COS SAFETY SHARE

WHAT WILL WE DO TO PREVENT THIS FROM HAPPENING HERE?

MISCOMMUNICATION DURING CRANE MAINTENANCE LEADS TO INJURY

What happened?

Maintenance was installing the east crane auxiliary cable on the boom tip approximately 9’ off the deck. A 20' ladder was placed against the boom tip to secure the cable. An individual was asked to hold the ladder.

There was miscommunication between the mechanic and crane operator when asking over the radio to auxiliary cable down; the crane operator boomed up. This caused the ladder to become unstable and the injured party (IP) fell approximately 4’ onto a battery box and rolled onto the deck striking his right side fracturing his right wrist and damaging tendons in his right shoulder.

What went wrong?

Safe Work Practice procedures were not followed.

Use of a ladder was not included in the Job Safety Analysis (JSA). The ladder was not secured or tied off. IP did not completely dismount the ladder after untethering fall protection.

Stop Work Authority (SWA) was not utilized by mechanic nor by the other person that was added to task.

Only 2 people were listed on the JSA. The addition of a 3rd person (to hold the ladder) to the job was not included in the JSA.

Limited access to the crane boom tip was not risked accessed.

The task performed was at height in close proximity to a handrail where there was risk of fall to lower level or GoM.

Why did it happen?

IP was a respected core team member, experienced and considered the “in house” expert on crane maintenance and repairs. The Crane Operator and Lead Operator that assisted are also respected and experienced core team members, thus leadership was not verifying or enforcing expectations appropriately to ensure established procedures and safe work practices were being followed.

What areas were identified for improvement?

- Quality of Task Planning and Preparation
- Individual or Group Decision Making
- Communication

2021031