MAIIS

AIR, MARITIME AND RAILWAY ACCIDENT AND INCIDENT INVESTIGATION UNIT

# FINAL REPORT

# ON LESS SERIOUS CASUALTY

# on m/v MINOAS IMO No. 9519315

## Personal injury of port worker during steel pipes discharging in the Port of Koper 27. 10. 2024

LESS SERIOUS CASUALTY EMCIP 2024/004764 Nat. No. 373-18/2024

REPUBLIKA SLOVENIJA
MINISTRSTVO ZA INFRASTRUKTURO

SLUŽBA ZA PREISKOVANJE LETALSKIH, POMORSKIH IN ŽELEZNIŠKIH NESREČ IN INCIDENTOV

Tržaška cesta 19, 1000 Ljubljana

REPUBLIC OF SLOVENIA
MINISTRY OF INFRASTRUCTURE

AIR, MARITIME AND RAILWAY ACCIDENT AND INCIDENT INVESTIGATION UNIT

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## Personal injury of port worker during steel pipes discharging in the Port of Koper 27. 10. 2024

Capt. Vladimir Vladović

Marine Accidents Investigator
**MINISTRSTRY OF INFRASTRUCTURE**
Air, Marine and Railway Accident and Incident Investigation Unit

Izola, 12. 12. 2024

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# PUBLICATION OF THE REPORT

This report has been prepared and issued by the Air, Maritime, and Railway Accidents and Incidents Unit (MAIIS) in accordance with the Maritime Code of the Republic of Slovenia (Official Journal of the Republic of Slovenia, No. 62/16 - Official Consolidated Text, 41/17, 21/18 - ZNOrg, 31/18 - ZPVZRZECEP, 18/21, 21/21 - Amended, and 76/23).
It is aligned with the provisions outlined in the Regulation on the Investigation of Maritime Accidents, which governs the procedures and conditions for conducting safety investigations of marine casualties and incidents. The report also adheres to Directive 2009/18/EC of the European Parliament and Council, establishing fundamental principles for investigating accidents within the maritime transport sector, as well as the provisions of IMO Resolution MSC.255(84) from the International Maritime Organization (IMO), which includes the Code of International Standards and Recommended Practices for safety investigations into marine casualties and incidents. Furthermore, the report complies with other applicable IMO regulations, circular letters, guidelines for safety investigations of maritime accidents, and relevant recommendations from the European Maritime Safety Agency (EMSA).

Extract from the Maritime Code:

> Chapter XI - INVESTIGATION OF MARITIME ACCIDENTS
>
> Art. 200a.
>
> The purpose of investigation of maritime accidents under this Act is not to establish the responsibility or fault, but to determine the causes of accidents and to prevent similar accidents.
>
> Art. 200e.
>
> Data obtained by an investigator during the investigation of a maritime accident shall be confidential and not publicly available. These data may be publicly available only if there is prevailing public interest arising from the investigator's final report on a maritime accident.
>
> Art. 200g.
>
> The investigation of a maritime accident shall be independent from investigations of criminal acts or other parallel investigations the object of which is the identification of responsibility and determination of fault. These investigations shall not unduly inhibit, interrupt, or defer the investigation of maritime accidents.

In accordance with the provisions of Article 2(2) of the Regulation on the investigation of marine casualties (Official Journal of the Republic of Slovenia No 67/11), a marine casualty is any occurrence on board or in connection with a ship where:

- a person dies or suffers serious injury in connection with the operation of the ship:
- a person falls from the ship due to the operation of the ship,
- the ship is lost, presumed lost or abandoned,
- the ship is damaged,
- the boat runs aground, unless she runs aground for a short period of time on purpose and is not damaged as a result,
- the ship is unseaworthy,
- the ship collides,
- property damage caused by the operation of the ship, or
- the environment is polluted as a result of damage to the ship or the operation of the ship.

In accordance with Chapter 2, Point 2.18 of IMO Resolution MSC.255(84) - Casualty Investigation Code (Annex 1), "serious injury" refers to an injury sustained by a person that results in incapacitation, preventing the person from functioning normally for more than 72 hours, with this period starting within seven days from the day the injury occurred. Based on this, the investigating authority decided to conduct an investigation into the maritime casualty – a workplace accident on board the vessel, which occurred in connection with the vessel or vessel operations.

- All times mentioned in this report are local (UTC+1h) unless otherwise stated.
- The provisions of the international conventions referred to in this report must be interpreted and understood in the light of the full text of those conventions, including any annexes.
- This report is published in identical Slovenian and English versions. In case of any disputes or disagreements, the Slovenian version of this report shall apply.

