



Number	2023-24	Date of Issue	03.01.23
Date of Incident	07.12.2023	Incident Classification	Near Miss - HiPo

Summary:

During an operation to install protective lids on electrical cable trays, a worker used a drill to modify the cable tray to align the holes in the cover with the holes in the cable tray to fit the securing bolts. When the drill bit passed through the cable tray it came into contact with a live cable drilling through the insulation into a live conductor. The circuit protection device tripped immediately and there was no injury to the worker.

Outcome: Near Miss - HiPo

Pictures:



Hole drilled through tray



Damaged cable with live conductor showing

Root Cause and Contributory Factors

Immediate/Direct Cause

- The operative contacted the live cable with the drill.

Contributory Causes

- In the POWRA (Take 5) form, the risk of working around energized equipment is not stated.
- Lack of detail within the POWRA (Take 5).
- The relevant supervisor did not check the work area after the break.
- The Operative did not follow the instructions he was given by not using the workshop available in the work area for modifications.
- The RAMS had not been revised from initial approval 25/11/2022
- In the related RAMS numbered ICE-EDRA-508602_0.0, it is not stated that lidding process.
- The live services risk box was not ticked on the T Card (PTW).

Root Cause

- Supervisor did not comply with HZI Procedure AA 426 26 Management of Point of Work Risk Assessment (take 5)
- Instruction Incorrect (RAMS did not include fitting the lids in the description of the task)

Lesson Learned

- Supervisors are to attend HZI Supervisor training to ensure that they can use the PORWA (Take 5) form properly
- Disciplinary Action will be taken if it is found that Operatives are not following the instructions of their supervisors
- RAMS must detail all tasks likely to be undertaken
- The POWRA must identify all hazards involved in the task
- HZI must ensure that Rams are reviewed at regular intervals and reflect the change of site hazard dynamics (live systems).



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

