SAFETY ALERT

OISD/SA/2025-26/P&E/04 Dt.: 11.11.2025

INTRODUCTION

Title: Fatal incident during static running of fire tender.

Location: Gas Processing Plant

Loss/ Outcome: One fatality.

BRIEF OF INCIDENT:

A major incident occurred during the static running of Fire Tender parked in tender bay of fire station at around 12:50 hrs in the morning shift. One assistant fire Inspector (injured person, (IP) was injured during static running and immediately shifted to plant's first aid center via ambulance stationed near the incident site. He was then shifted to city hospital for further examination.

On arrival at the hospital, the on-duty doctor evaluated his condition and referred him to the Intensive Care Unit (ICU). Where he succumbed during the treatment.

OBSERVATIONS/ SHORTCOMINGS

a) Fire Tender was parked in drive away position in Tender Bay of Fire Station.
b) The vehicle was secured by 03 nos. of wheel stoppers; one temporary metallic stopper in front of the front (driver side) tyre, and two permanent stoppers located behind the rear wheels.
c) Static running was done as per SOP to keep the tenders ready for emergency response.
d) As explained by Senior Operator (F&S), Fireman (F&S) and Shift In–charge (F&S), there was a loud abnormal sound from Tender Bay. All three rushed towards Tender Bay and found IP was lying on the ground and Fire Tender was in moving position.
e) Investigation committee found that SOP (static running) states that all fire tenders to be started while sitting on driver's seat. However, position of DP after the incident strongly suggested that he was not on driver's seat when he started tender.
f) Scratch marks were found on body of the tender on the driver side at mid-section. The marks commenced at the rear cabin door. This suggested the vehicle moved forward and hit the adjacent concrete column at driver side mid-section of tender.
g) After the site visit by investigation committee, it was opined that when the vehicle started moving, driver side tyre could not move freely due to the vehicle stopper, and it dragged the stopper. Since left side front wheel was freely moving, it resulted in the vehicle

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veering to right side towards the concrete column as evident by skid marks made by vehicle stopper.

h) Concave depression was observed on the mudguard of front wheel of tender.

ROOT CAUSE OF FAILURE / CONCLUSION

a) Based on the evident scratch, committee concluded the most probable cause was that the tender, was started while the IP was standing outside of the vehicle. When the vehicle moved (probably due to gear being engaged), he was trapped between mudguard of front wheel and adjacent concrete column.

b) The above action was in deviation from Standard Operating Procedure: “Start the engine with operator positioned on driver seat & run at idle speed”.

RECOMMENDATIONS

a) Strict adherence of Standard Operating Procedure to be ensured.

b) The activity to be incorporated in HIRA (Hazard Identification & Risk Assessment) register of the company and risk rating to be revised."

c) Behaviour based training to be imparted to all employees/ workers periodically.

PHOTOGRAPHS

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