**The aim of safety investigations is in no case determination of liability or apportioning blame.**

Information:
The Marine Casualty Investigation Reports are published on the Ministry of Infrastructure web link:

https://www.gov.si/drzavni-organi/ministrstva/ministrstvo-za-infrastrukturo/o-ministrstvu/sluzbe-za-preiskovanje-letalskih-pomorskih-in-zelezniskih-nesrec-in-incidentov/preiskovanje-pomorskih-nesrec-in-incidentov/

MINISTRY OF INFRASTRUCTURE
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# ANNEXES

# MEANING OF TERMS

| Pojem / *Abbr* | | Opis / *Description* |
|---|---|---|
| CNP | - | Center za Nadzor Prometa (URSP) / *Traffic Control Center (SMA)* |
| D | - | Deplasman / *Displacement* |
| EU | - | Evropska unija / *European Union* |
| GT | - | Bruto tonaža / *Gross Tonnage* |
| IMO | - | Mednarodna pomorska organizacija / *International Maritime Organization* |
| LOA | - | Dolžina preko vsega / *Length Over All* |
| LPP | - | Dolžina med perpendikularji / *Length Between Perpendiculars* |
| LT | - | Lokalni čas / *Local Time* |
| LTD | - | Luško Transportni Delavec / *Port Transport Worker (PTW)* |
| m | - | meter / *meter* |
| MSC | - | Odbor za pomorsko varnost (pri IMO) / *Maritime Safety Committee* |
| NT | - | Neto tonaža / *Net Tonnage* |
| PGE | - | Pristaniška Gasilska Enota / *Port Fire Brigade* |
| PPV | - | Področje Pristaniške varnosti / Port Security Department |
| SMS | - | Sistem varnega upravljanja / *Safety Management System* |
| T | - | Metrična tona / *Tonne (metric tone)* |
| URSP / SMA | - | Uprava Republike Slovenije za pomorstvo / *Slovenian Maritime Administration* |
| UTC | - | Univerzalni koordinirani čas / *Universal Time Co-ordinated* |
| VNC | - | Varnostno Nadzorni Center / *Port Security Center* |
| VTS | - | Služba za nadzor prometa / *Vessel Traffic Services* |
| VZD | - | Varovanje zdravja pri delu / *Health protection at work* |
| VZE | - | Področje Varovanja zdravja in ekologije / *Health protection and ecology* |


*Figure 1: Vessel M/V Minoas (source: authors)*

# SUMMARY

On 27 October 2024, a port worker was injured while discharging steel pipes from the vessel MINOAS at the Port of Koper.

The vessel, a commercial ship carrying 2,560 packages of hot-rolled seamless steel pipes, tubing, and steel coils, departed from Tianjin, China, on 30 August 2024. After stops in Zhangjiagang and transiting the Suez Canal, the vessel arrived in Koper on 20 October, anchored, and berthed on 22 October. Unloading operations began shortly thereafter. The cargo, with a total weight of 12,271 metric tons, was loaded into holds 2, 4, and 5.

During the discharging operation on the morning of 27 October, workers began unloading steel pipes from hold No. 4 using cargo lifting beams and a shore crane. At approximately 08:30, as workers moved away from beneath a suspended load of steel pipe bundles, an uncontrolled shift occurred. One of the bundles shifted and pressed down on the worker's left ankle. The lifting wires and lining materials originally used to handle the cargo during loading were misaligned and some were damaged, contributing to the instability of the stowed pipe bundles. Despite efforts from colleagues to free him, the worker sustained an ankle fracture and was transported to the hospital for surgery.

The analysis of the incident identified issues with cargo stowage, deteriorated lining materials, and the safety procedures during cargo discharge operations.

Based on these findings, the investigating authority issued a safety recommendation.

