

## IMCA Safety Flash 05/18

March 2018

These flashes summarise key safety matters and incidents, allowing wider dissemination of lessons learnt from them. The information below has been provided in good faith by members and should be reviewed individually by recipients, who will determine its relevance to their own operations.

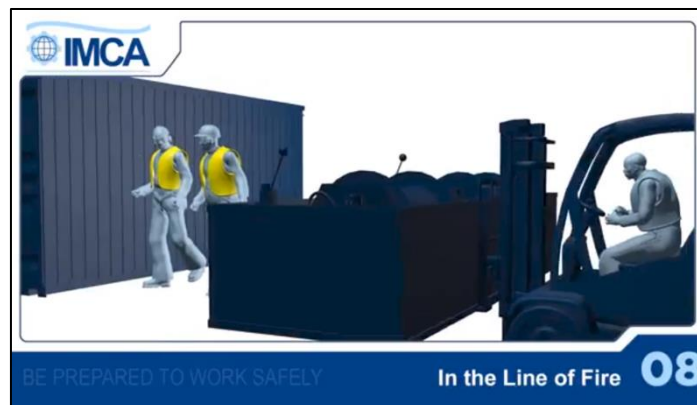
The effectiveness of the IMCA safety flash system depends on receiving reports from members in order to pass on information and avoid repeat incidents. Please consider adding the IMCA secretariat ([imca@imca-int.com](mailto:imca@imca-int.com)) to your internal distribution list for safety alerts and/or manually submitting information on specific incidents you consider may be relevant. All information will be anonymised or sanitised, as appropriate.

A number of other organisations issue safety flashes and similar documents which may be of interest to IMCA members. Where these are particularly relevant, these may be summarised or highlighted here. Links to known relevant websites are provided at [www.imca-int.com/links](http://www.imca-int.com/links). Additional links should be submitted to [info@imca-int.com](mailto:info@imca-int.com)

Any actions, lessons learnt, recommendations and suggestions in IMCA safety flashes are generated by the submitting organisation. IMCA safety flashes provide, in good faith, safety information for the benefit of members and do not necessarily constitute IMCA guidance, nor represent the official view of the Association or its members.

### Incidents Following Unsafe Management of Vehicles

These four incidents come from the UK Health & Safety Executive (UK HSE). These injuries or fatalities occurred because heavy vehicular plant and workers were not safely managed. Whilst these were not incidents from the maritime or offshore sector, there are lessons to be drawn from these incidents in terms of ensuring safe systems of work, management of simultaneous operations, ensuring crew are not in the “line of fire”, lift planning, and working at height.



#### 1 Fatality: Worker Crushed Between Two Items of Moving Plant

##### What happened?

The UK HSE reports that a civil engineering company has been sentenced for safety breaches after a worker suffered fatal crush injuries when he was caught between two pieces of heavy plant.

##### What went wrong? What were the causes?

The worker was caught between a 21-tonne tracked excavator moving backwards whilst involved in digging, and a stationary dumper truck. He was crushed and pronounced dead at the scene.

The HSE inspector noted: *“If the two separate work activities cannot be avoided, then the area should be safeguarded and effectively managed with segregation in place, for example using fencing or barriers to delineate the ‘no go’ areas for pedestrians.”*

The full press release can be found on the [HSE website](#).

Members may wish to review the importance of traffic separation and the safe-guarding of pedestrian workers in the context of quayside, dry dock bottom, and ship yard.

## 2 Worker Lost His Leg When He Was Hit by A Forklift Truck During Lifting Operations

### What happened?

The UK HSE reports that an engineering company has been fined after a worker lost his leg from the knee down when he was hit by a forklift truck.

### What went wrong? What were the causes?

A worker was seriously injured whilst carrying out a lifting operation involving the transporting and loading of pipe spools onto a flatbed truck. A forklift truck, for which he was acting as banksman, drove into the back of his left heel. His left leg had to be amputated at the knee.

UK HSE investigation found that the company had failed to properly plan, organise and carry out the lifting operation in a safe manner.

The HSE inspector noted: *“All lifts must be properly planned, assessed and carried out in a safe manner. There were other safer, reasonably practicable options that the company could have taken to prevent the forklift coming into contact with the individual. The safest method in this instance was to use tag lines or push sticks to control the load, as opposed to controlling the load by hand.”*

The full press release can be found on the [HSE website](#).

## 3 Worker Fatally Injured in Falling from A Scissor-Lift Platform Which Collided with Another Vehicle

### What happened?

The UK HSE reports that a company has been fined after a worker suffered fatal injuries. The worker was operating a scissor-lift working platform when this was struck by a Long Goods Vehicle (LGV), causing him to be ejected onto a roadway from a height of 1.5 metres.

### What went wrong? What were the causes?

An investigation by the UK HSE found:

- ♦ The company had failed to plan and organise work at height in a manner that ensured the safety of their workers;
- ♦ The work at height should have been organised to segregate activity in space and/or time from adjacent workplace transport operations.

The HSE inspector commented: *“This was a tragic and wholly avoidable incident, caused by the failure of the company to implement and monitor safe systems of work. The company did not undertake the simple safety measure of segregating those working at height from adjacent workplace transport operations, in line with widely available industry guidance.”*

The full press release can be found on the [HSE website](#).

## 4 Worker Struck and Injured by Tipper Truck

### What happened?

The UK HSE reports the prosecution of a building contractor after a worker was struck and injured by a tipper truck. The incident occurred at a time of simultaneous operations; there were a number of tipper trucks delivering material to the site and various workers were directing the drivers to different areas.

### What went wrong? What were the causes?

The injured worker was walking along a haul road in an attempt to attract the attention of a vehicle in another area of the site when he was struck and run over by a tipper truck. The worker suffered serious injuries including several broken bones in both legs and feet and severe damage to the blood vessels in his legs. His injuries resulted in him having his right leg amputated to the knee over 12 months after the incident.

A HSE investigation found that there were insufficient protected walkways across the site and that there was no control over access to the site. The investigation also found that there was an accepted practice of walking on haul roads and that there was a lack of an up to date traffic management plan.

It was noted that worksites where plant and pedestrians may be operating together should be organised in a way which prevents pedestrians and vehicles coming into contact with each other. This is as true of quaysides and dry dock bottoms as it is of the land-based construction site in this example.

The full press release can be found on the [HSE website](#).

With reference to the incidents above, the following incidents may also be of interest:

- ◆ [Near Miss: worker in dockyard almost struck by a 'cherry picker' crane](#)
- ◆ [Worker trapped and injured by reversing vehicle](#)
- ◆ [Worker was injured by a fork lift truck](#)
- ◆ [Two Industrial Vehicle Incidents](#)
- ◆ [Fatality: crew member struck by forklift during quayside operations](#)
- ◆ [Fatality during basket transfer](#)

Members may wish to refer to:

- ◆ IMCA videos
  - [Working at height](#) (short) and [Working at height](#) (longer)
  - [Lifting operations](#) (short) and [Safe lifting](#) (longer)
  - [Line of Fire](#) (short) and [In the line of fire](#) (longer)
- ◆ IMCA Guidance
  - [Guidance on safety in shipyards](#) SEL 032
  - [Guidelines for lifting operations](#) SEL 019

Further IMCA Safety promotional material can also be found on our [website](#).