Temasek POLYTECHNIC	Incident Report		
Document No: EFM/FMO/006	Version No: 01	Revision No: 0	Date: 03/6/2024

Report No:	SMM/TP/< East ZONE>/IR/<006>
Date & Time of Report:	03 June 2024
Reported by: (Name & Designation)	HAN, Assistant Operations Manager
Reviewed by: (Name & Designation)	Ken Chang, Director of Operations, Primech A&P

Nature of Incident:	Struck by Object		
Date & Time of Occurrence:	03 June2024, 07:25 hr		
Location:	Blk 1A near level 1 bin centre		
Duration of Service Disruption (if applicable):	Unknown,		
Type of Incident: (Select the type of incident) *[For fire alarm activation, the fire alarm zone and time when DECAM was called to inform of the nature of the alarm must be clearly indicated in the report]*	S/N	Type	
	1	Fire Alarm	☐
	2	Mechanical System	☐
	3	Electrical System	☐
	4	Plumbing and Sanitary	☐
	5	Building Facilities	☐
	6	System Application	☐
	7	Cleaning and Pest Control	x
	8	Landscape	☐
	9	Others (Please specify):	☐

Incident Description *(append & label photos of the incidents where applicable)*:	
Summary:	On 3rd June 2024 7:30am, Supervisor Rahimah was cleaning the Ride on scrubbing machine water tank when the water tank hatch slammed shut and injured her left hand causing her fingers to swell. Afterwards, she asked for help as she felt pain in her fingers. Floater Helmi went over to assist Supervisor Rahimah as he is nearby the area. Floater Helmi immediately turn off the water supply and took over the T7080 Ride-on machine. He informed OE Charles, whom arrived at 7:35am to update the situation to AOM Han. When AOM Han was informed about the incident, he brought Supervisor Rahimah to the office and performed first aide by applying cold compress to lessen the pain and reduced the swelling.

	Supervisor Rahimah was sent to nearby clinic for further medical treatment.
Impact:	Injuries to her left fingers due to the ride on scrubber hatch dropped and finger got caught in between
Cause:	 Position of Rahimah when incident occurred  Rahimah was standing at the edge of the curb



Placement of fingers



Hatch dropped and finger got caught in between

Immediate Corrective Actions *(immediate actions taken after incident occurrence)*:

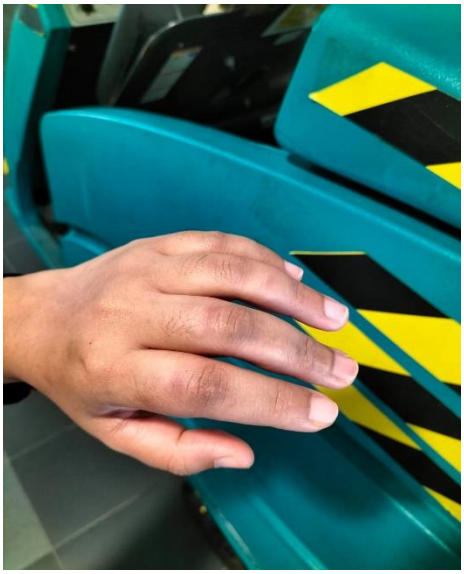
Supervisor Rahima immediately stop work. Primech Management team Assess IP conditions, provide first aid and send to nearby clinic (Little Cross Family Clinic) for further check.

Investigation Findings *(append & label photos of the incidents where applicable)*:

Image of the site of incident



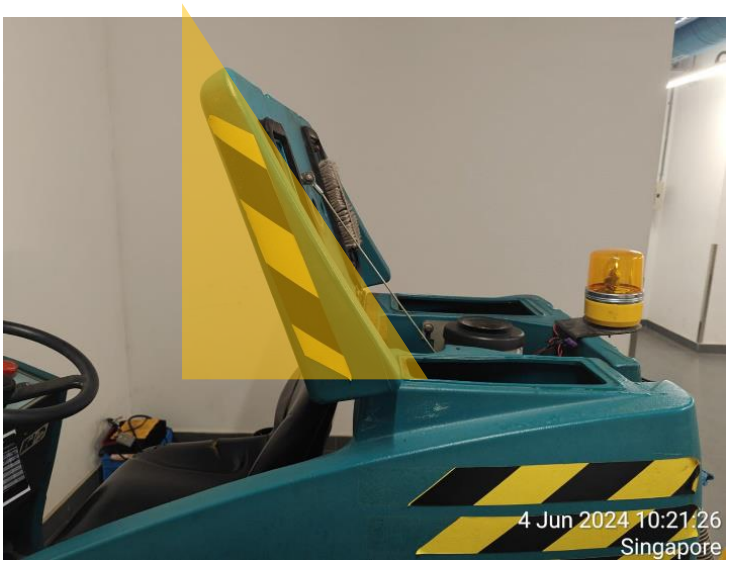
Image of the condition after the incident





Root Cause Analysis:

Rahimah was complacent and assumed that the hatchet will not drop down due to the fact she does it daily and nothing happened. In additional, the wire latch provided is not long enough to fully extend the hatchet and there is a likelihood that the hatchet will fall forward due to external factor such as uneven ground or direct impact with the hatchet.



Did a physical check on the scrubber.
• The hatch can be fully extended.
• No signs of damaged or loose of the wire latch

However, the angle of elevation is almost 45°. There is a tendency for the hatch to fall forward which can be avoided by lowering the angle elevation to 25° or lower such that the gravitational force of the hatch is falling backwards.



RCA Method: 5 Whys Analysis

Problem Statement: Rahimah got injured during washing of scrubber Tank

1st Why: The hatchet dropped down while Rahimah was washing the tank.
2nd Why: The hatchet was not fully extended.
3rd Why: The wire latch was not long enough
4th Why: Rahimah assumed that the hatchet will not drop.
5th Why: Rahimah does it 5 times per week.

Additional Preventive Actions *(Additional follow up to prevent future occurrence)*:

• To lengthen the wire latch such that it is long enough to extend the hatchet further as to prevent the hatchet from falling forward.

• To conduct in-house training periodically to warn all users of the scrubbers to be wary of the hatchet and not be complacent.

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