# CHAPTER 1 - FACTUAL INFORMATION

## 1.1. SHIP'S PARTICULARS

| **SHIP'S PARTICULARS** | |
|---|---|
| Name of ship | MINOAS |
| Type of ship | BULKCARRIER |
| Owner | CLIPPER ENTERPRISES SA |
| Operator | ATHEMAR MARITIME SA |
| Year of construction | 2011, Jiangsu Hantong Ship Heavy Industry Co. Ltd. |
| Classification Society | ClassNK |
| Flag | MARSHALL ISLANDS |
| Port of Registry | MAJURO |
| IMO number | 9519315 |
| MMSI number | 538009011 |
| Call sign | V7A4195 |
| Length | 189,98 |
| Width | 32,26 |
| Maximum draft | 12,80 |
| Maximum height | 46,846 |
| Gross tonnage (GT) | 32.897 |
| Net tonnage (NT) | 19.236 |
| Displacement (D) | 67.681 |
| Engine | MAN B&W 6S50MC-C ( MARK7) |
| Engine power | MCR 9,480 kW at 127 rpm |
| Thrusters | N/A |
| Propellers | Fixed pitch, Right-handed1 set x 4 blades; diameter: 6,000 m.; pitch: 3909 mm. |
| **VOYAGE INFORMATION** | |
| Previous port | SUEZ, EGYPT |
| Port of destination | PLOČE, HRV |
| Voyage type | WORLDWIDE |
| Cargo | STEEL PIPES, SEAMLESS TUBING, STEEL COILS |
| No. of Crew | 24 |
| **CASUALTY OR INCIDENT INFORMATION** | |
| Date and Time | 27.10.2024 at 08:40 |
| Type of accident or incident | PERSONAL INJURY |
| Location of the event | PORT OF KOPER, BASIN II, BERTH 11 |

| | |
|---|---|
| Part of the ship | HOLD #4 |
| Human injuries / casualties | PERSONAL INJURY / 1 PORT WORKER (BROKEN ANKLE) |
| Environmental pollution | N/A |
| Ship's operations | DISCHARGING CARGO |
| Travel segment | ALONGSIDE |
| Weather and weather effects | N/A |
| Draft at the time of the accident | N/A |

