

# ACCIDENT ALERT

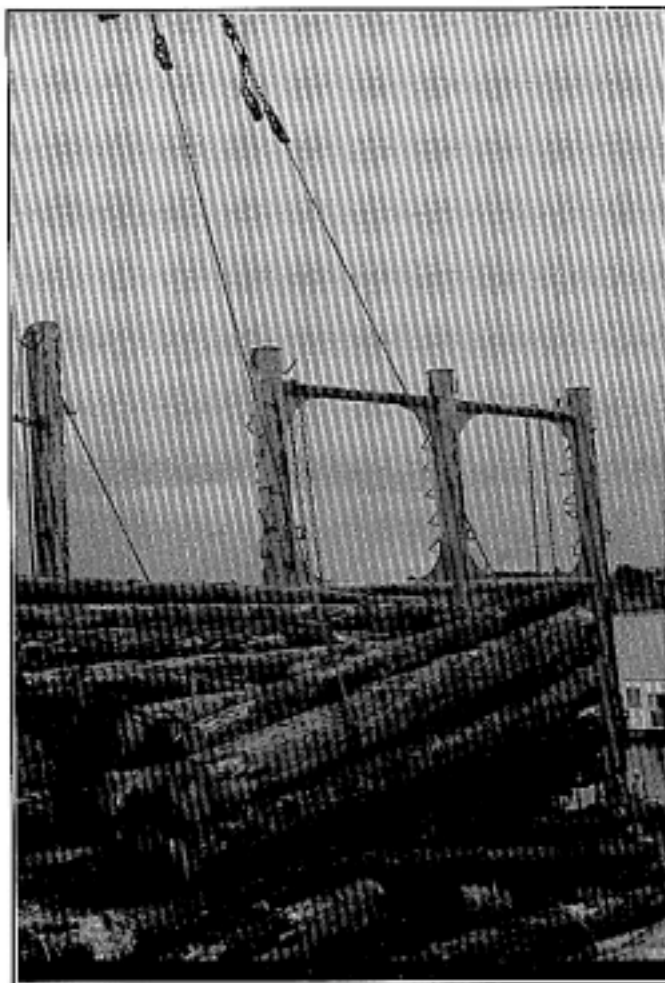
## Fall during log-loading kills waterside worker

### The incident

A part-time cargo worker was fatally injured when he fell some 4.5 metres from a ship's ladder onto the deck below.

A metal rung came away from the ladder, causing the fall.

The deceased was an experienced worker and at the time was involved in a log-loading operation taking place on the vessel's deck, the hold having already been filled. Manually-releasing lifting gear was being used and the worker was climbing onto a load of logs via a ship's ladder to release this gear, when the accident occurred.



Log-loading operations underway spot, rather than walk around the crane tower.

### Inspector's findings

The OSH inspector found that the method of work required the worker to climb onto loads of logs to manually release slings, in the ship's hold and on deck, thereby exposing the worker to a potentially hazardous situation.

The manual-release lifting gear was not defective or at fault.

The worker had used the ship's ladder as it was in a convenient

one side of a rung had broken away prior to the accident, and that rungs both above and below the broken rung were so squashed against the post that the watersider would not have been able to gain a hand hold once the rung he was holding parted from the securing post.

### Action taken by inspector

The OSH inspector issued a notice prohibiting the company from carrying on the activity requiring an employee to release manually log-loading gear at the port until such time as the company:

- obtained self release gear; or
- developed acceptable safety procedures work when manual release gear is being used.

### Maritime Transport findings

Staple-type ladder rungs frequently become severely damaged on vessels involved in the log trade. It would appear that the cause of this unfortunate accident was the use of an unsafe securing post ladder in an attempt to release a cargo sling. Investigations showed that

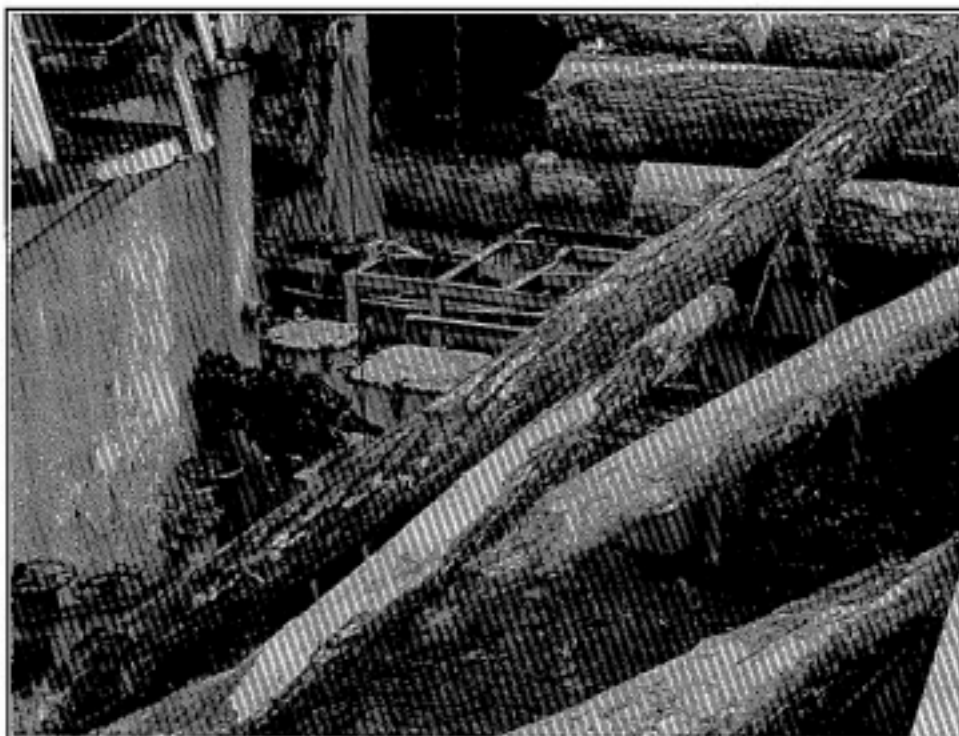
### Other action taken

Following the accident, meetings were held between the employers and employees involved and the Department of Labour to discuss safety as regards the company's stevedoring operations. During these discussions the company

advised it had earlier commissioned work on the design and manufacture of automatic-release lifting equipment and that this would be introduced in the near future for use as appropriate to individual operations.

As a result, the following action has been taken:

- Written procedures for the safe handling of the manual release gear have been devised;
- Induction courses have been put in place for all part time staff;
- Supervisors and all employees have received further training in hazard identification, management and accident investigation;
- Safety check sheets have been devised in regards to a visual inspection of all vessels by supervisory staff to identify hazards prior to the commencement of work and a notice board is to be placed at the foot of the gangway to alert all personnel to safety in the workplace; and
- A health monitoring system is being developed to comply with applicable legislation.



Ship's gear on to which the cargo worker fell

### **Further information**

Enquiries about safety and health at work should be directed to OSH branch offices in the following areas:

Christchurch North	Palmerston North
Christchurch South	Penrose
Dunedin	Rotorua
Hamilton	Takapuna
Invercargill	Tauranga
Lower Hutt	Wanganui (sub-branch)
Manukau	Wellington
Napier	West Auckland
Nelson	Whangarei
New Plymouth	