NTPC Limited

Mouda Super Thermal Power Station

Reportable Incident

A. Particulars of incidents:

Date & Time of Accident : 01.12.2021 at about 1640 Hours

Location of Accident : Near TP#12 (rear side of coal pile#3, CHP)

Type of Accident : Reportable

Nature of Injury : Minor cut injury at epigastric region

B. Brief History of Incident:

Two persons were engaged through sub-contractor for coal yard H/K work. On the day of accident both were deployed for grass cutting work near TP-12 on the pile side at back end of coal yard in CHP area. At about 1640 Hrs. Grass Cutting Operator was cutting the grass with grass cutting machine (FS 230, M/s XXXX make, cutting attachment - 2 teeth blade). Suddenly, the cutting blade failed and hit another person, who was standing about 6m away him. That person sustained superficial laceration at the point of contact (near brush) on the epigastric region (below left ribs) of his stomach and was immediately taken to nearest Hospital. After administering first aid treatment (stitching and medication) he was referred for further medical evaluation. After examination and rest he was discharged from hospital.

Immediate Action Taken:

- 1. Grass cutting Machine confiscated.
- 2. Instruction issued for stoppage of grass cutting work through machines deployed in Plant & Township area till further instruction.

C. Incident Enquiry Committee (IEC) Members:

Matter was referred to standing committee constituted to investigate the reason and identify the root cause and suggest corrective action to prevent reoccurrence of such events in future.

D. Investigation:

a. Observation and Findings

The 'IEC' visited the incident spot and interacted with concerned persons associated persons on 01.12.2021, 04.12.2021, 06.12.2021, 07.12.2021 and took the status of the 'Approach' & 'Safety Aspects' of that area and discussed in detail about the accident with grass cutting operators, supervisors of agency, employees & injured person.

Many grass cutting machines are used at multiple locations in plant and township. These machines are of different make and used for small grass, large bushes and at some places shrub's with use of nylon rope and metal blades. However, largely nylon ropes are being used to cut grasses and bushes. Grass cutting machines are very handy, simple to use and gives maximum output within minimal time in comparison to manual work. As it is very easy to use, many safety practices and machine instructions are overlooked.

Following observations were recorded during investigation of this incident and interaction with other usage area:

At Incident Site: Bushes/ shrubs at incident place i.e. backside of TP 11- TP 12 were of large size with thick stems at some places. The nearby area was also waterlogged. Operator was supposed to clean this area with the machine along with assistant. Operators informed that shrubs with thick stem were being cut by sickle (इंसिया). Assistant was standing 20-25 fts away behind and on right side of operator. Metal blade broke into two pieces and injured the assistant. The piece that injured the assistant was recovered, but other piece couldn't be recovered. However, exact location of injured person cannot be verified at site, except information received from operator.

At other Sites and Offices:

- 1) After the incident all the grass cutting machines were inspected by concerned department along with safety. It was observed that different agencies were using different cutting blades/wires.
- 2) Burrs were observed on the damage blade due to continuous usage.
- 3) As per manufacturer manual, interaction with M/s XXXX service engineer and Operators, possibility of blade breaking is minimal if checked thoroughly.
- 4) Many Operators were not aware of the proper sequence of fitment of cutting blade.
- 5) Record of training for safe operation of machine was not found for this case and other places of operation.
- 6) SOP was not found prepared. Record of HIRA and JSA not found available for grass cutting operation.
- 7) Machine issuing details and daily safety check report not maintained by the contractor in general.
- 8) The injured person was not standing at a safe distance during the grass cutting operation while as per OEM recommendation is 15 meter.
- 9) Manufacturer's instruction not followed in general for this case and others.
- 10) No permit system for grass cutting operation.

b. Root-cause Analysis of Incident

Based on site visit and interaction with concerned officials, root-cause analysis by committee members is as under: -

Immediate Cause: -

Failure of blade of grass cutting machine during operation.

