SAFETY ALERT

"Sharing incident learnings amongst ASI member companies"

AUSTRALIAN STEEL INSTITUTE
SAFETY GROUP

"A vision of a safer steel industry"

Number:	SA0002
Subject:	**Dropped Coil from Cranes**
Date:(mth/yr)	March 2005

Incident: (Brief facts only, do not include company name or location, insert picture if available)

Operator removed a 5 T coil from the east arm of the carousel using a radio-controlled crane and placed it on the ground for packaging. After the coil was packed the Operator lifted the coil and started to transport it to the Paint Line bay coil storage area. At some point the Operator realised that the coil should have continued down the coil transfer path to the Despatch bay coil storage area. The Operator attempted to return the coil to the carousel east arm but found another coil in its place and decided to place the coil on the northern arm of the carousel. The load was then moved north and lowered. This placed the load in line with stored coils to the east of the carousel northern arm at a height of approximately 2.5m. The Operator attempted to drive the Crane west but the crane travelled east resulting in the coil striking the coils to the east. The crane movement dragged the C-hook out of the coil resulting in the coil falling to the ground and coming to rest against the coil arrester.

Key Lessons: (maximum of 3)

- Suspended load positioned close to stored coils and crane driven in wrong direction.
- Crane Operator failed to check orientation of controller to crane.
- Crane Operator not focusing on critical task.

Recommendations: (maximum of 3)

- Communicated to all remote controlled crane drivers they must check the orientation of the controller to crane before moving the crane.
- Modify Job Cycle Check auditing roster to reflect auditing of safety critical tasks as a priority.
- Add key learning to remote Crane Job Cycle Check audit.

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