FEDERATION OF PILING SPECIALISTS

SAFETY ALERT

The below information has been issued on behalf of the FPS to make others aware of the potential risks and possible precautions to take in order to avoid these.

Date/Time of Incident:	23/02/2018 12.15pm
Type of Incident:	Struck by Moving Part
Nature of Incident/Injury:	Fractured Hand
Details of Incident:	During anchor installation works an operative injured his hand between the spanner and the clamps in the process of adding additional augers. The injured person was assessed at hospital and found to have non-displaced fractures to two metacarpals in his right hand and a cut on the soft tissue between his thumb and fore finger. He returned to site with soft plaster strappings and was taken home at the end of the day. The accident happened during/after the installation of the final auger. It was necessary to pull back the final auger that had been placed on the string to release the auger spanner from the top of the casing in order to continue drilling to depth. The spanner man had his hand under the auger spanner handle which was facing down (not up which would have cleared the clamp shelf) and was expecting the auger to be raised as the rig operator has pulled the wrong lever. The spanner is shaped with the handle formed at an angle to the horizontal to ease manual handling and facilitate easy lifting. Instead the auger rotated clockwise at speed with the spanner man's hand attached to the spanner and this rotation caused the spanner to rotate clockwise and his hand hit the auger clamp.
Root cause (if known):	A defective safety interlock on an access gate to the podium, that was not reported, resulted in the site operative bypassing the safe access steps and gate
Action Taken:	Work was stopped and not restarted until all safety devices had been inspected and confirmed as working correctly. All machines were inspected by the plant technicians to confirm that they were fit for use. All operatives were re briefed to ensure that they were fully aware of the safe working practices and how safety devices are used. Disciplinary action was taken against all operatives involved in the improper and unsafe use of equipment and for the continued use of defective

	equipment without reporting it to site management A warning light system was installed on the podium to visually confirm when safety devices are inactive/active Briefing records and plant / equipment check sheets were and continue to be reviewed both on and off site to ensure that they are completed
Lessons Learnt:	If equipment is modified for a specific contract then the pre-use checklists should be amended to reflect the modifications Not all rigs and podiums were compatible with each other and although this was known by the site teams, it was not communicated to management. This resulted in some devices being inoperable. All equipment is now interchangeable Operators and rig attendants were trained on the daily and weekly check requirements but supervisors must confirm that the learning is embedded Management must confirm that daily and weekly inspections are being carried out and records are being correctly maintained