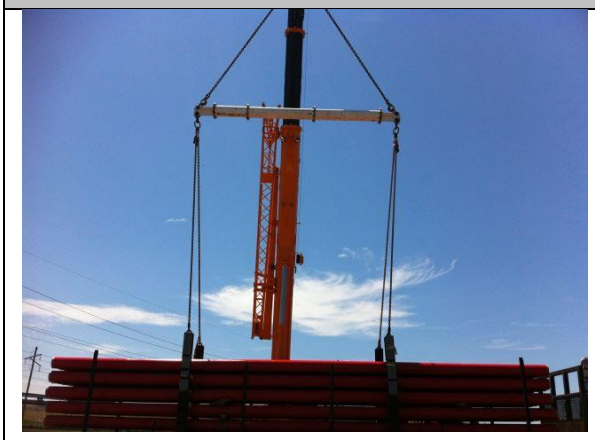
Significant Safety Occurrence

Date:	31 Jan 2013	**Reported By:**	Richard Quinn
Date of Incident:	23 Jan 2013	**Location:**	NCIG
Approved for Release By:	Tertius de Vries	**Incident Number:**	INC35000

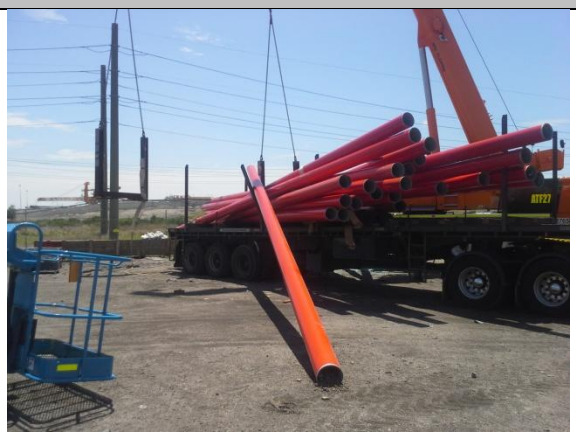
Incident Description

At 11:15 am on the 23rd January 2013 a crane was involved in an incident whilst working on the NCIG Project.
The crane was lifting a load of pipes from a truck that was suspended by two cradles. The cradles slid from underneath the pipes during the initial stage of the lift resulting in the load being destabilised and making contact with the crane superstructure and the trailer section of the truck. The crane window was broken and a number of vertical supports on the truck were damaged. There were also a number of the pipes that were damaged. No injuries resulted from the incident and an incident scene was established immediately, prior to an investigation being undertaken by the Senior Safety Advisor for the area.

Photographic Evidence



Lift immediately before Incident



Side of truck after incident

Crane Side after incident

Similarly configured pipes from supplier

Root Causes
Procedure Breach – Site procedure for loading and unloading procedure not complied with **Design** – Hazard not identified/communicated by designer/supplier **Hazard Awareness** – Failure to identify potential hazard on multiple levels
Extent of Injury / Damage
Injury: Nil Actual (0), Potential LTI (3). ***Damage:*** Actual 2(>$10,000), Potential 3 (>$100,000),
Corrective Actions
• Cradle design to have fixed bracing to prevent cradles from moving independently • Pipes to be restrained to the cradle • Task specific risk assessments required for all lifts (TSRA) • Designer/manufacturer recommendations to be included in SWMS (JSEA) • Inspection regime to be implemented for loads arriving on site prior to unloading commencing as per AH Procedure
Additional Comments
The incident occurred due to a combination of factors.: The lifting cradle design configuration had no fixed ties between each cradle, without any strapping of the pipes to the cradles and the use of nylon carpet. These factors meant there was minimal misalignment tolerance on the rigging and spreader assembly before a failure occurred. The information regarding the importance of this rigging arrangement was not provided and hence the use of standard rigging practices led to the load destabilisation. A specific risk assessment for Risks must be undertaken by persons knowledgeable in the failure modes of the plant used to undertake the lift and the plant being lifted.
Potential Severity of Incident
Potential LTI if someone had been struck by the falling pipes
Contact For Further Information:

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