

Accident Details - 2025 (Upto Nov-25)																				
Sl.NO	Date	Time/Shift	Name	CC No.	Dept	APU	Repeat?/1st time	Accident Area	Category of Accident	Nature of Injury	Injured Part	M/c Name & No.	Return to work	USC	USA	Description Of Accident	Root Cause	Corrective action	Responsibility	Status
1	05.01.2025	5.20 AM & 3rd Shift	Manikandan	RS10368	FPD	Filter	1st time	Filter - Rework area	Minor	Cut Injury	Left hand thumb finger		Immediately	1		While working at the rework station, the victim tried to loosen the bracket mounting screw from the filter component to reuse the bracket. During this course of activity, the victim was holding the filter component firmly in one hand and operating the torque switch on another hand at that time, part slipped and sustained a deep cut injury in his left hand thumb finger.	Poor Design of fixture for Component reworks	1. Fixture design to be improved to effectively perform all type of reworks and can also be able to perform reworks in all filter variants. 2. SOP to be made for all the activities involved in filter component reworks (Visual representation) 3. New SOP awareness to be given to all trainees through OPL	Thiyagarajan	Completed
2	07.01.2025	1.30pm & 1st shift	Balakumar	NA1463	FPD	Filter	1st time	Filter - Pleating cell	First aid	Burn injury	Right hand wrist	Pleating machine - 2	Immediately	1		While working at the Pleating machine, the victim tried to correct & clear the filter paper pop up issue in the heater section at forward mode. During this course of activity, Victim holds filter paper in one hand and operates the push button switch on another hand as well as Heater is moved forward direction & heater contact into his right hand with high temperature. It resulted in accidentally getting a burn injury over his right hand wrist.	Lack in safety system - Interlocking b/w heater and safety guard was not available	1. Interlocking to be provided to cut off the heater when the safety guard was in open condition Monitoring of safety guard interlocking ensured thorough machine FLM 2. Two Hand push button to be provided in the machine	Thiyagarajan	Completed
3	18.01.2025	1st shift - 10am	Bidya sagar	RS12218	FPD	Filter	1st time	Filter - Pleating cell	First aid	Swelling	Left leg	Pleating machine - 2	Immediately		1	While change over the clipping roll in the pleating process at the 2nd station, where the trainee placed the clipping roll beside the machine support. The roll slipped, resulting in the trainee injuring his left leg. The trainee was promptly taken to the Occupational Health Center (OHC) for further treatment.	No SOP available for Clipping coil changing activity	1. SOP to be provided for the Clipping coil loading 2. Clipping coil movement trolley with adequate support for coil feeder	Thiyagarajan	Completed
4	26.01.2025	10.40am & 1st shift	Vasu	RS12844	FPD	Rail	1st time	Rail assembly and testing -1	First aid	Swelling	Right leg	Aquarese testing station	Immediately	1		After the machine cycle completion, the front door starts moving to its home position. At that time, the front door was completely detached from the machine and fell onto the victim's right thigh while he was standing in front of the machine to unload the rail component. It resulted severe pain and swelling in his right leg.	Machine front door connecting hinges was poorly designed	1. Design to be improved on machine front door hinges to eliminate the impact of load on machine front door hinges 2. In TBM, ensure the machine doors working condition and all its parts are available in proper manner and it has to be evidenced quarterly 3. In MQ new machine safety audit, Check the machine doors movement and its actuating position from start to end and ensure there shouldn't be any load acts on cylinder connecting part & door	Selvakumar	Completed
5	04.02.2025	6.10am & 3rd shift	Santhosh kumar	MA1251	FPD	Injector	1st time	Nozzle Soft - machining	First aid	Laceration	Head		Immediately		1	Operator entered into a gap at the bottom of the quality display board instead of gateway for reporting with supervisor from Fanuc machine to ECM machine, So he was hit with a power box corner at the near(Victim used shortcut). It resulted in a laceration of his scalp.	Trainee used shortcut way to reach the location - Unsafe act	1. As per Reaction plan for Identified Unsafe act (WIN) - Counselling to be given to the trainee 2. OPL to be made to follow the SOP	Anantharaj	Completed
