IMCA Safety Flash 22/17

August 2017

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 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.

1 Counterfeit Training Certificates

What happened?


Certificate of Authenticity
"Black Elephant"
SAMPLE
George Gordon
Calder Airplane Projects, Inc.
Cold Spring, NY
USA

IMCA has been advised that there has been a recent increase in counterfeit training certificates in circulation for crane operators, riggers, banksman/slingers etc. It is reported that the majority of these seem to be originating from Asia but some have also been discovered in the Middle East.

Many of these counterfeit documents are very good computer generated copies and almost indistinguishable from the genuine certificates. Some of these counterfeit certificates purport to be issued by leading training providers.

Members are advised that prospective employers should check the authenticity of any certificates presented by candidates, with the training provider who issued the certificate.

Members may wish to review the following incidents:

- Counterfeit Admiralty Products;
- False Or Scam Emails – Warning.

The remainder of the incidents in this Safety Flash relate to incidents involving land-based vehicles – including fork lift trucks – but are nevertheless considered worthy of bringing to members' attention.

2 Passenger Safety in Retrofitted Mini-Vans/Buses

What happened?

An International Association of Oil & Gas Producers (IOGP) member reports on an audit into the use of retrofitted vehicles, e.g. converted cargo-duty mini-vans/buses for passenger transportation. Inspections undertaken in Azerbaijan demonstrated that retrofitted vehicles with supplier certification (e.g. "letter of conformance"), for the retrofit installation and anchoring of seats can potentially be unsafe. Inspected vehicles were found to be out of conformance with the standards set out by United Nations Vehicle Regulations 17 for seat anchoring – see here for details.

Where the seat anchoring is inadequate, there is a potential risk that in the event of a collision, the seats could pull from the floor.

Figure 1: Inadequate seat anchorage bolts with welded square plate

Figure 2: Inadequate anchored rail and beam (e.g. welded instead of bolted)

What lessons were learnt? What actions were taken?

Members may wish to thoroughly inspect the seat anchorages on any retrofitted vehicles in use, and where issues with inadequate seat anchorage bolts are identified, take appropriate action. The IOGP Safety Alert (#287) notes:

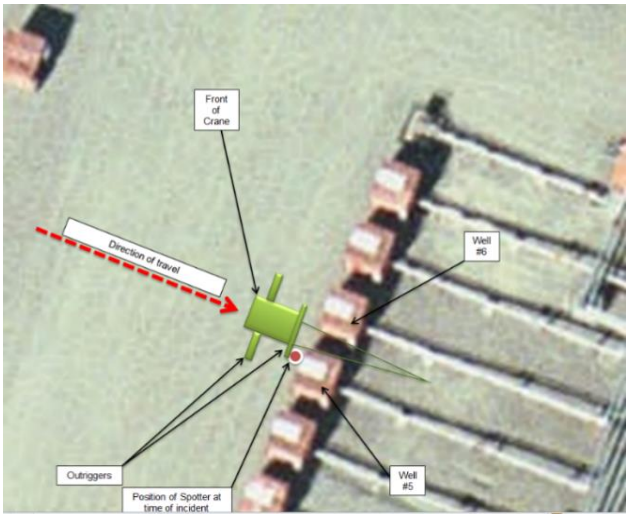
- Verify through inspection the type of seat anchorage bolts used. Seat anchorage bolts where "square plates" (Figure 1) are welded to the bolts might be inadequate in holding the seat in its position in the event of lateral force being applied (e.g. during collision). Only use appropriate, fit for purpose, bolts (e.g. made out of one piece) to robustly secure the seat.
- Verify through inspection the anchoring of the supporting rails and rail supporting beams. These might be inadequately anchored to the vehicle when retrofitted (Figure 2). These rails and beams must be adequately anchored to the chassis (e.g. bolted).

3 Worker Trapped and Injured by Reversing Vehicle

What happened?

An IOGP safety alert recounts how, at a land-based seismic survey camp, a worker was trapped and injured when a reversing vehicle did not stop. Someone was working as a spotter helping a crane operator reverse a mobile crane into position. As the crane reversed to approximately 1.5m from the desired position, the spotter reached for his radio to give the **STOP** command, but lost his balance in snowy conditions. While he regained his balance, the crane continued to reverse. As a result, the spotter was caught between the outrigger and the well house, causing an injury to his right wrist.

Aerial view of spotter and crane position



Aerial/plan view of scene of incident

What went wrong? What were the causes?

- The spotter lost his balance placing him in the line of fire;
- The crane operator continued to reverse after losing visual contact with the spotter. The spotter and the crane operator had previously agreed that if visual contact was lost that they would rely on verbal communication but did not agree that the verbal communication would be constant;
- This method of positioning the crane was considered normal by the two employees;
- While moving, the crane outrigger was left extended to prevent potential hydraulic oil leaks;

- The pre-task discussion had not identified these hazards.

What lessons were learnt? What actions were taken?

- Users of mobile equipment or vehicles (cranes, fork lift trucks etc.) should establish clear communication protocols before starting work;
- Persons on the ground or on deck near moving vehicles should never allow themselves to be "in the line of fire";
- When operating mobile equipment or vehicles, if visual or verbal contact is lost with people nearby on the ground, **STOP** immediately until contact is re-established and safe operation can continue.

In summary, IMCA notes that this was a wholly avoidable injury for which one causal factor was lack of communication, and as such it is of interest to IMCA members in the marine or dockside context. The IOGP Safety Alert can be found here.

Members may wish to review the following incident:

- Fatality: Crew Member Struck By Forklift During Quayside Operations.

4 Worker was Injured by a Fork Lift Truck

What happened?

A worker was struck by a reversing fork lift truck which resulted in him fracturing his pelvis. His employer was prosecuted by the UK Health & Safety Executive (HSE) and fined. See the press release here.

What went wrong? What were the causes?

Investigation by the UK HSE found that the company had:

- Failed to consider the risk created by vehicles and pedestrians operating in the same area;
- Failed to implement a traffic management plan to ensure workers and vehicles were adequately segregated;
- Failed to install physical barriers to clearly segregate pedestrians and vehicles.

An HSE inspector said: "*This incident could so easily have been avoided by simply carrying out correct control measures and safe working practices.*"

Members may wish to review the following incident:

- Fatality: Crew Member Struck By Forklift During Quayside Operations.

5 Worker Crushed by Dropped/Falling Object

What happened?

A load from the top of a double-decked trailer fell onto a worker, causing life-changing injuries. His employer was prosecuted by the UK HSE and fined. See press release here.

The employee was injured when a piece of metal ducting, six metres long and weighing 28kg, fell from the top deck of a trailer, hitting him on his head. The blow caused serious, life changing injuries, including a fractured skull.

What went wrong? What were the causes?

Investigation by the UK HSE found that:

- Whilst the company had developed systems and procedures for unloading of trailers at depots, these had not been implemented at this site;
- Employees were not properly informed about pedestrian and vehicle segregation rules, and little was done about these rules not being followed.

An HSE Inspector said: "*This incident could so easily have been avoided by simply implementing suitable control measures and safe working practices. The company itself had identified and easily implemented the necessary measures after this tragic event.*"

Members may wish to review the following incident:

- Near Miss: Dropped Object From Cargo.