**Type of Incident:** NII  
**Incident No:** INC/530/14/80  
**Country:** UKCS  
**Date of Incident:** 09.09.14  

**Brief Account of Incident:**

During the start-up process the crane slewed to the right without positive clearance (approx. < 2 metres). This caused the chocks to be dislodged from the rest. One chock remained on the rest whilst the other fell 8 metres to the below area (considered a fatality on the drops matrix).

Weights and dimensions L170 x W20 x D25 cm weighing 80kg.

**What went well?**

- No injuries.
- Actions carried out post incident by onsite supervisor.
- The job was immediately stopped to instigate an investigation.

**What went wrong?**

- Due to design, no secondary retention or robust securing held the chocks in place.
- Procedure and lifting plans did not state specific requirements for general crane operations.
- The drop was not identified in a recent drops survey nor is it mentioned in any specific guidance.
- These items were not considered as being a drops risk (overlooked). They can appear to be fixed when checked by hand due to weight.
- Operator did not have positive clearance before slewing.

**Lessons learnt**

- Both chock rests have been modified to prevent the chocks from free falling. Other potential scenarios include:
  - Impact by head ache ball.
  - Impact with a suspended container.
  - Wood deterioration due to weather exposure.
- Procedures have been updated to implement additional information. Risk Assessments and Lifting Plans have been revised and updated.
- A safety stand down to discuss the incident and raise awareness.
- This LLR has been issued to ensure other units check their crane rests and include in drop surveys.