6	04.02.2025	2.30am & 3rd shift	Sethupathi	RS 12711	FPD	DFP4	1st time	DFP4 Testing area	First aid	Cut Injury	Left hand middle finger	Functional testing machine	Immediately	1		During the manual activity, the Operator tried to adjust the struckup fixture in the loading test pallet machine conveyor. It was released from the conveyor & moved suddenly. So that pallet hit over his hand. It resulted in a small cut injury over the left hand middle finger.	No periodical maintenance is carried out in conveyor	1. Misalignment in conveyor to be corrected 2. Guard to be provided 3. PM schedule to be prepared for coneoyr system and adhere it	Anbarasan	Completed
7	24.02.2025	3rd shift & 12.40AM	K Raghuraj	RS11702	WED	UPCR	1st time	UPCR	Minor	Cut Injury	Right hand middle finger	AMS Buffing machine	Immediately		1	Maintenance technician tried to remove the spindle with a wooden piece by hand, At the same time the spindle indexer moved and hit his hand. It resulted in a minor cut injury to his right hand middle finger.	No SOP available for spindle changing activity	SOP to be made for spindle changing and setting change activities	Ravikumar	Completed
8	02.03.2025	7am & 1st shift	AKSHAYA	RS11017	FPD	Injector	1st time	Injector finish off L-3	First aid	Swelling	Head		Immediately		1	Victim tried to take an empty bin at the backside of the machine, Because of oil spillage occurred by the maintenance, She got slips and fell down at the floor . It leads to swelling in her forehead at the right side.	Lack of safety awareness – Victim's safety shoes bottom was in worn out condition	Awareness to be given to avoid this type of unsafe behaviours	Palanivel	Completed
9	05.03.2025	6.50 pm & 2nd shift	AKASH	DNA159	FPD	DFP6	1st time	DFP6 finish off	First aid	Cut Injury	Right hand index finger	Near bubble leak test machine	Immediately	1		Victim attempted to lift the upper part of a pump component from the trolley. During this process, the victim's right hand finger became caught in the lock mechanism of the upper rack. As a result, the individual sustained a cut injury on his right hand index finger.	Presence of sharp edges on the upper lock hinges Failure to follow the MHE Checklist (EOHS-P07-121-F03) for condition monitoring of trolleys - USA	1. Awareness to be given to all the trainees and line supervisors to properly adhere the MHE checklist for conditional monitoring of all component handling trolleys 2. Deburr the sharp edges from the lock hinges of trolley	Nandagopal	Completed

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10	05.03.2025	10.30 pm & 2nd shift	KARTHICK M	NA1322	WED	DFP3	1st time	EOU Drive shaft Hard stage	Minor	Cut Injury	Right hand index finger		Immediately		1	Victim was assisting his supervisor on the front side of the machine, while the supervisor manually controlled the hydraulic system by using a tool, instead of the machine's panel controls, on the back side of the machine. During the activity, the tailstock moved backward from the home position. As the drive shaft fell into the machine, the victim attempted to retrieve it. During this process, the tailstock moved suddenly forward due to the manual operation and struck the victim's right hand, resulting in a cut injury to the ring finger of his right hand	LOTO procedures were not followed during the troubleshooting activity	1. Comprehensive LOTO procedure has to be made that it must be followed for all troubleshooting /PM activities 2. Procedural training to be imparted to all maintenance personnels about the effective implementation of LOTO	Sriram	Completed
11	14.03.2025	6 pm & 2nd shift	S.Sowmiya	RS12383	QED	Injector	1st time	Nozzle hard	Minor	Cut Injury	Middle finger		Immediately		1	Trainee was trying to open the main door when, suddenly, the door closed without any manual force, resulting in a minor cut injury on the right hand's middle finger. The trainee immediately visited OHS for further treatment.	No periodical condition monitoring carried out for that nozzle hard single door	Periodical condition monitoring schedule has to be prepared (Verify that all the doors are included in it) and adherence to this schedule should be ensured.  Monitoring record to be maintained	Praveen	Completed