## 1.2. VOYAGE PARTICULARS

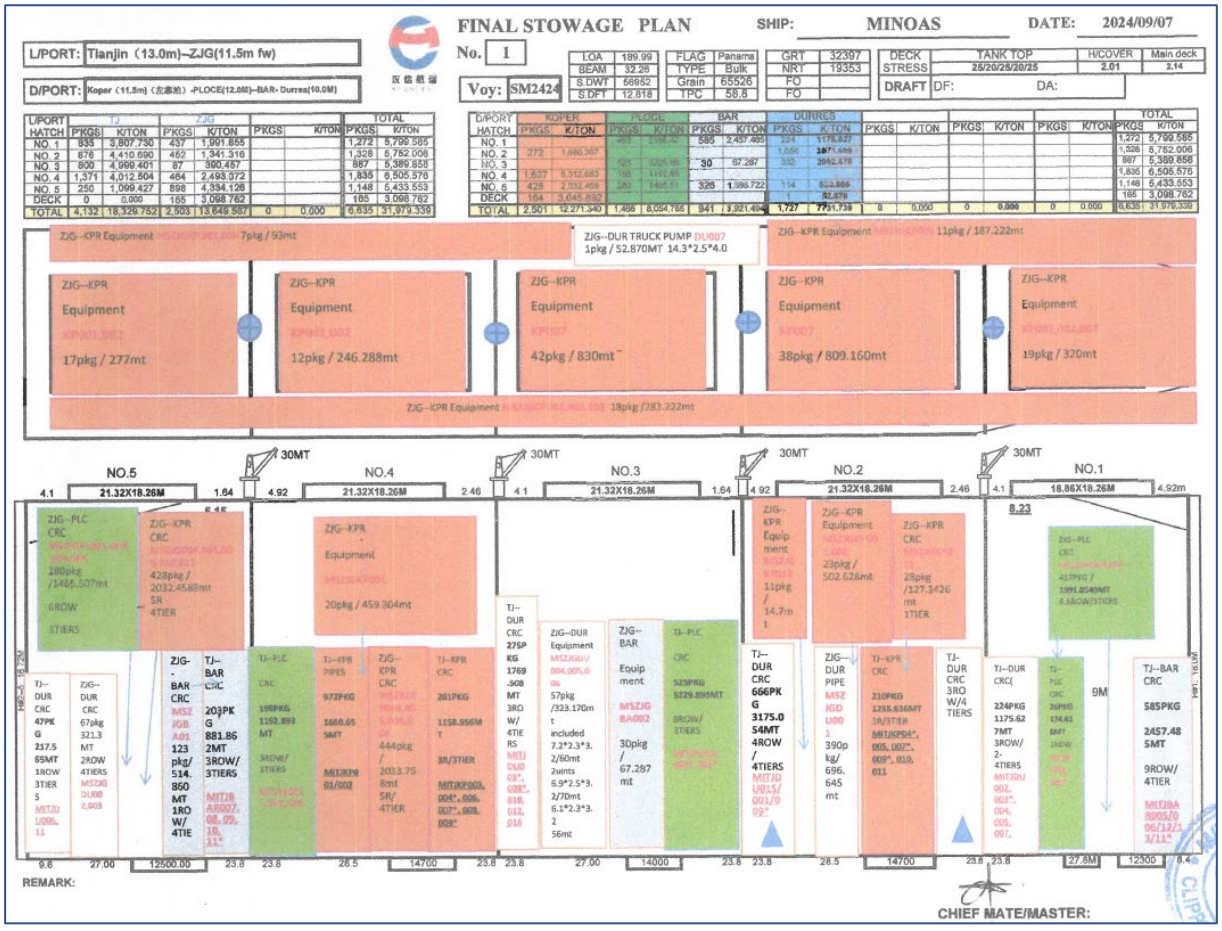



*Figure 2: M/V MINOAS Cargo Plan, source MV Minoas*

Ports of Call: The vessel began its voyage on 30 August 2024, departing from the general cargo terminal at Tianjin Port No. 1 Stevedoring Co., Ltd. in Tianjin, China. The vessel sailed to Zhangjiagang, where it arrived on 1 September 2024. After a stay, the vessel then departed toward the Suez Canal on 14 September 2024, arriving at the Suez Canal on 13 October 2024. The vessel transited the Suez Canal and continued its journey, leaving the canal on 14 October 2024.

The vessel arrived at the Port of Koper on 20 October 2024, anchoring at 05:45, and was subsequently berthed at Berth No. 11 in Basin II at 17:47 on 22 October 2024. Discharging operations commenced shortly thereafter, with the vessel unloading steel products destined for Koper. The discharging was completed, and the vessel departed from Koper on 30 October 2024.

Type of Voyage: Commercial Voyage

Cargo Information: The vessel carried 2,560.1 packages of hot-rolled seamless steel pipes, seamless tubing, and prime organic-coated steel coils and equipment with a total weight of 12,271 metric tons. The cargo was loaded into holds 2, 4, and 5.

At the time of the accident, there were no crew members present in hold No. 4, nor were there any crew members on the deck near the hatch of hold No. 4.

## 1.3. EXTERNAL and INTERNAL ENVIRONMENT

Weather was cloudy, sea calm.

## 1.4. SHORE INVOLVEMENT

Following the initial call from the supervisor, the Port Security Department promptly deployed duty personnel and a representative from the fire brigade to the scene. Upon arrival, they assessed the situation and facilitated the transportation of the injured worker to shore. The Port Security Department also called for emergency medical services, which arrived immediately and transferred the injured worker to the General Hospital in Izola for further treatment.

## 1.5. CONSEQUENCES AND IMPLICATIONS

Excerpt from doctor's Letter of dismissal: The injured worker, O.N., was admitted to the General Hospital trauma ward on 27 October after sustaining an injury to his left ankle at work. A diagnosis of a bimalleolar luxating fracture was confirmed. The patient underwent surgery on the same day, which involved open reduction and internal fixation with a plate and screws. The procedure was completed without any surgical complications.

Diagnosis: Fractura bimalleoralis sin. Luxativa

Next checks: Suture removal is scheduled for 13 days after surgery. Analgesics should be taken as needed. The next follow-up appointment is set for 4 December 2024.

## 1.6. HUMAN FACTORS DATA

- The injured worker, O.N., has been employed as a Port Transport Worker since 2017. During this time, he has gained experience in cargo operations at both the General Cargo Terminal and the Livestock Terminal.
- On the day of the incident, O.N. arrived at work at approximately 05:40, changed into his work clothes, and reviewed the work schedule. Around 05:50, he boarded the port bus, which transported him and other workers to the ship. His work shift on board began at 06:00. No cargo discharging operations were conducted overnight.
- In the four days leading up to the incident (24-26 October), O.N. worked the same shift schedule.
- Prior to this, on 22-23 October, O.N. was on leave.

# CHAPTER 2 - NARRATIVE

Morning shift started discharging steel pipes in bundles from hold no. 4 at 0600 hours, by means of cargo lifting beam and shore crane. There were 5 port workers presented in the hold during the discharging. Those were supervisor, signalman and four dock workers (port handling workers). About 8-10 bundles of steel piper were lifted at the time (see figure 3).

