The Swedish Club

MONTHLY SAFETY SCENARIO

FEBRUARY 2022

Stevedore injured by twistlock

A container vessel had been at anchor for a week waiting for its berth. When the berth was free the vessel berthed starboard side alongside. The cargo operation began as soon as the vessel was cleared.

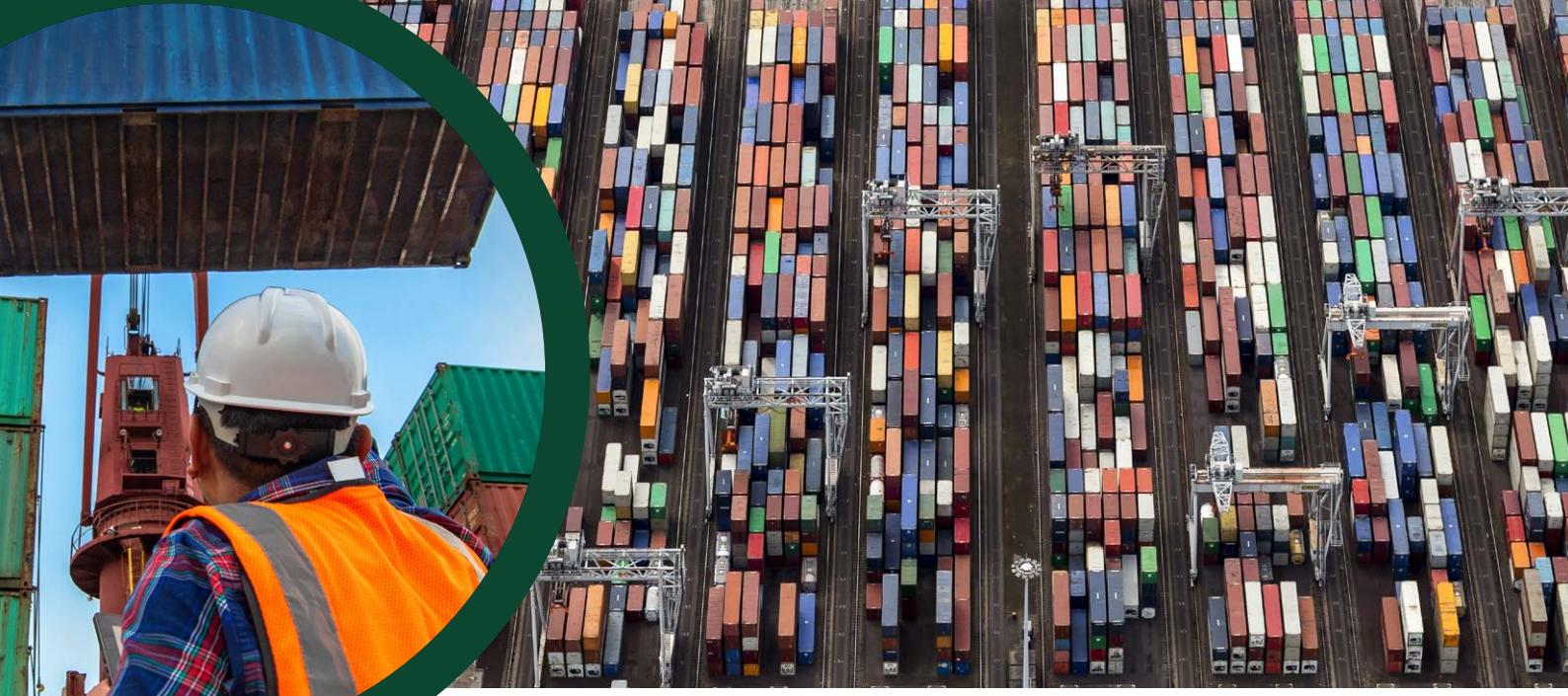
It was early morning just before dawn with clear skies and light winds. The Chief Officer was in the cargo office going through the stowage plan. The stevedore supervisor entered and handed him the loading plan which they briefly discussed. The supervisor said they would try to work as quickly as possible as there were a lot of vessels waiting to berth. Three gantry cranes were planned for the cargo operation. The Chief Officer provided the supervisor with the lashing plan.

The Chief Officer was not on his regular four-eight watch but was trying to be available during the entire cargo operation. The Second and Third Officers were on six on six off watches when in port to assist and monitor the stevedores and make sure any issues were cleared, and that the containers were secured correctly and loaded as per the loading plan. Three ABs also assisted in the cargo operation while one AB was on ISPS (International Ship and Port Facility) duty on the gangway.

Stevedores were working shoreside and attached the automatic twistlocks to the container's corners before the gantry crane lifted them into position on the vessel. The crane operator adjusted the alignment before putting down the container on the container below.

There were several stevedores on board the vessel securing containers with lashing bars and ensuring the manual twistlocks were locked where they were used. It was very busy, and the stevedores were moving all over the deck. The officers and ABs tried to monitor what was happening, assist where needed, and help replace faulty equipment.

The following evening the Second Officer was on deck monitoring the containers being loaded into cargo hold 3. He could see the stevedores standing on a container in the cargo hold and they seemed to be underneath the container which was being lowered into the hold. He then heard a scream and one of the stevedores was waving and shouting on the radio to stop the operation while another stevedore was lying on top of a container. The lowered container was already in position, but the



crane operator stopped, and the Second Officer climbed down into the hold and saw one of the stevedores lying unconscious with blood on his head and his cracked helmet lying beside him. There was also a twistlock lying close to the helmet.

The Second Officer called the Chief Officer on the radio and informed him that a stevedore had been injured and medical assistance was required. The injured stevedore was only briefly unconscious. The uninjured stevedore called the terminal's own emergency response team which arrived in ten minutes and gave the stevedore first aid while waiting for an ambulance. The ambulance arrived shortly afterwards, and the stevedore was taken to hospital. He had concussion and a scar on his head but was not seriously injured.

It is unknown why the automatic twistlock released itself. This again highlights the importance of never standing close to objects being lifted or lowered. This could have been much worse if, for example the container had dropped.

Questions

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. How could this accident have been prevented?
4. Do we have a risk assessment for this kind of job?
5. If we do, could this risk assessment be improved?
6. What are our procedures when we see stevedores or contractors working unsafely?
7. How should we approach a person working unsafely?
8. Are all the relevant crew trained in how to act in a situation like this?
9. Would a toolbox meeting with the stevedores have improved the situation?
10. Is there any kind of training that we should do that addresses these issues?
11. What sections of our SMS would have been breached if any?
12. Does our SMS address these risks?
13. How could we improve our SMS to address these issues?
14. What do you think was the root cause of this accident?