

Hydro Tasmania

SAFETY OR ENVIRONMENT BRIEF

Topic

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| Brief Number (YYMMDD) | 250827 | Date Issued | 28 August 2025 |
| SAP Number (if applicable) | 77780 | Approved By | Head of WHS |
| Action Required? | Yes | | |

Summary

A contractor sustained a head injury while removing a cable tray in the hilltop valve tunnel at Poatina. During the task, the tray unexpectedly swung, dislodging the worker's helmet and in swinging back a second time striking their head, causing a laceration.

Preliminary investigation revealed a deviation from the planned methodology: the work was performed by one person using one scissor lift and handling 6m tray lengths, instead of the intended two-person, two scissor lifts approach cutting 2.5m lengths.

The worker was treated at hospital and discharged without requiring stitches.

Photos



Ceiling of tunnel where cable trays were installed



6m length removed cable tray

Message

Uncontrolled Movement of Equipment

The cable tray swung unexpectedly during removal, striking the contractor and causing a head injury. This highlights a risk associated with handling long, unsecured materials overhead.

This incident highlights the importance of assessing potential for stored energy and movement in structural components before undertaking work. Routine tasks like bolt removal can pose serious risks if underlying tension or instability is present. It is important that prior to undertaking work an assessment of potential hazards is undertaken:

- Use Take 5's or safe work method statements as a tool to identify hazards and assess risks
- Conduct a thorough visual and physical inspection before starting work
- Consider the possibility of stored energy or movement in components
- Use appropriate restraints or supports when removing fasteners
- Communicate hazards clearly during pre-starts and toolbox talks.
- Monitor control effectiveness and respond to any necessary changes
- And as a last line of defence (hierarchy of controls), ensure effective use of appropriate PPE

PPE Limitations

The contractor's helmet was dislodged upon impact, reducing its protective effectiveness. This suggests a need to review helmet fitment and retention systems for overhead work.

Deviation from Planned Methodology

The task was performed by one person using one scissor lift and handling 6m tray lengths, instead of the planned two-person, two-lift method with 2.5m sections. This variation increased manual handling risks and reduced control over the equipment.

Work-as-Imagined vs. Work-as-Done

The incident underscores a gap between the documented safe work method and actual site execution, indicating a need for better supervision, communication, and adherence to safe work plans.

Injury Outcome

Although the injury required hospital treatment, the worker was discharged without stitches. This outcome reinforces the importance of prompt medical response and the potential for more serious harm under similar conditions.