

Maintenance job lead to injuries

The left fork on the vessel's forklift truck was stuck. Two ABs and an engineer inspected the forklift to try and find the problem. They were all wearing the correct PPE: hard hats, boiler suits, high visibility vests and boots with steel caps. After consulting a blueprint and the locking pin arrangement for the fork, it was decided that the first attempt would be to free the pin by trying to lift the fork, allowing a screwdriver to be placed in the pinhole and lifting it clear of the locked position. The plan was to slide the fork clear of the carriage on the outer side and then repair the pin once the fork had been removed. This plan required a safety stop to be removed to allow the fork to be slid off. This safety stop was subsequently removed.

After this there was a discussion on how to approach the job. After some failed attempts it was decided that the forks should be rotated so there would be better access to the locking pin. This was done by having the weight of the fork hanging upside down to provide a gap big enough for a screwdriver to be placed in the pinhole.

The engineer left for the workshop to get some tools. The two remaining ABs continued to try to find a solution. AB1 started the forklift and rotated the forks with instructions from AB2. The plan was to get the forks in a level position. This was to prevent them from sliding off when the pin had been freed. The engine was switched off after the forks had been rotated and AB1 joined AB2 by the forks. AB1 realised that the good fork was in a position which was preventing easy access to the broken pin, so



they started to release the securing pin for the working fork to pull it out of the way. At this point AB2 held the fork in position with one hand as there were no other securing arrangement. With the other hand he tried to pull the pin out. While he was doing this, he slipped and fell onto the deck. This caused the fork to come lose and hit his hard hat and his hand, it also hit AB1's foot just above the steel cap on his boot. AB1 called for help on the UHF.

The vessel was in port, so an ambulance came quickly and took the injured ABs to hospital. AB1's foot was severely injured, and he could not return to work.

When AB2 was moving the fork, it slid past the groove. This caused the fork to come off the carriage. The manual for the forklift was never reviewed and no risk assessment was completed for the job.

Discussion

Go to the "File" menu and select "Save as..." to save the pdf-file on your computer.

You can place the marker below each question to write the answer directly into the file.



When discussing this case please consider that the actions taken at the time made sense for all involved. Do not only judge but also ask why you think these actions were taken and could this happen on your vessel?

1. What were the immediate causes of this accident?

2. Is there a risk that this kind of accident could happen on our vessel?

3. What would you have done to prevent this accident?

4. What are our procedures about similar maintenance jobs?
5. Would this job require a risk assessment?
6. Would this job require a work permit?
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8. Do we have a tool box meeting before maintenance commences?
9. If not, could this be useful
10. What sections of our SMS would have been breached, if any?

11. Does our SMS address these risks?
12. How could we improve our SMS to address these issues?
12. How could we improve our Sivis to address these issues:
13. What do you think was the cause of this accident?
14. Is there any kind of training that we could do that addresses these issues?