TAQA Bratani Ltd - HSSE ALERT

Date of Incident: 16/02/2012 **Location:** North Cormorant

Description: **Unexpected movement of crane**

What happened?

Due to a crane engine failure and being unable to lower the crane boom into the rest safely, the headache ball had been anchored to the boom structure using a chain block to prevent it moving in high winds.

The facts are:
On the 16th February 2012, during maintenance of the crane, engine checks were carried out by activating the high revs within the crane cab. The Occupant left the cab to return to the crane machinery house leaving the high revs running.

The crane was felt to shudder; Occupant immediately returned to the crane cab to turn off the high revs and shutdown the engine.
It was noticed at this point that the headache ball had moved up several feet and the chain block had snapped.

Findings:

The investigation team found that:

1. The crane would not have activated had the boom been in the rest
2. The crane cab chair arm inadvertently activated the main hoist joy-stick, whilst the engine was being commissioned at high revs.
3. The work party, toolbox talk, WCC & risk assessment all failed to identify any concerns with the “crane controls” being live and the crane boom not in the rest.

What can we learn from this?

1. There was an ergonomics design flaw with the cab, the chair could physically activate one of the controls. This went unreported for many years - perhaps because people believed it couldn’t cause a problem
2. The change of conditions associated with the crane not being in the rest was not recognised. This meant that the risk of inadvertent activation of the crane was completely missed.

What can we do?

Highlight awareness throughout the work force to;

1. Consider the potential for hidden hazards
2. Be vigilant and aware of any changes imposed by your actions (e.g. moving a chair) and confirm that no hazards have been introduced as a result
3. Challenge the norm – don’t accept “it’s always been like that”