IMCA Safety Flash 04/07

May 2007

These flashes summarise key safety matters and incidents, allowing wider dissemination of lessons learned 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

1 Forklift Truck Incident

A member has reported an incident in which an employee was injured whilst working with a forklift truck. Two crew members had placed slings on a pipe and planned to move it with a forklift truck and a spreader bar consisting of an i-beam 2½ metres long by 20cm wide. The pipe was located in a pipe rack.

The forklift was parked on the opposite side of the spreader bar with the forks on the deck with the motor turned off. One of the crew got in the forklift, started it and lifted the forks to position them to have the slings placed on the forks. The other crew member was holding the slings and standing between the rack and the spreader bar.

The forks hit the spreader bar and moved it toward the rack, catching the individual's left calf between the bar and the rack and causing severe bruising. He subsequently had to visit the doctor and the injury lead to a time lost from work of around two weeks.

The injured crew member was a short service employee who was being mentored by a more experienced 'lead man'. The more experienced mentor had left the scene before the forklift truck was started to perform another task elsewhere, leaving the lift to another crew member and the short service employee.

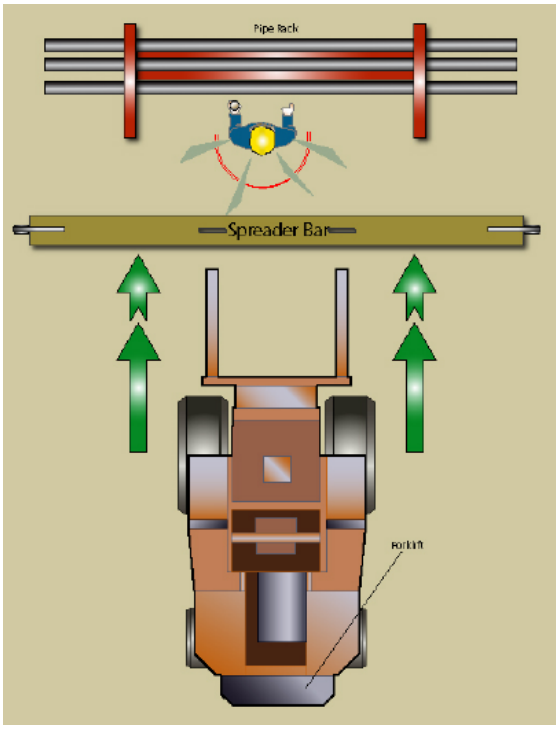

Figure 1 - Scene of incident

The company has noted the following lessons learned:

- The inexperienced crew member did not appreciate that he was putting himself in a hazardous situation; nor did his co-worker take action to prevent this unsafe act;
- The mentoring program had not worked as intended. The mentoring program and a proper explanation of work procedures should be emphasised in pre-shift meetings and during vessel orientation;
- If the mentor had to leave the immediate work area during lifting operations, work should stop until that they returned;
- Personnel should inspect their work areas and identify hazards that need to be removed;
- Mentors should to emphasise work procedures in a toolbox talk whenever there are changes to the circumstances of the work being conducted;
- Mentors should identify the risks associated with a task to short service employees and explain the hazards and preventative measures;
- All workers should remember the saying "never place yourself between a rock and a hard place" and beware of potential crush zones!