Probable Route Causes: Operator was not aware of the Stones & Pebbles or metal parts beneath the shrub's. As Brush Cutter Strikes at a very high-speed, it leads to failure of blades resulting into injury.

- Operator who was operating the machine was not aware about the correct & intended operations
 of FS 230 cutting machine due to that unintentionally rotating blade collided with ground.
- Machine Failure may be due to wrong use or sudden breakdown.
- Use of Defective/Cracked blade knowingly/unknowingly may lead to breaking down of blades into pieces resulting in projectile motion striking the associate, who was standing at about 6 meters distance.

E. Conclusion:

No concrete reason could be ascertained for failure of the blade. However, sudden Failure of blade may be because of -

- a. Usage of defective/cracked blade which may have failed as it struck with stones/pebbles/metal during grass cutting operation
- b. Wrong fitment of cutting attachment resulting in failure of cutting blade also cannot be ruled out.
- c. Operational error & machine breakdown while using grass cutting machine.

F. Recommendations:

- 1. Grass/bush cutting to be done primarily with nylon rope attachment only. If use of metal cutting attachment found necessary, then bush cutting to be done under expert supervision with intimation to EIC (Engineer-In-Charge).
- 2. Training to all Operator's, Safety Supervisor's, Site In-charge's & concerned Owner's by OEM/Expert on safe operation of the machine. Record of the same to be maintained.
- 3. SOP to be prepared and HIRA & JSA to be done. Workers to be educated. Permit system to be used for grass cutting as well. This will be useful for information to operation, identification of site condition, SOP and JSA.
- 4. Signage's to be provided and area to be barricaded with Safety cone/appropriate tools in a 20-meter radius of working area to warn the other people. While cutting grass on roadside or other area in vicinity of people movement appropriate barricade like green cloth material is to be suggested.

- 5. Blades not to be changed at site in any condition by operator. It is to be changed by responsible trained person with correct procedure of OEM at designated place.
- Mandatory PPE's for operator and Safety Equipment's- Cut-resistant Gloves with anti-vibration property, FFP1 Dust mask, Ear Muffs, Safety Goggles, Gum Boots with Steel toe, Face Shields & Fire Extinguishers. Coveralls (Leather/Cut-resistant) is also suggested.

G. Other Precautionary Measures:

- 1. Area should be inspected before work commencement for pebbles/Stones.
- 2. Min. 20 m distance should be maintained from the Brush Cutting Operations.
- 3. Specially in Township areas, all work should be done under expert supervision.
- 4. All logs of machine issuance to operators in the form of machine issue register, repair & maintenance register to be maintained. Also, all machine to be checked before issuance and at regular intervals by responsible person. Record of the same to be maintained.
- 5. Operation of the grass cutting machine to be done as per manufacturer instructions (period of operation with rest intervals). The same to be mentioned in SOP.
- Guard/deflector necessarily to be placed on machine at correct distance from cutting portion.
 Also, Healthiness Certificate to be made available for every single machine by authorized Service Provider.
- 7. The machine to be operated with all recommended fittings as per manufacturer's instructions.

H. Photographs:

Initial Inspection of Grass Cutting Machines conducted by user dept. along with Safety.





Technical Safety Precautionary Measures



- If the cutting attachment makes contact with a foreign object during operation, the object or parts of it may be thrown at high speed. Persons may be injured or property damaged.

 Remove foreign objects from the working area.
- If the rotating metal cutting attachment makes contact with a hard object, sparks may occur and the cutting attachment may be damaged. Sparks can cause fires in a flammable environment. Persons may be seriously or fatally injured and property may be damaged.
 - Do not use the chain saw in a flammable environment.
 - Make sure the metal cutting attachment is in a safe condition.
- Note that the cutting attachment continues to rotate for a short period after you release the trigger. They may cause serious injury to persons.
 - Wait until the cutting attachment comes to a complete stop.

- 5 Safety Precautions
- In an emergency, the user may start to panic and forget to take off the carrying system. This may result in serious injury to the user.
 - Practice taking off the carrying system.

