

TOWER CRANE INCIDENT REPORTING April to June 2008

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1 Summary of Incident	2 Category	3 Causes	4 Action taken
Mobile crane working near tower crane. When slewing around into crane area it almost made contact with the falls of the tower crane. The load came within 2m of the falls before it was stopped. Anti crash procedures were in place.	Near Hit	Operator error	All Drivers and Banksmen involved were re-briefed on the anti crash procedures via a toolbox talk.
Steel rebar was being lifted by tower crane made contact with pedestrian walkway.	Collision	Operator error	Toolbox talk given to the banksman.
Crane was working blind under the control of a qualified slinger /signaller. One of four legs of the chain sling landed inside the scaffold. The crane continued lowering the main block beyond the level and dragged the chain back over the outside edge of the scaffold.	Collision	Operator error	Toolbox talk given to all slinger /signallers about blind lifting. Slinger /signaller induction is to be amended.
During erection of tower crane, two fish plates / spacer plates were dislodged from a section of the mast whilst installing the slewing ring. The plates fell 70m close to the base of the crane.	Fall of material	Operator error	Preparation of an incident and a lessons learned report. Review erection procedure.
A cladding panel was being manoeuvred when it was caught by a gust of wind causing it to rotate out of the control of the operatives holding the guide lines. It made slight contact with the top of the mast climber causing no visible damage.	Collision	Operator error and environmental conditions	The wind was not gusting high as the operation was beginning and, apart from the one gust which caused the incident, was not an issue for completing the operation.
Whilst removing chains from the block on tower crane, the operative felt an acute pain in his lower back. Strained back.	Lost time injury	Physical failure	Accident investigated by the Safety Manager. Operative advised to seek assistance and use the proper handling technique for the works.
A 50t mobile crane was slewing a load when the load spun and made slight contact with the mast of tower crane.	Collision	Operator error	Briefing to all drivers & banksman to highlight the importance of following the agreed procedures.

Whilst slinging loads on tower crane, Slinger had to move out of way of a reversing vehicle. Banksman was not aware that the crane had lowered its block to ground level and Slinger had to shout to the Banksman to stop the vehicle. The vehicle stopped approximately 4ft from the crane ropes.	Near hit	Operator error	Incident is to be communicated to all Banksmen stating that more awareness is required whilst working in the same areas of cranes.
A pair of 8m nylon web slings had just been released from a load and the Slinger gave the all clear command to the tower crane driver. The Slinger's leg became entangled in the web slings lifting him off the ground.	Process failure	Operator error	All Slingers / Signallers and Crane Drivers were re-briefed to highlight the incident and ensure that the all clear signal to the lift is not given until such time as this is the case. All Slingers are to stand clear of lifting equipment.
Crane Driver was operating in the blind spot Without the Slingers direction, the crane block was lowered onto the floor touching one of the Signallers shoulder. The Slinger / Signallers had told the Crane Driver to stop once the crane hook was at their head level but the Crane Driver stated that he did not hear anything on the radio. Both companies admitted that there were communication issues due to the poor radio signal.	Collision	Operator error	Supervisors were to carry out toolbox talks with regards to incident reporting, to discussing the near miss and working with crane drivers in the blind spots Crash radios were inspected and recommendations made to improve existing system or getting digital radios for site.

KEY:

SHADED AREA CONFIDENTIAL INFORMATION – **CONSENT NEEDED FOR RELEASE**

1. **Summary of incident** – brief overview of what happened
2. **Incident category** – outcome - one of the following 4 categories
 - a. **FATALITIES** – The death of a person, whether or not they are at work resulting from an accident arising out of or in connection with work – thus could include members of the public.
 - b. **MAJORS** – as defined in RIDDOR 1995
 - c. **OVER 3 DAYS** – as defined in RIDDOR 1995
 - d. **NEAR HITS**
 - a. **Dangerous Occurrences** – as defined in RIDDOR 1995, in particular the collapse of, the overturning of, or failure of any load bearing part of any tower crane – NEAR HIT

b. Other failures – not categorised as a dangerous occurrence under RIDDOR but resulted in a significant failure (physical or process)

3. **Causes** – whether mechanical failure, operator error, management failure etc
4. **Action taken** – bullet points
5. **Location** – of site
6. **Technical details** – such as crane type, period in situ, erection/dismantling and other relevant factors
7. **Levels of Training** – of those involved in the incident (appointed person, operator etc)
8. **Contact details** – such as individual, organisation, manufacturer or web material