TOWER CRANE INCIDENT REPORTING – August 2008

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1 **Summary of Incident**	2 **Category**	3 **Causes**	4 **Action taken**
Two mullions were being lowered horizontally to the ground when a gust of wind started to gently rotate the steel. A single tag rope attached to one end of the steel was out of reach of the ground personnel and nothing could be done to prevent the end of the steel touching a pane of glass already fitted to the building. An exclusion zone was present and no materials fell.	Collision	Weather conditions	The steel was landed on a nearby terrace when rotation had ceased and the damaged window section was removed. Loads being positioned in this tight area are to have two tag lines fitted and they are to be of sufficient length to allow access to them before the load is at building level. Loads are to be either lifted clear of the building with persons present to ensure tag lines do not get fouled or persons present at roof level to take control of tags and guide over roof level and pass off to persons below.
Whilst lifting trailer protection frames into the storage area, between a building and the adjacent hoarding, the frame swung over the hoarding due to wind and hit an adjacent 360 excavator working behind the hoarding. No damage was caused to the excavator.	Collision	Weather conditions	Operations were temporarily stopped and a new system of banking was established to prevent a reoccurrence. A task assessment briefing was carried out.
Tower crane was being operated to install a set of pre-cast stairs. A crawler crane made contact with its hoist rope.	Collision	Lack of communication	The cranes have been taken out of service until the hoist rope is inspected by a 3rd party along with the fly jib section of the crawler crane. Contractors are to ensure that any changes with planned activities are communicated with the risks re- assessed. Prior to works recommencing, the process of the crane operators and slingers communicating effectively as the primary method by use of the crash radios will be re-briefed.

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