.9 Reactive Forces



- Kickout can be caused for the following reasons:

 The shaded area or the black area of the rotating metal cutting attachment comes into contact with a solid object and is suddenly braked.

 The rotating metal cutting attachment gets
- pinched in the cut.

The risk of kickout is greatest in the black area.

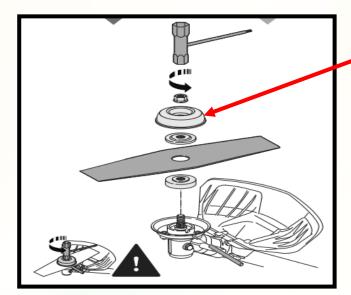
▲ WARNING

- These situations can abruptly decelerate or stop rotation of the cutting attachment and cause the cutting attachment to be thrown to the right or in the direction of the user (black arrow). The user can lose control of the trimmer. This can result in serious or fatal injuries.
 - ► Hold the trimmer firmly with both hands.
 - Use the working techniques described in this instruction manual.
 - Do not use the black area for cutting.
 - Use a combination of cutting attachment, deflector and carrying system recommended in this instruction manual.
 - Sharpen the metal cutting attachment correctly.
 - ► Cut with the motor running at full speed.









Some Vital Parts Missing during operation & Fitments also not in correct sequence as per manufacturer recommendations



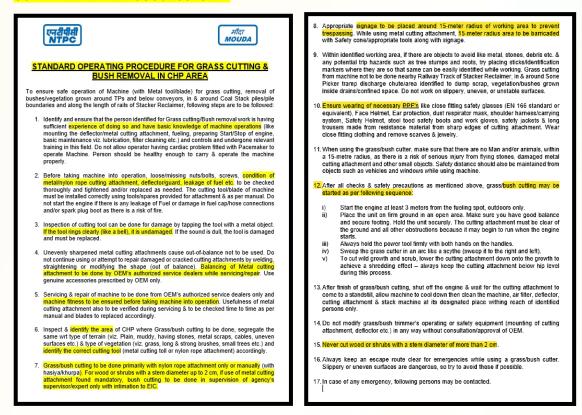








SOP IMPLEMENTED SUCCESSFULLY



Case Study of Near-Miss

01. Near-Miss-

Reported on 12.10.2022, Unit-02 Boiler & Aux, During box up of RCF 2G Front door, hinge head got detached due to ageing and fallen on Workers Leg. #Luckily escaped with no injury.













Recommendation suggested by HOP (Mouda) implemented for all 37 feeders to avoid any such occurrence in future.

It was shared by Worker named Mr. Namdeo working in M/s Simar (BMD), during interaction in safety induction on 24.07.2023 While asking with the group, 'How many of you have ever faced the near-miss at your site".

He suddenly replied <mark>"सर मैं) एक</mark> दिन बाल बाल बच गया" Gone into depth & then came to know about the similar incident which genuinely saved him from a major incident.

CAPA (Corrective Action Preventive Action) saved a Major Incident

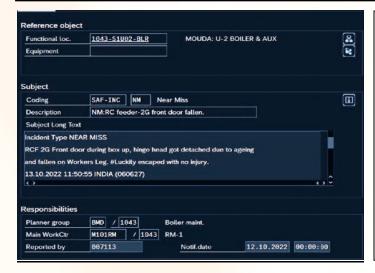


saved a major Incident ocation:- U#2 Boiler Feeder-F Date-29.05.2023









We have Suraksha APP for Reporting Unsafe Observations/Incidents in much easier way which is further directly linked with SAP systems to effectively monitor the same.

As per the Location Management Instructions (LMI) for Safety Awareness Communication & Promotion, Ref:-LMI/MOUDA/SAFETY-10/OD/OPS/SAFT/007/Rev0

Above Person has been rewarded for reporting the near-miss.

