Point Lisas Energy Association
Event Learning

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WHAT HAPPENED?

- During the process of removing, one of the two nuts on a hydraulic puller dislodged/gave-way; ricocheted and struck a worker above his left eye, which resulted in profuse bleeding and a half-inch laceration.
- The operation was immediately stopped; first aid treatment was administered and the work area was secured.

WHY IT HAPPENED?
Brief description of current causes

- There was a change in the execution method because the bearing cover was left off the shaft following the thrust bearing installation works, and an attempt was made to retrieve it while saving the newly installed bearing.
- Change in execution method should have been documented and risk assessed prior to continuing the works

WHAT DID WE LEARN!
Connect lessons to causes in the context of Life Saving principles or Process Safety fundamentals.

- Risk assess and document changes in the method of execution before executing the works.
- Site leaders need to ensure that all relevant documents are used to drive the toolbox discussion and are on-site (hardcopy) during the works e.g. method statement; JHA etc. Leaders must properly check and manage changes where there is need.