IMCA Safety Flash 11/16

April 2016

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) 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 Additional links should be submitted to webmaster@imca-int.com

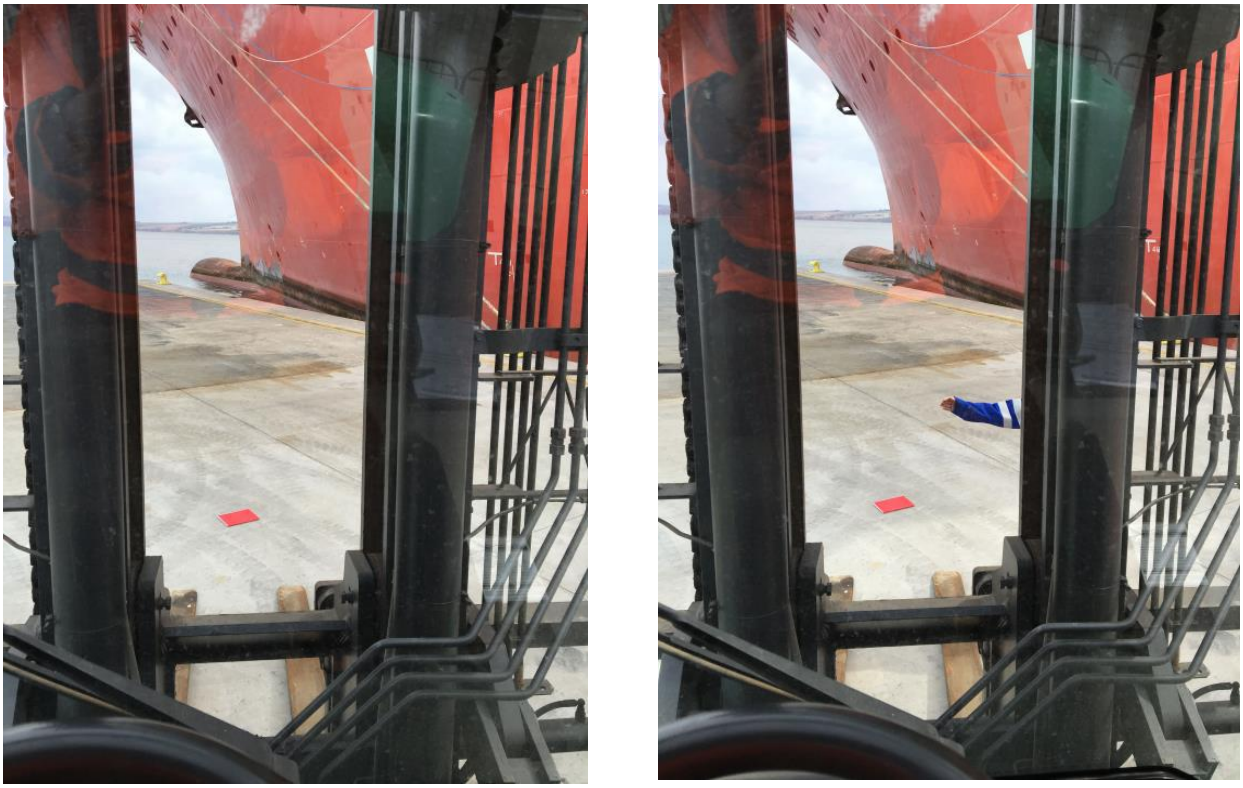
Any actions, lessons learnt, recommendations and suggestions in IMCA safety flashes are generated by the submitting organisation. IMCA safety flashes provide, in good faith, safety information for the benefit of members and do not necessarily constitute IMCA guidance, nor represent the official view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