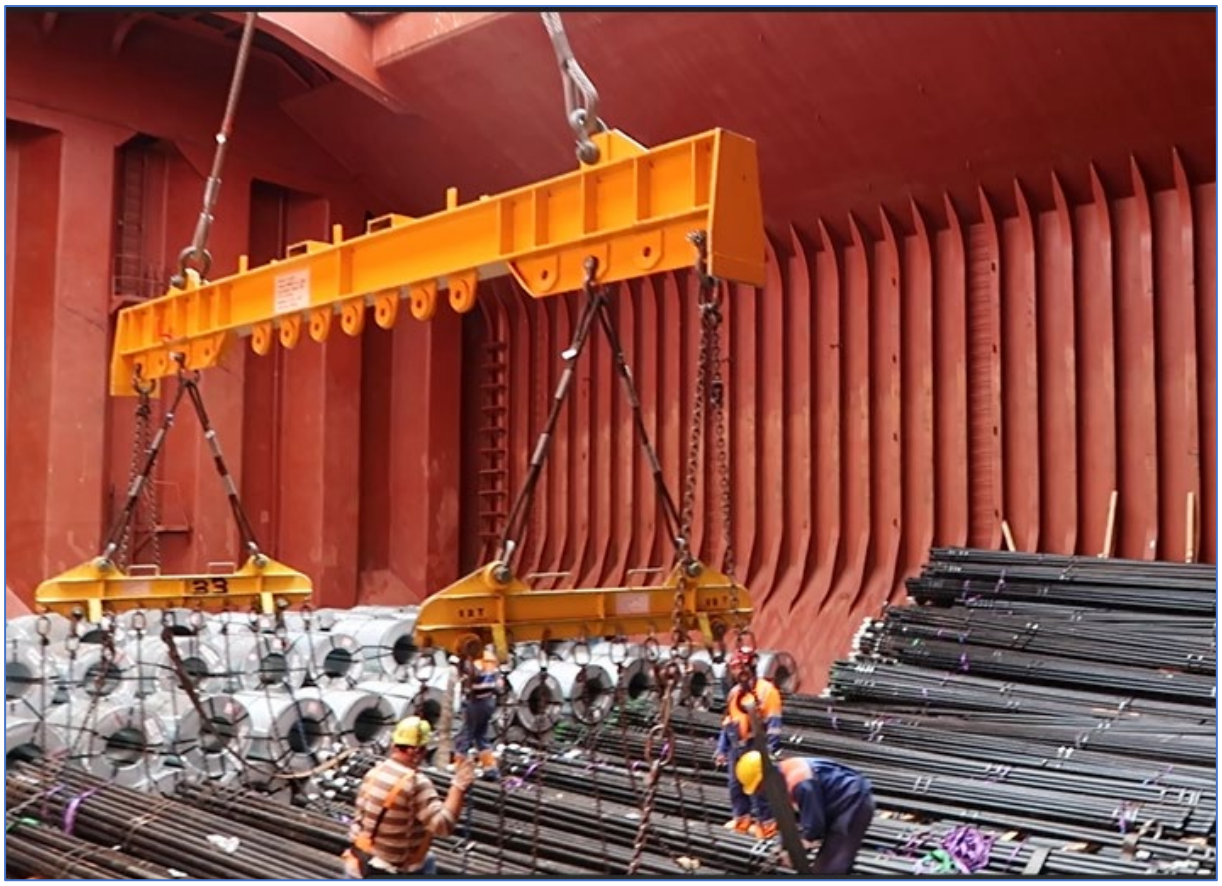


*Figure 3: Pipes discharging using lifting beam*

The cargo was equipped with lifting wires (rope slings), which were used for loading at the previous port. However, these lifting wires are misaligned and not properly centered, and due to prior use, they have become stretched. Additionally, it is unclear whether the wires are damaged. As a result, the lifting wires are deemed unsuitable for lifting the cargo from the ship's hold.

Cargo discharging continued eventless until the time of accident.

At approximately 08:30, according to the participants, the injury occurred during the lifting of the cargo (pipes in bundles) when the workers were moving away from beneath the suspended load near the "wing" (the side of the ship's hold). While the workers were walking on the pipes, the injured worker, O. N., was positioned approximately one meter in front of the nearest colleague. At that moment, there was an uncontrolled shift of the pipe bundle directly in front of his legs. On the aft side, the bundle became caught on the pipe bundle ahead, while on the opposite side, the bundle pressed down on the worker's left ankle.

In response to the pain, the injured worker cried out, and two nearby colleagues immediately used crow bars to move the pipes. In the meantime, another worker inserted a wooden wedge (shim) between the bundles, allowing them to free O. N.'s foot from between the two bundles.

At 08:31, the foreman notified the Port Security Department.

At 08:35, two members of the Port Fire Brigade arrived at the scene.

