



Number	2024-06	Date of Issue	23/02/2024
Date of Incident	22/01/2024	Incident Classification	LTI

Summary:

The ongoing activity was stripping the central pillar of a tank, with only half the metal formwork remaining, rigged to the crane (to prevent unwanted wide movement of the formwork, overturning). A worker was using a crowbar as the half formwork was stuck to the central pillar (support of hand tool is an usual practice).

Outcome:

When the formwork got detached from the pillar, the movement was slight as forecasted, as the crane was holding the formworks for safety reasons, but wide enough to touch the right foot of the IP, due to his wrong position, causing a superficial fracture to his right foot.

Pictures:



Root Causes and Contributory Factors	Lesson Learned
<p>Root Cause: Low-risk perception leading to keep a wrong position (Line of Fire).</p> <p>Contributory Factors:</p> <ul style="list-style-type: none"> • Project Procedure / Risk Assessment needs improvement: RAMS did not detailed all possible types of formwork at site. • Pre-job meeting needs improvement: Take5 was not implemented as HZI HSE TII was not attached to contractors' contracts. • Lack of Experience: Worker in young age (20 y.o.), with low experience 	<p>More emphasis and detail on identification and communication of risks and mitigation also in low-risk activities..</p> <p>Procedure to be detailed also for routine activities and when hand tools are to be used.</p> <p>Daily briefing on safety to be more effective, particularly when unexperienced manpower is engaged.</p> <p>Ensure HZI HSE Requirements are part of Contractors' contract requirements.</p>



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

