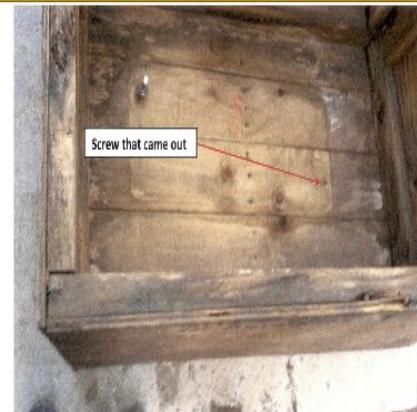


SAFETY ALERT

INCIDENT: An accident occurred while lifting of ID fan bearing housing blocks along with wooden packing box (Size:1.1M x 0.7M x 0.6M and gross wt. 252 kg) by using a 100 MT crane from a distance of 40 M to a concrete platform. The lifting was done by putting wire sling & D-shackles in the two eye bolts fixed in the bearing block. Suddenly the wooden box fell down (leaving the bearing block on the crane hook) and hit one worker involved in the job at ground. He succumbed to injuries after 4 hrs.



Detached Wooden Box



OBSERVATIONS: The supervisor was giving direction from the top of ID fan platform to rigger and the rigger in turn standing on the ground was giving signal to the crane operator. The load while swinging at about 13 M height, collided with overhead structure member. One number of 12mm dia. screw provided on foundation hole of bearing block pedestal got dislodged resulting in tilting of the wooden box. Then the box was further lifted to get proper height for clear passage to swing the load as desired. After swinging, the load was lowered down by the crane operator. At that instant, the box got detached and fell down and hit the victim (i.e. supervisor on the platform) .

ROOT CAUSE: The accident happened due to deployment of inexperienced rigger, supervisor along with use of damaged, improper lifting tools & tackles.

RECOMMENDATIONS: a) Laid down SOP should be strictly followed for all critical jobs involving hanging, lifting / lowering of loads. b) Proper tools-tackles and machinery should be used. c) Job execution to be initiated only after proper planning and Job Safety Analysis. d) Required number of skilled and experienced riggers should be engaged for lifting of loads by crane. e) Before undertaking job of lifting material by crane, critical area beneath and operating area of the crane boom to be adequately assessed and man movement should be strictly prohibited there by adequate barricading and alert messages.

WORTH MENTION: Similar near miss incidents:

July-2018: Reactor inlet elbow along with attached diffuser fell from height of 1.5 metre near reactor due to improper placement of sling. It was found that stud was used instead of D-shackles for anchoring the sling.

July-2018: Control valve which was mounted on the structural frame, fell down during shifting operation due to improper placement of sling. It was found that the sling was tied with the frame instead of body of control valve.

DO YOU KNOW?

**DO YOU KNOW,
ROOT CAUSE &
ACTION TAKEN OF
ALL THE INCIDENTS
HAPPENED IN YOUR
UNIT?**

*If Yes
Very good*



*If Not..... Not only **You**
but **everyone** is at risk.*



Unit training module should include detail study of all the incident happened till date in that unit/similar units.

This safety alert is based on the Investigation report submitted by industry and published for information purpose only.
(April/2019/05)