12	29.03.2025	6.15 pm & 2nd shift	Kanchu charan basher	RS12705	FPD	DFP6	1st time	DFP6 assembly and testing	First aid	Laceration and Swelling	Thumb finger		Immediately		1	When the victim was closing the upper tray of the component loaded trolley, at that time the upper tray fell and impact his right hand, which he was placed at the connecting point of the trays. Due to this impact, the victim got swelling and mild laceration in his right-hand thumb finger .	Functional failure of installed Gas spring in trolley  MHE Checklist (EOHS-P07-121-F03) for condition monitoring of trolleys was not followed- USA	1. All the gas springs must be replaced with new one By MSE) 2. Gas spring life to be determined in all trolleys and also periodical monitoring and replacement has to be done by WED 3. Awareness to be given to all the trainees and line supervisors to properly adhere the MHE checklist for conditional monitoring of all component handling trolleys	Nandagopal	Completed
13	04.04.2025	09:00 pm & 2nd shift	MANIKANDAN	TIT1092	FPD	Injector	1st time	Nozzle hard cell	Minor	cut injury	right-hand ring finger	OM12017 Bahmullar head & shank grinding	Immediately		1	Trainee was attempting to remove the nozzle component from the tailstock while the grinding wheel was near the tailstock(Instead at home position). During this action, the operator's hand slipped, causing accidental contact with the grinding wheel. This resulted in a minor cut injury to the operator's right-hand ring finger.	Unsafe Act - The trainee bypassed the standard procedure for the warm-up activity and used an unauthorized method	1. Counselling to be given to the trainee for this SOP violation 2. Awareness should be provided to all trainees through OPL to avoid performing unauthorized work on machines without supervisor knowledge 3. Skill evaluations should be conducted for all jobs requiring specific skilled manpower	Surenderraj	Completed
14	04.04.2025	7.45PM & 2nd shift	K ABINAYA	TIT1188	FPD	Injector	1st time	Finish off	First aid	Laceration	left thigh	OP105 Coil orientation & cone leak checking station	Immediately		1	The injector trolley's top tray, which was not locked in place As a result, the top tray slipped and descended. While attempting to reposition the tray by another trainee, the component trolley skidded and fell onto the trainee's left thigh. It resulted over her left thigh, sustained a pain and mild abrasion.	Lack of awareness on importance of safety system (Victim didn't lock the upper rack while handling the trolley)§	OPL & Awareness to be given on safe handling of trolley	Palanivel	Completed
15	12.04.2025	04:00PM& 1st shift	Deepika	RS12088	FPD	Injector	1st time	Nozzle hard line -2	First aid	Swelling	left-hand Ring finger	EDM 8-Passivation Station	Immediately		1	While attempting to start the cycle on the passivation bench, the trainee operated the machine with one hand. During this process, the trainee's left-hand finger became trapped in the top cover, resulting in a hand injury. . The trainee immediately visited OHS for further treatment.	Poor design: The two-hand control could be operated with one hand, violating ISO safety standards.	1. Two hand push button design has to be modified as per the standard requirements (Center-to-Center Distance Between Buttons must be minimum distance of 260mm) 2. In MQ new machine safety audit, Two hand push button operation and also compliance of installation requirements has to be ensured (i.e Distance between the buttons must meet the standard requirements.) 3. Awareness to be given to all the trainees through OPL to properly adhere the two-push button operation	Kailash	Completed
16	15.04.2025	01:00 PM& 1st shift	Arunachalam S.R.M	102921	WED	Injector	1st time	Nozzle assembly line	First aid	Cut Injury	finger	Lift grinding machine 3	Immediately		1	The shuttle movement was stuck on Lift Grinding Machine 3 due to a fallen needle. While attempting to rectify the problem, the shuttle was moved manually. At that moment, it disengaged from the needle and moved rapidly, causing injury to the operator's finger. . The trainee immediately visited OHS for further treatment.	LOTO procedures were not followed during the troubleshooting activity	1. Comprehensive LOTO procedure has to be made that it must be followed for all troubleshooting /PM activities 2. Procedural training to be imparted to all maintenance personnels about the effective implementation of LOTO	Sarvankumar	Completed
17	16.04.2025	7.45am & 1st shift	Arun		Security Guard	HR- Security	1st time	Main gate	Minor	Cut Injury	head	Main Gate	Immediately		1	The parking main gate moved back automatically without any external input. The bottom roller of the gate hit the stopper and jumped off, causing the gate to come off the track and fall. The PRR Transport Supervisor, who was standing nearby, attempted to stop the falling gate and sustained a head injury. He was immediately taken to OHC for further treatment	No periodical maintenance for the sliding gate system	1. Periodical maintenance schedule to be made 2. Sliding gate shall be operated through motorised mechanism instead of manual movement 3. Wheel stoppers shall be maintained in good condition 4. Additional upper guide roller support shall be provided before end of the track	Jayseelan/Kumaresan	Completed