1 Fatality – Crew Member Struck By Forklift during Quayside Operations

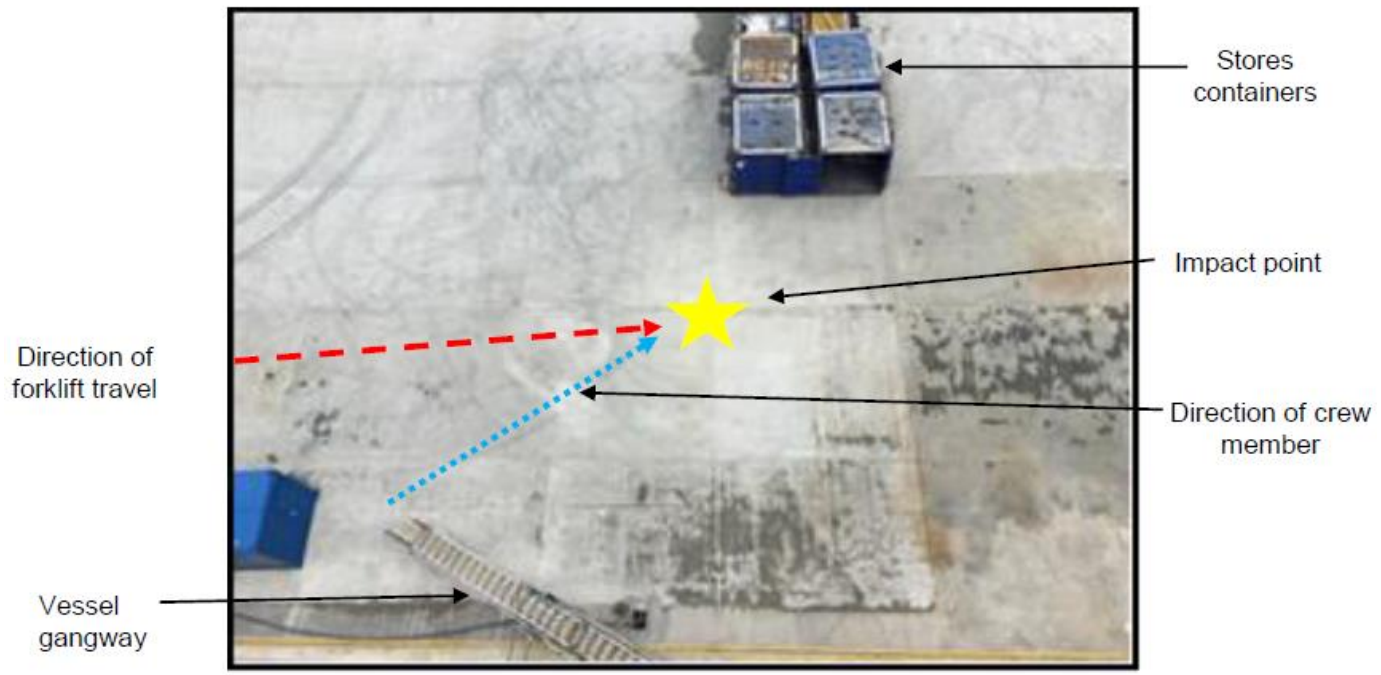
A member has reported an incident in which a crew member was struck by a forklift truck during quayside operations, and suffered fatal injuries. The incident happened when a vessel crew member was tasked with unloading stores from a container on the quayside. He descended the vessel gangway and headed towards the containers situated close by. It was during this short excursion that the crew member was struck by a forklift and fatally injured.

The investigation is still ongoing, but initial findings have indicated the following as possible contributory factors:

- Blind spots within the forklift operators field of view from the operating cab;
- Obscured vision due to sunlight.

