Class 1P Lessons Learned

(March / 2019)

Event No:		**Event Date:**	20th March 2019
Incident Type:	LTI		
Project:			
Business Unit:	Infrastructure		
Incident Classification:	2A/1P		

Description of Incident:	A subcontractor operator was involved in an incident that resulted in a fractured lower left leg. The operator was operating a 1.7 tonne excavator in the bottom of the 1.4-metre deep trench. The excavator was 0.8 metres wide and the trench was 1.0 metres wide, allowing minimal clearance on either side of the excavator. The subcontractor was placing bedding sand into a trench (1.4 metres deep) using a live bed trailer. The sand was being spread utilising a mini (1.7 tonne) excavator, which had been driven into the trench via a ramp. As the excavator was reversing, the operator believes his left leg extended outside of the ROPS stanchion and that he accidentally contacted the slew control lever. This caused the excavator to slew to the left, jamming his leg in between the roll over protection stanchion and the side of the trench, fracturing the lower left leg.
Photos / Sketches:	 

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Key Contributing Factors:	• Placement of bedding was excluded from the activity main steps and not included in the risk register. • Did not identify placement of bedding as a risk. • AMS not developed as effectively as required under SQERM process. • SQERM process not effectively followed or understood. • XX did not review or sign off the TRA. • Changed methodology for placement of bedding not reflected in documents. • Small excavator was placed in the bottom of the trench resulting operator being exposed to high risk. • XXXXXXXXX and Subcontractor personnel failed to identify the risks associated with the excavator in the trench.
Preventative Actions:	• Accountable culture tool applied to persons involved. • Superintendent and supervisor to present to the team and subcontractor forum on lessons learnt to assist in culture step change. • Risk-based review of resources with respect to supervisory and engineering coverage to be undertaken across the Project. • Development of updated AMS with subcontractor and client prior to possession of site from XX being granted. • Subcontractor supervisor to be approved by superintendent and client prior to possession of site from XX being granted. • Review of all current SQE documentation in place across project, with subcontractors. • Internal HSE System audit to be undertaken by XX regional team. • XX to provide mandatory training on SQE requirements for all new subcontractors. • All relevant Project AMSs and TRAs to be reviewed to ensure that they address the placement of pipeline bedding. • XX delivery, HSE team and subcontractor supervisors to attend Change Management toolbox training session. • All field delivery team members to attend a toolbox training session on identifying triggers for change management and when to review a TRA. • At the 4 Weekly Look Ahead, Safety and Environment Managers and Superintendent to be involved and set the high-risk activities inspections for the upcoming week and allocate responsible individuals.
Key Lessons Learned:	• A clear methodology for all tasks needs to be determined and agreed prior to works commencing and all methodology changes must go through the change management process. • The SQERM process is to be followed and all parties must be involved in the AMS development. • There was a clear lack of understanding around the change management process by both XX and the Subcontractor. • SQE processes are not being consistently followed on the Project. • XX personnel not taking accountability for the Principal Contractor role of on the project as they incorrectly assumed the risk was with the Subcontractor. • Governance activities need to be more deliberate to improve HSE performance of subcontractors. • HSEMP was generic and needed to be more project specific and governance was required to ensure the project was adhering to the HSEMP.
*** Recommendations to embed lessons across the group**	• Ensure that the XX SQERM processes are clearly understood and followed by both XX and subcontractor personnel. • Key subcontractor personnel to undergo XX SQERM training. • Post investigation, a safety re-set to confirm safety expectations on the Principal Contractor.

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Key Post Incident HSE Behavioural Analysis:	The key negative or absent HSE behaviours that are relevant to this incident / event (all supported by the evidence associated with the incident investigation):		
Theme	**Everyone**	**Supervisor**	**Manager**
Standards	The operator failed to follow the rules of having a risk assessment for the task being undertaken.	Failed to comply with SQE requirements. Failed to comply with Change Management including stopping the works and reassessing after methodology changed.	Failed to ensure that the SQERM process was implemented as per requirements.
Communication	The operator failed to communicate the change in the methodology of putting a excavator in the trench. All failed to discuss the risk of the new methodology in the pre-start.	Failure to communicate the Change of Methodology to trigger a risk review of the changes.	
Risk management	Operator failed to understand the risk of working in trench with an excavator.	Failed to ensure that the subcontractor was compliant with SQERM requirements.	Failed to set high standards by failing to recognise the risk associated with operating an excavator in the trench.
Involvement			

Reported on time? (Yes/No)	GMR Complied with? (NA/Yes/No)	EGM Involvement / Intervention (Yes/No)	Close Out Status (Closed/open)	Was the Accountable Culture Tool applied? (Yes/No)
Yes	No	Yes	Open	Yes