

Enclosure 4 – Root Cause Analysis Report Addendum

Report Addendum

The original report identified the initiating actions for the Moss Landing tower collapse as: “From the findings identified, the tower collapse event was initiated by the incorrect settings of the stub angle due to a human error in reading the drawing heel batter; and the subsequent communication of this incorrect heel batter to the crew for use in setting the stub angles.” Further discussion of the initiating events relative to the root cause analysis is provided since the nature of the initial human error cannot be determined with certainty.

The Moss Landing root cause analysis was performed to determine the cause of the event and to define corrective actions that prevent recurrence of the event. Based on a review of the job package, drawings, field inspection and stub angle setting demonstration, the initiating action that caused the tower collapse was an incorrect stub angle due to human error made at some point during the tower erection process (from construction receiving job package to installation of the stub angles). The bases for this conclusion:

- The job package and drawing contained the correct stub angle batter angle.
- The field inspection after the event indicated that the stub angles were set at a different batter angle than the drawings indicated.
- The stub angle demonstration showed that the stub angle setting process is driven by human performance in locating the stub angle sites, placing the stub angles, and verifying the stub angles.

The personnel interviews indicated that there was most likely a misreading or miscommunication related to the stub angles and that during the construction process, the correct batter angles were not obtained. However, human errors could occur in the tower erection process including reading information from the job package, communicating information to and among the construction crews, locating stub angles, installing stub angles, and verifying dimensions. The root cause process was performed to identify corrective measures to prevent any human error from impacting the design intent of the tower. The causal analysis reviewed the barriers in place to prevent human error and developed recommendations to address improvements in these barriers to prevent recurrence.