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|  | <div style="display: flex; align-items: center; justify-content: center;">  <div style="text-align: center; margin: 0 10px;"> LESSON LEARNED </div>  </div> | Doc. No.: GP426 F39 Rev. 01 |
| Hitachi Zosen Inova | | |

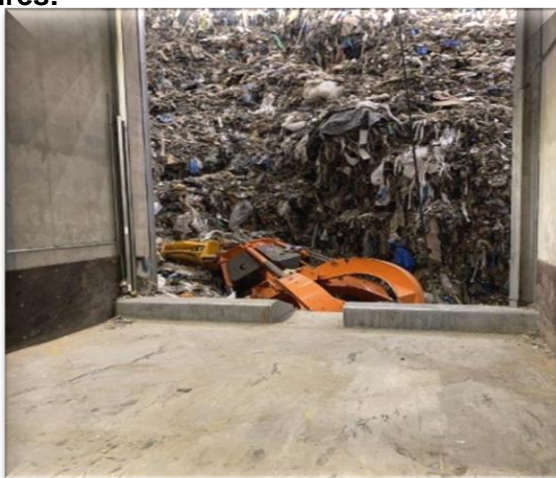
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|-------------------------|------------|--------------------------------|------------------------|
| Number | 2024-10 | Date of Issue | 03.05.2024 |
| Date of Incident | 13.04.2024 | Incident Classification | Property Damage - HiPo |

Summary:

During commissioning at a UK construction, the waste crane 2 operator was working on waste transfer within the bunker. When lifting the waste and traversing the crane the grab began to Swing. The operator attempted to stop the swing by lifting the grab, during this operation the 11 tonne Grab struck the main support beam of the crane causing the crane cable to snap. The grab fell opposite a bay with an open door where there was an O & M operative cleaning nearby. It was determined that the crane operator was using the waste crane 2 in manual mode at the time of the incident.

Outcome: No Injury, Property Damage (RIDDOR Reportable) - HiPo

Pictures:



Viewed from the Tipping Hall



Viewed from the Control Room

| Root Cause and Contributory Factors | Lesson Learned |
|--|---|
| <p>Immediate/Direct Cause</p> <ul style="list-style-type: none"> In an attempt stop the grab from swinging and spinning the crane operator lifted it too quickly allowing the grab to strike the support beam snapping the cable <p>Contributory Causes</p> <ul style="list-style-type: none"> Fatigue, Operator had done 5 days of shifts. Time pressures: The crane operated at full speed to prepare the bunker prior to more deliveries. The bunker was full because the plant continued to receive waste during an unforeseen shutdown. The profile of a full bunker meant limited space for grab movement. There is no evidence of a lesson plan, learning outcomes or structure to the waste crane training. Although the disabled interlock did not contribute to the failure of the crane cable it was a contributory factor in the HiPo incident category incident due to the proximity of a worker to the open door. <p>Root Cause</p> <ul style="list-style-type: none"> Training – Improvement – Instruction/ proficiency testing | <p>Competency Training</p> <ul style="list-style-type: none"> Crane Contractor to review training package to include a lesson plan, learning outcomes and test criteria, HZI to monitor for future projects to demonstrate that the agreed HZI training Programme is being followed All HZI O & M team previously trained get structured refresher training from the Crane Contractor. HZI to verify compliance of provider training with HZI standards and requirements. <p>Documentation</p> <ul style="list-style-type: none"> O & M team to review the door interlock system and override procedures. |



Every Lesson Learned is an opportunity to avoid recurrences.
What have you done to avoid a similar incident on your project?

