IMCA

Safety Flash

Fatal Traffic Accident on Board a Large Vessel

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A member reported a fatal incident which occurred on a large Ro-Ro vessel during loading operations.

IOGP Life Saving Rules:

What happened?

A trailer loaded with two large wooden boxes drove down the ramp to deck number one and parked shortly after clearing the ramp on the port side of the cargo hold. With guidance from the stevedore foreman, the wooden boxes were unloaded by a forklift. When the unloading was finalised, the trailer reversed back up the ramp to deck two and hit the duty officer currently observing the cargo operations. The duty officer received medical assistance from shore very quickly, but unfortunately died in the ambulance on the way to hospital.

What went wrong?

Our member made the following findings:

- No one witnessed the trailer hitting the duty officer.
- The site of the accident is in a blind spot for the CCTV cameras.
- The noise level on the cargo decks on this kind of large vessel during loading and discharging is rather high, particularly on cargo deck one. It is not clear that an audible reversing alarm would have changed the outcome in this case.
- There was no indication that the duty officer was standing outside the yellow safety zone on the ramp when he was hit by the trailer.
- The duty officer was not wearing his safety helmet as was required. Based on his injuries, the assumption was made that he was hit by the trailer when he was looking up towards deck two.
- The driver of the trailer did not use any signal man/reversing assistant, nor did he look backward through his trailer window before starting to reverse.
- Criminal proceedings in the country in which this incident occurred resulted in:
  - the driver of the trailer being prosecuted for negligent driving and sent to prison for 10 months
  - the Stevedore foreman and the head of the stevedore contractor were both fined.

What were the causes?

- he immediate causes were found to be:
  - the trailer driver failed to ensure that there were no obstructions when starting to reverse
  - driver did not use a signal man/reversing assistant when reversing, even

though he was driving a heavy vehicle.

- A causal factor was inadequate supervision/planning – the requirement to use a signal man/reversing assistant when reversing larger vehicles and trailers on board was not followed.
- The **root cause** of the incident was found to be an inadequate management system, which was not strict enough. The sub-contracted stevedore company did not ensure that the owners' cargo handling instructions were followed.

What actions were taken? What lessons were learned?

- Better situational awareness is required, particularly in the cargo holds, during cargo operations, and anywhere were vehicles are working.
- A strengthening of PPE requirements particularly for high visibility clothing. Vessel management teams to ensure that existing requirements for hard hat or safety helmet is always complied with.
- A better awareness should be developed of control measures for non-routine operations.

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