on the Bug. Unfortunately the bottom lock was not engaged properly which allowed the Bug to detached from the Band and fell to the grating. IP sustained bruising/contusion to upper right thigh

Root Cause Analysis

- **Human Error**
- **Lack of Care/Attention**
- **Failure to follow procedures/rules**

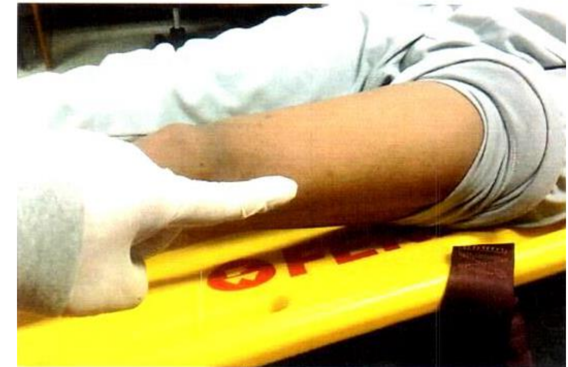
Global Corrective Action

- **All-Stop called**
- **Carry out toolbox talk**
- **Communicate Focus on Lessons Learned**

Photos

Locking mechanism on Bug, wasn't fully engaged.

Position of welder when Bug detached



IP thigh after contact with Bug

Why analysis:

Why 1: Why did the incident happen?

Answer: Because the locking mechanism was not engaged fully.

Why 2: Why was it not engaged correctly?

Answer: Because the welder helper was not following procedure

Why 3: Why was the welder helper not following procedure?

Answer: Lapse of concentration, lack of care and attention