02. Near-Miss

As reported in SAP:-10.06.2022 18:21:20 INDIA (PM_BATCH)

Unit-4 SB tape off vent valve electrical actuator fallen from 90 mtr to 80 mtr. Scaffolding and piping support got damaged.

After Reviewing the Site Location & On interaction with BMD (Boiler Maint. Dept.) & TMD (Turbine Maint. Dept.) Managers:-

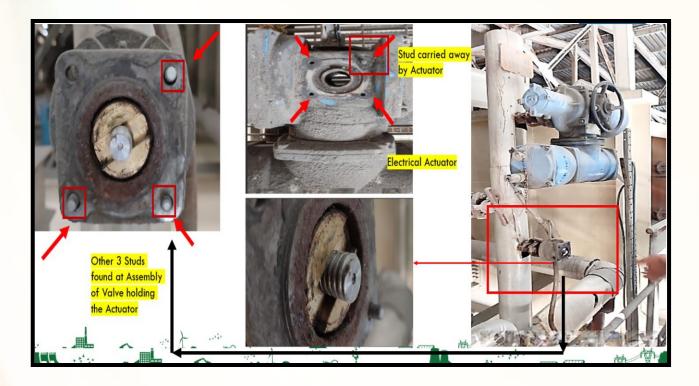
On 10/06/2022, afternoon 12:10 hrs When agency workers (SIMAR) reached for resumption of work (Reheater preservation line modification) on Scaffolding, they found the Structure damaged & Electrical Actuator laid near by. Hence, reported to BMD.

After reviewing the Site location, It seems that weight of SB TAP OFF VENT RHS Electrical Actuator, approx. 40-45 kg have been completely dependent on 4 Studs which hold the actuator, & Owing to the possibility of loosening of such studs due to certain reasons like (might have left to tighten it properly in previous Overhauling, or it may get loosened due to hammering/vibration) could resulted into such menace, self weight is catalysing factor here. Scaffolding Structure damaged very badly, We are fortunate that no one was working during that time.

Time of Falling the Actuator have been ascertain, as nobody saw it during fall.









Route-Cause identified:-

Owing to the possibility of loosening of studs responsible for holding the Electrical actuators due to certain reasons like (might have left to tighten it properly in previous Overhauling, or it may get loosened due to hammering/vibration) could resulted into such menace, self-weight is catalysing factor here.

Committee Recommendations: -

- 1) All such Electrical Actuators & other Equipment's held by such means should be checked thoroughly & re-tighten again on or before 20/06/2022 for all 4 units. (Recommended by HOP).
- 2) Preventive Maintenance Schedule should be made such that all such equipment's at a certain frequency can be inspected to prevent similar kind of incidences in mere future.
- 3) Also, one aspect of "Effectiveness of holding such equipment's" shall be explored & design of other such assemblies can be reviewed again pertaining to safety.

	TURBI	NE SIDE	
UNIT	TOTAL ACTUATORS	ACTUATORS CHECKED	ONE BOLT MISSING TO BE ATTENDED
1	145	145	11
2	145	145	15
PI	ATFORM ISSUE / UNSAFE		
	UNIT 1	UNIT 2	
Turbine side	32	41	

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UNIT	ACTUATOR NAME LOCATION Gty TIGHTNESS STATUS OTHER PROBLEMS				SUPPORTING PICTURES		
1	FDV-9.8.7.9.5.4.10,12,16 ALL IBV	8.50 MTR TURBINE	9		PLATFORM N/A	SUPPORTING METORS	
2	AS-21 A	33 MTR TURBINE	,	TIGHTNESS DONE	A-UNSAFE PLATFORM		
3	SG ECW SUCTION VALVE-A+B	O MTR TURBINE	2	TIGHTNESS DONE	PLATFORM N/A	a sampa	
4	CDV-9,7 IBV	O MTR TURBINE	2	TIGHTNESS DONE	A-UNSAFE PLATFORM	• • • • • • • • • • • • • • • • • • • •	

