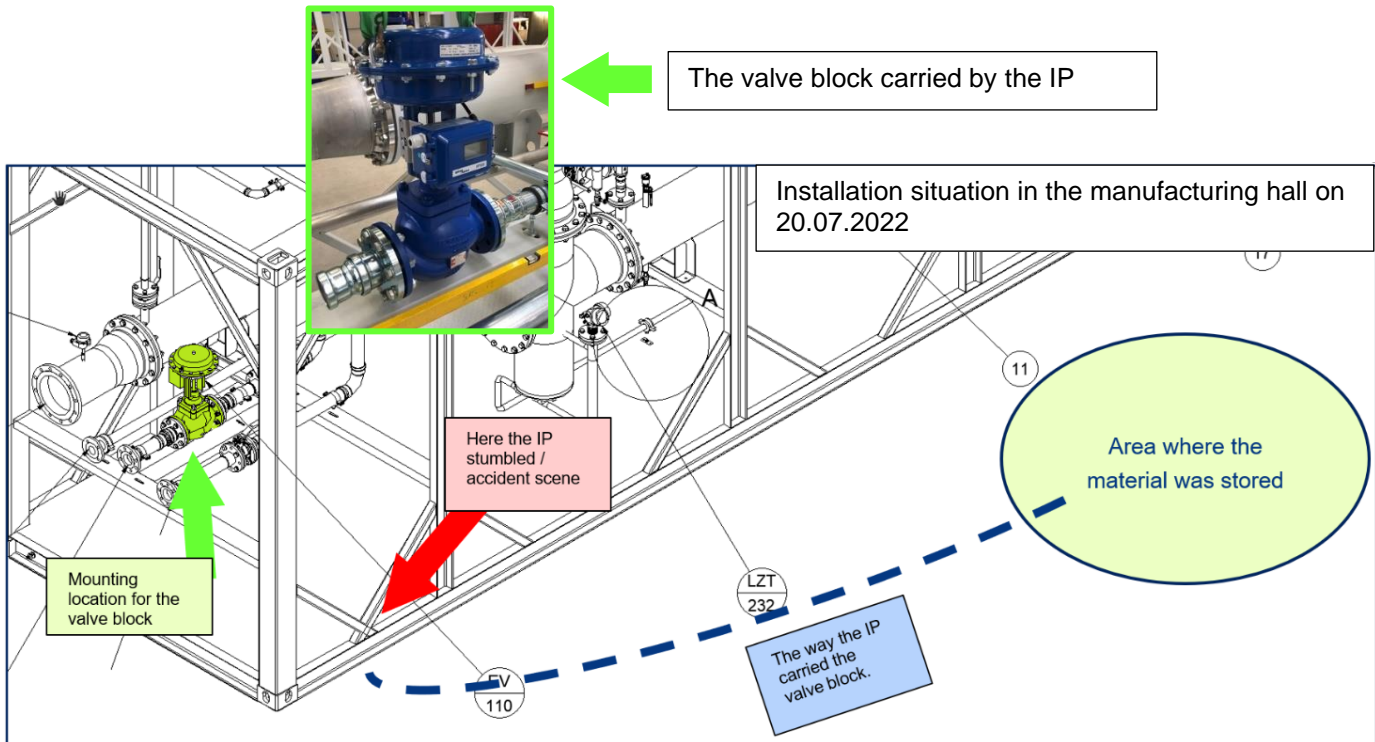




	 LESSON LEARNED 	Doc. No.: GP426 F39 Rev. 00
Hitachi Zosen Inova		

Environmental – LTI Broken arm by manual handling without mechanical aids			
Number	2022-09	Date	20/07/2022
<p>Summary: At the time of the accident, the IP was assigned to install components in a system skid. In the scope of these activities, a valve block weighing approx. 60 kg also had to be installed. To move the valve block, the IP does not use the existing overhead crane, which is usually used for transporting and positioning heavy components. Instead, he tried to carry the valve block to the installation site by hand. While trying to lift the valve block into the rack, he lost his balance and the valve block slipped away.</p> <p>Outcome: Broken elbow bone in the right forearm</p> <p>Incident Classification: LTI , Level 2</p>			
 <p>The diagram illustrates the accident scene in a manufacturing hall. A green box shows a close-up of the valve block being carried. A green arrow points from this box to the main diagram. A red arrow indicates the path the IP took while carrying the valve block, leading to the accident scene. A blue dashed line shows the path the IP took to carry the valve block. A green oval highlights the area where the material was stored. Labels include: 'The valve block carried by the IP', 'Installation situation in the manufacturing hall on 20.07.2022', 'Here the IP stumbled / accident scene', 'Area where the material was stored', 'Mounting location for the valve block', 'LVT 110', and 'LZT 232'.</p>			

Root Causes and Contributory Factors	Lesson Learned
<ul style="list-style-type: none"> • Stumbling while carrying a heavy load. • Non-compliance with safety measures and relevant Method Statement & Risk Assessment for handling heavy loads. • Lack of Risk perception. • The combination of new work tasks and low staffing levels coupled with increased time pressure can be seen as an additional hazardous factor. 	<p>The accident could have been avoided if the available tools had been used. The non-use of these tools indicates that the IP misjudged the dangers of his actions. This in turn may indicate that the IP's awareness of HSE was insufficient. Therefore, please note:</p> <ul style="list-style-type: none"> • Always check that you are carrying out the work safely. • Ensure the task is executed as per approved RAMS, otherwise engage your leader to revised it together with your HSE person in charge. • Do not take any short cut • Always follow manual safe handling techniques

	Every Lesson Learned is an opportunity to avoid recurrences. What have you done to avoid a similar incident on your project?	
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