The injured worker, O. N., was then lifted ashore by the shore crane and transport basket and moved to a safe area. Upon the arrival of the emergency medical service, O. N. was transported to the General Hospital in Izola for further treatment.

# CHAPTER 3 – ANALYSIS

Using the photos taken in the hold no.4 shortly after the accident, statements taken from the port workers present, the foreman and the injured person and available documentation, analysis revealed that:

- The cargo handling operations during discharging were conducted in accordance with the guidelines provided in the document "Technology – Handling of Steel Bars, Pipes, and Profiles."
- During a typical cargo lift, lifting slings are usually inserted through openings between wooden pallets. In this case, due to an uneven distribution of bundles and damaged pallets, an alternative lifting method had to be used. The cargo was initially lifted approximately 50 cm using a steel wire or sling attached to the hook of a spreader beam. A wire loop can also be used for this purpose, but only if it is thoroughly inspected and free from damage. Once the cargo was raised, standard lifting slings were secured underneath.
- As the cargo was being lifted, workers visually assessed situation with cargo and moved to a safe distance towards the shoreside of the hold, ensuring their safety for the next phase of unloading.
- The injured worker, O. N., was the first to move and was positioned about one meter ahead of the nearest colleague.
- At the time of the injury, an uncontrolled shift occurred with one of the pipe bundles, which shifted directly in front of O. N.'s legs. On the aft side, the bundle became caught on another pipe bundle (indicated by the orange arrow), while on the opposite side (indicated by the white arrow), the bundle rolled and applied pressure to O. N.'s left ankle (see Figure 4).


*Figure 4: Situation in the hold at the time of injury - Simulation*

- Two workers used crowbars to lift the pipe bundle, while another worker placed a wooden wedge between the bundles to free O. N.'s foot and alleviate the pressure on the ankle.
- Injured O. N. is experienced port worker employed in Port of Koper with seven years working experience on various tasks and duties. O. N. has completed comprehensive training and testing related to safe and healthy work practices. In addition to the general aptitude test, he successfully passed the specific portion of the test for operations at the general cargo terminal, the cargo-handling warehouse, and other job-specific requirements. The most recent periodic test was completed in August 2023. His physical and mental conditions were appropriate as confirmed by periodical medical examination. He worked the same shift schedule during the four days leading up to the incident (24-26 October). At the time of accident, O.N. was using prescribed safety personal protection equipment.
- Cargo (pipes) was stowed using the wooden linings. Due to (presumably) uneven stowage of bundles, almost all wooden linings were deformed and/or destroyed (Figure 5).

*Figure 5: Lining material between bundles*

- The cargo (bundles of pipes) was discharged in a manner that most of the bundles were removed from the central part of the hold, resulting in an uneven distribution of height at both ends of the hold (Figure 6).

