INTERNAL INCIDENT ALERT

For all 'Moderate' and 'Serious' Incidents

DETAILS OF INCIDENT		
Date:	30/10/2016	
Time:	11:10 AM	
Location:	Scholey Street	
Rating:	☐ Moderate ☒ Serious	
Classification: (e.g. WHS, RCI, etc.)	☒ WHS ☐RCI ☐Other _____ If RCI, what is the TCR: _____/20___	
Is the incident reportable to Comcare:	☒No	☐Yes, If yes, when was it reported Click here to enter a date.

DESCRIPTION OF INCIDENT (who, what, how, when)

October Mains Closedown - Job #15 - Scholey St - 96pts crossing replacement.

A contract welder was attempting to repair a hand held rail profiler when the steel strap contained inside the housing cover unravelled, sprung free and contacted (wrapped around) the workers uncovered hands causing serious cuts to both left and right hands.

The worker had taken the housing cover off the fly wheel, and had wound the pull cord manually on the fly wheel before starting the machine. The worker then attempted to replace the cover whilst the grinder was still operational. The fly wheel then came in contact with the steel strap inside the housing cover (which acts as a spring to recoil the pull cord) causing it to unravel and spring free.

The worker was not wearing gloves at time of incident. This decision had been made considering the task of replacing the cover required replacement of 4 x 10mm screws which would have been difficult whilst wearing gloves.

Separate unit shown below with pull cord and cover in place.

DETAILS OF INJURY/ILLNESS/IMPACT/DAMAGE (include photographs and, if possible, an estimate for when the track can be released)

Right Hand: Superficial bruising to 3 fingers and knuckles with minimal skin loss.
Left Hand: Lacerations to ring finger and palm of hand which both required suturing.
Injured worker was administered pain relief, tetanus shot and antibiotics at hospital before being transferred back to barracks by the Project Safety Officer.

IMMEDIATE ACTIONS/CONTROLS TAKEN FOLLOWING INCIDENT TO PREVENT A REPEAT INCIDENT UNTIL INVESTIGATION IS COMPLETE
Injured worker was immediately transferred to John Hunter Hospital by the worksite Project Safety Officer. All work on the site was stopped and crew removed from the rail corridor. Rail profile grinder was physically tagged “out of use" so no further repair work or further grinding could be undertaken with faulty machines. Worksite Supervisor and ARTC Project Manager facilitated a group discussion with the entire crew regarding the actions that had led to the incident and the seriousness of it. A key focus of the discussion was how dangerous it was to attempt this type of repair – or any task – without an understanding of the risks involved or adequate training. The discussion covered the importance of change management and the requirement to "Stop & Think" before implementing a change. Direction issued by the Contractor to the crew that any breakdowns or faulty equipment must be immediately reported to the Worksite Supervisor. And that no amended task is to be performed on site prior to the persons involved undertaking an adequate and relevant risk assessment. Crew roles and tasks reassigned to utilise alternate welder and complete grinding scope to facilitate hand back. All site personnel were made clear on each other's roles and responsibilities to complete the remaining scope. Alternate grinders were sourced from another crew working close by to support remaining work to enable completion of work and track hand back. Entire crew provided opportunity to ask questions and identify hazards or concerns with recommencing works to compete scope. Debrief recorded and entire crew requested to sign that they understood the expected requirements. Once satisfied works could be safely recommenced. Work recommenced on site approx. 1300hours. Full investigation to be undertaken.

AUTHORISED BY	
Name	Anne Modderno
Position	Manager Corridor Works
Shared Learnings	*This incident highlights the critical importance of effective change management. Teams must recognise what actions constitute a ‘change’, and understand that work should be stopped to allow dedicated time to spend assessing the risk prior to taking action. The change can be a large change to scope or delivery, or in this case it was a new task required to operate a piece of equipment.* *Risks and hazards associated with any change to a task being performed on a worksite must be adequately assessed prior to implementing the change. If the associated hazards cannot be controlled to a reasonable level then the change should not be implemented.*