18	20.04.2025	6.30pm & 2nd shift	Minnal Kodi	RS1248	FPD	Injector	1st time	Nozzle hard	First aid	Swelling	left leg thumb		Immediately		1	Victim entered the IAT area from nozzle hard to collect empty pallets for a nozzle needle assembly. After collecting the five pallets from the area, she returned. While doing so, she slipped and it caused the pallets in her hands to fall onto her right leg thumb finger and it resulted a severe pain and swelling in her right leg thumb	Unsafe Behaviour - Victim was not wearing the safety shoes while entering the Injector Assembly and testing area	1. Counselling to be given to the trainee for this SOP violation 2. Awareness should be provided to all trainees through OPL to avoid	Palanivel	Completed

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19	28.04.2025	7.30pm & 2nd shift	Hariharasudhan	RS12806	FPD	Injector	1st time	Nozzle Soft - machining	First aid	Cut injury	Right hand index finger	Tsugami 4	Immediately	1		While attempting to remove a nozzle component from a machine, the operator's hand came into contact with burr particles present on the part. The sharp burrs caused a cut on the index finger of the operator's right hand.	No scheduled periodic maintenance was carried out for the auto conveyor of the Tsugami machine	1. PM schedule to be prepared for conveyor system and adhere it 2. Awareness should be provided to all trainees and line supervisors to properly wear cut-resistant gloves when handling burr particles in case of any malfunctions in the auto conveyor or in the machine	Sarvankumar	Completed
20	05.05.2025	4.30pm & 1st shift	Mary	DNA020	FPD	Injector	1st time	IAT Finish off	First aid	Swelling	Left leg		Immediately		1	After shift work completion, the victim ran fastly to get out of the IAT area. At that time, She slipped and fell down on the floor due to oil spills. It leads to severe pain in the left leg and neck.	USA - victim ran fastly in the workplace Oil Leakage from the Injector testing machine and overflow from the secondary containment	1.Counselling to be given to the trainee to avoid this unsafe behaviour 2. Oil leakage from the Injector testing machine to be arrested	Sarvankumar	Completed
21	07.05.2025	4.30pm & 1st shift	HARITH	DNA205	FPD	DFP6	1st time	DFP6 –Helium Leak test m/c entrance	Minor	Cut injury	Left Hand index finger		Immediately		1	After collecting the rejected pump component trolley from the helium leak testing machine, he returned to the entrance and opened the door to pull the fully loaded trolley out. As he did this, the door swung back and at that moment, his forefinger became trapped between the door and the trolley handle which resulted a minor cut injury on his left hand forefinger.	Lack of proper training or awareness on safe material handling practices	Awareness should be provided to all trainees on safe material handling techniques	Nandagopal	Completed
22	17.05.2025	8pm & 2nd shift	Surya K	DV214	FPD	UPCR	1st time	UPCR Testing area	Minor	Cut injury	Left hand	Bubble Leak testing machine	Immediately		1	After completion of HP & LP bubble leak test on the machine, the victim noticed air leakage from the connecting pneumatic port and so attempted to adjust it. While doing so, he held the pneumatic port with one hand and supported himself by holding the connecting guide rod frame of the cylinder unit with the other hand. At that moment, the pneumatic cylinder moved upwards, causing his hand to get trapped between the connecting guide rod frame and the machine frame, resulting in a cut injury to his left hand.	Unsafe Act - Trainee attempted to adjust the pneumatic port before the machine cycle operation completion	1. Counselling to be given to the trainee for this SOP violation 2. Awareness should be provided to all trainees through OPL to avoid performing unauthorized work on machines without supervisor knowledge 3. Machine switch box frame to be relocated to avoid performing the	Ravi kumar/Nandagopal	Completed