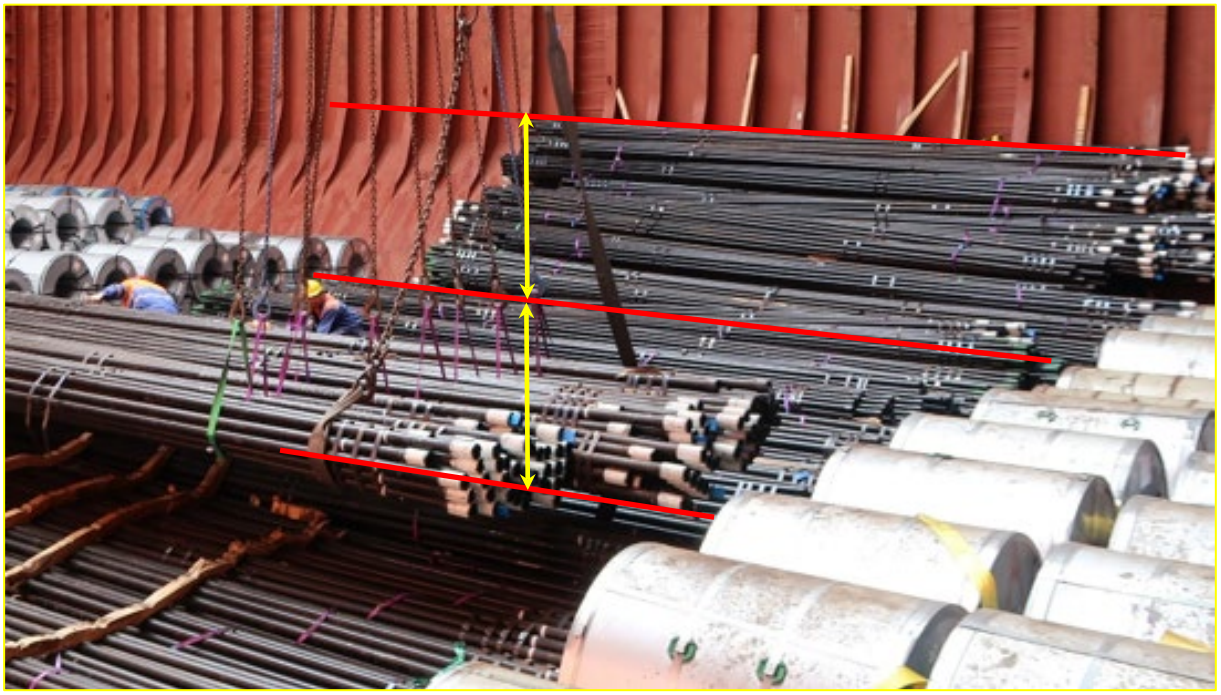


*Figure 6: Uneven distribution of cargo following discharging from the middle of the hold*

