INFORMATION


# Safety Alert

## Lifting Incident: Lowered Hook Block

25 July 2023

The following pages of this safety alert were issued by:

## HS2



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Safe at heart
I care. You count. We matter.

# Lessons Learned

## Lifting Incident: Lowered Hook Block – Old Oak Common

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|---|---|---|---|
| Date of incident: | 11/05/2023 | Incident type: | HiPo Level 1 |
| Incident ref: | INC15626ec | Contractor: | Select Plant Hire |
| Location: | Old Oak Common (BBVS) | Issued by: | James Smith |
| Keyword Search: | Lifting Incident | | |

## Summary of Incident

Tower Crane 1 (TC01) Lifting Team were lowering the hook block (no load attached). The lift was a blind lift for the Tower Crane operator.

The team consisted of the Crane Operator, Crane Supervisor who was at ground level on the slab, and two Slinger Signallers, who were below ground in the station box. The instruction was then given by the Slinger to lower the hook block down into its final position to attach the slings of the lifting tray which was located on the slab floor.

Upon command from the Slinger, the hook block descended towards the lifting beam and didn't stop resulting in hook block striking the spreader bar on the top of the lifting beam, which subsequently rocked to one side.

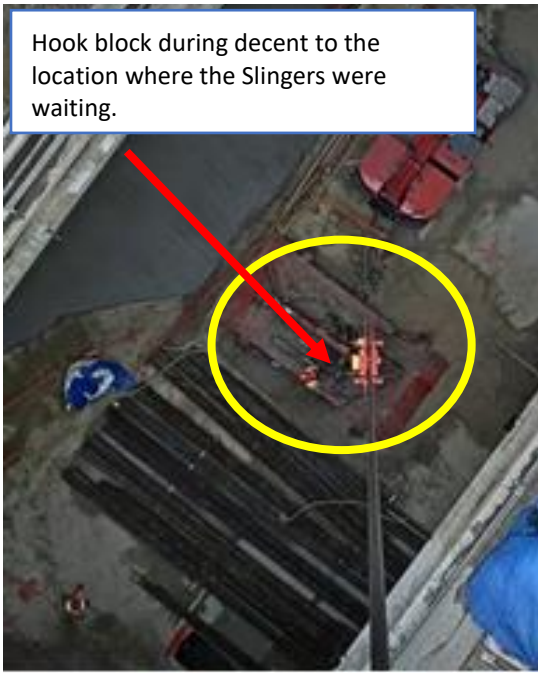
The Slinger Signaller had to jump clear and tripped subsequently falling to the ground landing on his shoulder causing a graze.

## Findings

- The standard radio communications were not monitored and enforced allowing for inconsistent language to be used by the lifting team.
- There was a breakdown in communication standards resulting in a lack on positive confirmation of instruction/command given.
- The Slinger Signallers waiting for the hook block didn't move out of the area where the hook block was descending.
- There was a reduced risk perception from team due to no load on the hook.
- The hook block was being lowered in 3rd. speed which was deemed to be too fast.
- The visual aids including block cam and speedometer were not used during the lowering of hook block prior to impacting the lifting beam which was situated on the ground.
- Slinger's instruction to slow down the descent of the hook block and ultimately stop was given but not heard by the Crane Operator.
- There was a delay in reporting the incident from the team.

## Photographs

Hook block during decent to the location where the Slingers were waiting.



Hook block just before the impact with lifting beam which subsequently caused the block to tip.

# Lessons Learned

## Lessons Learned and Actions

- Criticality of clear radio communication and instruction from the lifting team. Set commands used across the lifting team. Confirmation of significant commands to be given by crane operators.
- Risk perception. Hook blocks without loads attached are still a risk. The lifting team should be aware of this especially during decent.
- Positive confirmation of significant commands to be given by Crane Operators to prove that have understood the instruction.
- It is criticality important that the aids provided for the Operator with the cab are used to enable full understanding of the lifting operation.
- While members of the lifting team are permitted within a lifting zone it is imperative that they understand the risks within it and act accordingly including when hook blocks are not carrying a load.
- Escalation routes for incident reporting to be clearly demonstrated and available to all members of the lifting team.
- The importance of incident reporting. All incidents should be reported immediately and dealt with appropriately.
- Performance monitoring to increase the likelihood of identifying incorrect behaviours to reduce the possibility of human error.