23	22.05.2025	3.15pm & 1st shift	Yogesh kumar	TIT1288	FPD	Injector	1st time	Nozzle hard	Minor	Burn injury		PMT machine 1	Immediately	1		After the grinding wheel's life was completed, the operator attempted to replace it with a new one but failed to adjust the offset setting. This oversight led to an overload on the chuck, causing excessive heat and resulting in a flame being produced from the machine. The flame made contact with the operator's hand, necessitating immediate treatment at the Occupational Health Center (OHC).	No SOP available for Grinding wheel changing activity and setting change	SOP to be made for grinding wheel changing and setting change activities Awareness should be provided to all trainees through OPL to follow new SOP of grinding wheel change and setting change activities	Sarvankumar/Surrenderaj	Completed
24	24.05.2025	11am & 1st shift	Rajesh K	TIT999	FPD	Rail	1st time	Rail machining 5 A	First aid	Prick injury	Middle finger	Port -2 - MAKINO	Immediately	1		An operator attempted to remove a rail component from a fixture too quickly. During the process, his finger was positioned between the component and the fixture. As a result, he sustained a nail injury to his middle finger.	Design issue - Ball bush provision on fixture was appropriate for easily locating component	Ball bush provision on the fixture was removed	Boopathi	Completed
25	25.05.2025	11.30am & 1st shift	Nalamani	WP064	FPD	Rail	1st time	Rail grey room	Minor	Cut Injury	Right hand elbow		Immediately	1		Victim was instructed to perform the fixture changing activity in Maximator -1. He removed the existing fixture from the machine and placed it on the fixture storage stand. He then properly positioned the scissor lift trolley at an even level and attempted to pull the new fixture by its handle from the storage stand to place it onto the trolley. During this process, his hand slipped and struck the end stopper on the trolley, resulting in a minor cut injury to his right elbow.	Poor Design - Stopper provided on the scissor lift trolley protruding in the direction of fixture handling, with sharp edges in that corners	Scissor lift trolley stopper design to be improved to eliminate the sharp edges and protrusions that pose a risk of contact injury during fixture handling	Boopathi	Completed
26	26.05.2025	3pm & 1st shift	Jayaprakash	103232	Methods	Rail	1st time	Rail power pack area	Minor	Cut Injury	Right hand and left hand		Immediately	1		Victim was instructed to perform the filter-changing activity on the rail power pack. While attempting to remove the filter bowl using a ring spanner, his hand slipped, and his finger got stuck inbetween the spanner and the filter bowl, resulting in a minor cut injury to his left hand ring finger. He didn't initially notice the injury and proceeded to perform the same activity on another filter. During this process, his hand got stuck on the power pack unit frame, causing an injury to his right hand thumb.	Inadequate SOP – Didn't clearly specify the type of PPE required for this specific activity Poor design of power pack unit equipment - There is no adequate clearance to perform the B/D activity	1. SOP to be revised to clearly specify the PPE requirements for this activity 2. PPE matrix to be provided for all the non routine activities 3. Design modification to be done in power pack unit to have adequate clearance and easy access for doing this type of activities 4. OPL to be made to educate all the trainees to properly use the appropriate gloves for all the non routine activities	Boopathi	Completed
27	02.06.2025	7.30pm & 2nd shift	Kaviya	C10066	FPD	Filter	1st time	Filter Assembly	Minor	Swelling	Right shoulder	Bracket position ( SL ATEQ)	Immediately		1	While attempting to transport input materials from the material room to the riveting operation, a trainee was involved in an incident. As she was moving the trolley, a bracket position bench operator unintentionally made contact with it. This caused the input trolley to become unbalanced, resulting in the material bins falling and striking the trainee's right shoulder.	Unsafe Act- Input bins are kept in the gangway, not maintaining the bins stack height and not maintaining the stack height input trolley poor design  Bracket assy station layout not designed to provide adequate working space, leading to obstruction of the gangway	Input trolley design to be improves which the wheels get extended for the entire gangway  Bracket Assy layout to be modified to avoid interference in gangway movements of trolley	Sundaresan	Completed