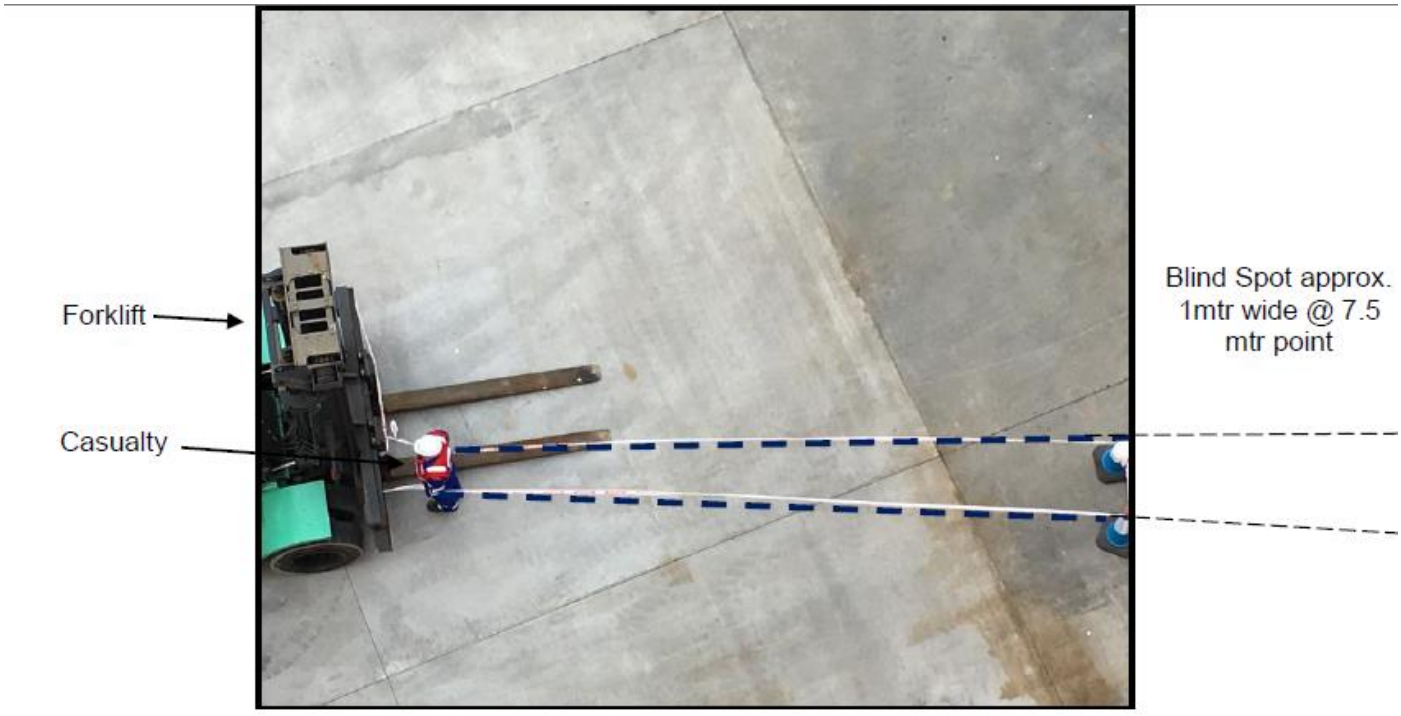


A mock-up showing the forklift operator's field of view, as impaired by the forklift mast. The two pictures demonstrate how a person can easily be concealed behind the forklift mast and missed by the operator. The picture on the left demonstrates the person fully hidden and the picture on the right demonstrates the person extending his arm to reveal his position.



Incident site

Showing incident site and directions of travel



Operators "Blind spot"

Showing forklift operator's 'blind spot'

Our member notes the following:

- This tragedy is a stark reminder that when working near moving vehicles or heavy equipment, persons must remain in the operator's full view;
- If you can't see the operator, they won't be able to see you;
- Remain vigilant at all times around routine activities through exercising situational awareness;

- Don’t ‘assume you are safe’, ‘ensure you are safe’;
- During project mobilisation/demobilisation(s) and vessel port calls with/without project activity, focus must continue to be given to the following quayside arrangements:
  - traffic management
  - designated walkways/segregation from traffic
  - crane operations
  - landing and loading areas
  - vehicle banksman (where required and assessed as not adding risk)
  - storage areas
  - parking areas
  - quayside edge operations
  - pre-shift briefings/toolbox talks.

Our member took the following actions:

- Circulated a safety notice to vessel crews via a scheduled ‘Time Out for Safety’ and to the industry via IMCA;
- Revisit and reassess mobilisation and demobilisation plans, procedures, practices and briefings in light of the above;
- Review all Project Hazard Identification & Risk Analysis (HIRA) and Vessel/Site Risk Assessments to ensure appropriate mitigation and controls are in place;
- Review effectiveness of toolbox talks, supervision and working practices on mobilisation sites.

Members may wish to refer to the following incident (search word: *hose*):

- IMCA SF 04/07 – Incident 1 – *Forklift truck incident.*