





2017 / January

Safety Alert - Contact with electricity

Safety Alert author: Richard Spence Phone: 0427 847 941

Incident location: BT Project Site, Museums Victoria, Melbourne

Incident date & time: 21/12/16 @ ~1:15pm

Incident type: Electrical Energy

Please communicate this Safety Alert and its key messages to your team. Ensure relevant actions are complete and delivered where appropriate.

For more information, please refer to the full incident investigation report.

Incident description

At ~1:15pm on 21/12/2016 an electric shock was received by a licensed electrician working as a subcontractor for Siemens on the Melbourne Museum site.

The electrician working as part of a team replacing over 6,000 fittings with LED alternatives as part of contracted works. He joined this work team just after 1pm on the day of the incident, after completing other work in another location on the customer site.

He opened a light fitting and began to disconnect the electrical terminals to remove the fitting from the supporting rail. The fitting he worked on was not electrically isolated and came into contact with the 220V supply when he touched the neutral wires in the terminal block (See Figure 1, below).

He completed the task and reported the incident shortly afterwards to his supervisor and left the site prior to the normal work day finish time. He attended a medical centre later in the day, was assessed including ECG, which confirmed no injury and normal heart function.

Work stopped to enable the investigation to start and verification that no further risk of contact with electricity existed. The incident was notifiable to both WorkSafe Victoria and Energy Safe Victoria. Neither regulator attended the site.

Actual and potential for injury and damage

Actual outcome: no injury.

Potential outcome: permanent injury or fatality.

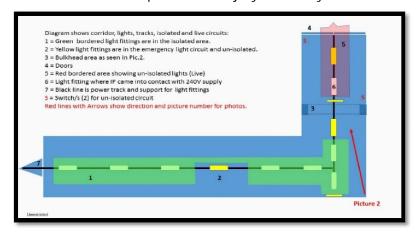


Figure 1. Plan of work area with electrically isolated area shaded green. Contact with electricity occurred at (6).

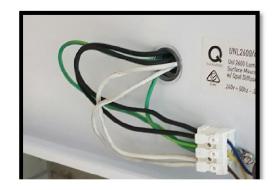


Figure 2. Terminal block in the LED light fitting. Note multiple active (white) & neutral (black) wires used to link this fitting to others in the circuit and that were energised at the time of incident.





Contributing factors

- 1. Failure to recognise boundaries of isolation and to follow Lock Out/Tag Out and test for dead requirements, as required by Work Method Statement
- 2. Failure to adequately supervise all members of the work group by the sub-contractor, given the team member had just joined this work group after finishing work in another location on site & received no briefing on the scope of work

Root causes

- 1. Failure to follow site isolation procedures for risk of electric shock as per agreed controls as detailed in Work Method Statement
- 2. Personal acceptance of risk when working with electricity, based on skills and experience

Action undertaken locally

Work ceased and the area was made safe

Investigation commenced and regulators notified

Sub-contractor supported team member leave site and undergo standard precautionary medical check.

	Key action required	Responsibility assigned to	Timeframe	Evidence required
	Revitalise Daily Prestart process &			Updated Pre-Start
	process implemented to brief any	Siemens PM	15.02.17	process; team Member
Key actions required within PS	individual who join work teams	0.00		sign-on to all Work Method Statements
	during a shift put in place Verify implementation of			Updated Work Method
	electrical isolation including LOTO	Siemens PM	15.02.17	Statement; Inspection
	as required by sub-contractor			to confirm practical
	Work Method Statement			implementation
	Monitor & check sub-contractor			
	works are completed in	Siemens PM	15.02.17	Inspections & Safety
	accordance with their Work Method Statement/s			Walks
				Cararacination to out
	Sub-contractor employee excluded from site	Siemens PM	25.01.17	Communication to sub- contractor
	These key actions will be applied across the relevant parts of the business to improve health and safety at Siemens.			Richard Spence EHS Professional Contact: 0427 847 941

ens	Key action required	Responsibility assigned to	Timeframe	Evidence required
actions to be across Siemens	Safety Alert distributed across Siemens	Head of EHS	31.1.17	Distributed Alert to People Manager group
ction				
Key a applied a	Siemens will complete these key ac	tions and continue to	improve the	 David Scott
ар	health and safety of our people.			Head of EHS