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28	07.06.2025	11.30PM & 2nd Shift	Muthukumar	MSSPL- 478	FPD	DFP6	1st time	DFP6 FQG area	First aid	Laceration	Right hand		Immediately		1	While the victim was attempted to lift the upper part of the rack of the component loaded trolley, at that time the upper tray fell and impact his right hand, where he was placed his hand at the connecting point of the trays. Due to this impact, the victim got swelling in his right-hand.	MHE Checklist (EOHS-P07-121-F03) for condition monitoring of trolleys was not followed- USA	Awareness to be given to all the trainees and line supervisors to properly adhere the MHE checklist for conditional monitoring of all component handling trolleys	Nandagopal	Completed
29	10.06.2025	3pm & 1st shift	Rushi Kumar	C10335	FPD	DFP1	1st time	Hydraulic Head soft	First aid	Cut Injury	Right hand	OM03001 - Mounting hole temp sensor IMV machine	Immediately		1	After machine cycle completion, Operator noticed the burr stuck in the machining tool and then he attempted to remove the burr by pulling it manually and it resulted cut injury in his right hand index finger	Unsafe Act- Victim was not using cut resistant gloves during the time	Awareness should be provided to all trainees and line supervisors to properly wear cut-resistant gloves when handling burr particles	Ananthakumar	Completed
30	30.06.2025	1.40PM & 1st Shift	Suryakanthan	NA1736	FPD	DFP3	1st time	DFP3 Drive Shaft	Minor	Fracture	Right hand - middle finger	OP-20 TP End Turning (Takisawa)	Immediately		1	In the TP end turning machine, Mr. Ganesh (Supervisor) was engaged in a runout correction activity and was supported by Mr. Suryakanth (STT). During this process, When the supervisor was forwarding the turret in X-axis, the victim had placed his hand near the tailstock and was checking the condition of the facing tool simultaneously. Unfortunately, the supervisor didn't see the victim's hand in the vicinity and continued with the X-axis movement. As a result, the victim's middle finger was caught between the turret and the tailstock, sustaining a crush injury in his right hand middle finger.	Unsafe Act - Victim was placing his hand on the Vicinity of Turret movement - (Lack of awareness) Two-personnels were working simultaneously on the same machine There was no clear coordination or communication between the trainee and the supervisor.	1. Awareness & OPL to be made to have safe operation while doing this type of Non- routine activities and avoid two personnels working simultaneously on the same machine. (No Simultaneous tasking) 2.Enforce a policy that only one person operates or inspects a machine at a time. 3. Activity matrix to be made for this type of identified non routine activities 4.Implement a clear standard operating procedure (SOP) requiring verbal confirmation before any machine movement when more than one person is involved.	Ananthakumar	Completed
31	04.07.2025	2.20PM & 1st Shift	Buddha Bhaskar Rao	C10198	FPD	Injector	1st time	IAT washing	Minor	Laceration	Right hand- four fingers		Immediately	1		During the relocation of the Nozzle Holder Body (NHB) storage rack, a trainee (injured person) attempted to assist midway while three other trainees were performing the activity. During the course of the activity, when the trainee tried to hold and pull the storage rack, he sustained a laceration on four fingers of his right hand.	Relocation/layout change activity was carried out by the internal team without proper planning. Instead of being executed by the Designated MSE Team Inappropriate PPE was used for this activity Sharp edges on the storage rack were not identified and corrected initially	Counselling to be given to avoid involving in unauthorized work without the supervisor knowledge Awareness and OPL to be made for all trainees to wear appropriate gloves for all this type of non routine activities Incoming inspection check sheet to be followed for all storage facilities before handing over to user department (New and Repair) and to be included in procedure	Palanivel/Sundaresan	Completed
32	26.07.2025	9.15 PM & 2nd Shift	Selvin	C10465	FPD	Injector	1st time	Nozzle Assy	First aid	Cut Injury	Right hand- Ring finger	Lift-2 machine	Immediately		1	While the trainee was loading the pallet in Lift-2 machine, he unknowingly placed his finger inside and closed the drawer, resulting in a mild cut injury to the nail of his right ring finger.	Lack of hazard awareness and insufficient training on machine operation procedures and design flaw	Handle need to be corrected and to be placed in middle position Awareness and OPL to be made for all trainees to use handle for drawer	Surenderraj	Completed