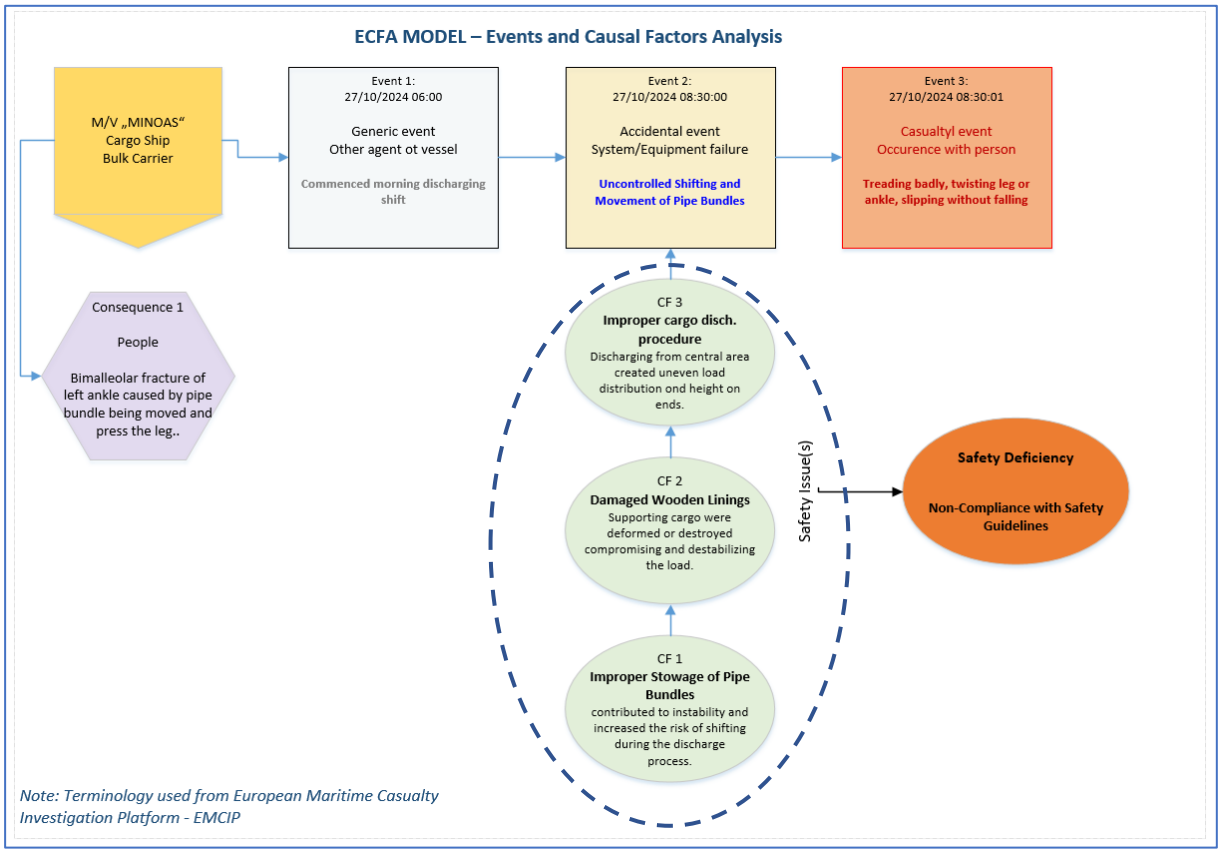



*Figure 7: ECFA Chart*

# CHAPTER 4 – CONCLUSIONS

**3.1**

| | |
|---|---|
| Accidental event: | ✓ **Uncontrolled Shifting and Movement of Pipe Bundles –** Accidental event was caused by uncontrolled shift and movement of one of the pipe bundles during cargo handling. |
| Contributing factors: | ✓ **Improper Stowage of Pipe Bundles** - The pipe bundles were unevenly stowed, which contributed to instability and increased the risk of shifting during the discharge process.<br>✓ **Damaged Wooden Linings**: The wooden linings supporting the cargo were either deformed or destroyed, compromising their structural integrity or further destabilizing the load.<br>✓ **Improper Cargo Discharge Procedure**: Discharging cargo primarily from the central area of the hold resulted in an uneven distribution of load height at both ends of the hold. This imbalance significantly increased the risk of uncontrolled shifting of the cargo, potentially leading to hazardous situations. |
| Safety issue: | ✓ **Potential for Injuries**: The method of discharging cargo, especially from the central part of the hold, created an uneven load distribution. This height imbalance could have caused or contributed to the uncontrolled shifting of cargo, posing a risk of injury to personnel during the operation. |
| Safety deficiency | ✓ **Non-Compliance with Safety Guidelines**: The incident involved a failure to adhere to the safety and handling procedures outlined in document TP: 10 002 0 TECHNOLOGY - Handling of Steel Bars, Tubes, and Profiles, Section 6, Guidelines for Quality and Safety Work, Paragraph 9, which addresses cargo collapse hazards in warehouses and aboard ships (Page 029). |

The identified safety deficiency is in direct contradiction of established safe working practices. Specifically, it contradicts the statement outlined in the "Questionnaire for the Examination of Competence for Safe and Healthy Working on Board Ships" – Special Part (PC GT).

In particular, Question No. 1 addresses the safe procedure for digging between cargoes during unloading: *"To what depth below the level of the loaded cargo in the hold is it permissible to dig between the cargoes during unloading?"*

The correct answer to this question is *"Up to a maximum depth of human height, taking into account the way the cargo is stacked or the stability of the stacked cargo."*

Failure to follow this protocol can significantly increase the risk of cargo instability and uncontrolled shifting, which in turn may jeopardize both the safety of personnel and the integrity of the cargo handling operation. This non-compliance with standard safety practices contributed to the hazardous conditions observed during the incident.

**Safety recommendation SI-MAIIS-SR028-2024 follows from points 3.3**

# CHAPTER 5 – SAFETY RECOMMENDATIONS

A safety recommendation is a proposal made by an investigating body, based on information obtained from an investigation, performed analysis and obtained conclusions with the aim of preventing accidents or incidents.

**Safety Recommendation SI-MAIIS-SR028-2024**

It is recommended to ensure strict adherence to safety guidelines that is essential for cargo handling operations. Specifically:

- To follow Safety Protocols by ensuring compliance with TP: 10 002 0 TECHNOLOGY – Handling of Steel Bars, Tubes, and Profiles, Section 6, regarding cargo collapse hazards.
- Training and Awareness: Reinforce safe unloading practices, particularly limiting digging between cargoes to a maximum depth of human height.
- Enhanced Supervision: Increase oversight during unloading operations to prevent instability and reduce risks of accidents or injuries.

These measures will help mitigate the risks associated with cargo shifting and enhance safety.

# CHAPTER 5 –ADOPTED SAFETY MEASURES AND ACTIONS TAKEN

**SI-MAIIS-AT003-2024**

Based on Safety Recommendation SI-MAIIS-SR028-2024, as recommended in the draft final report, the responsible parties at PC General Cargo conducted a renewed and additional familiarization session on technological procedures for terminal foremen and dispatchers at the General cargo terminal.

Discussions were held with the participants and direct supervisors, where they were re-familiarized with the technological procedures and practices for safe and healthy work, which include, among others:

- Regular alerts,
- Increased supervision, and
- Adherence to prescribed technological procedures, which are key factors in ensuring a safe and healthy environment.

Particular attention was paid to the procedure determining the extent to which "digging”" operations are permitted during cargo discharge. In cases where it is determined that the cargo poses a risk or is contrary to established work practices, an agreement on the safe conduct of operations shall be made before the commencement of discharge. (Appendix 2).

The adopted safety measure **SI-MAIIS-AT003-2024** is assessed by the investigating authority as appropriate and acceptable.

# APPENDICES

## APPENDIX 1 – Excerpt from "Questionnaire for the Examination of Competence for Safe and Healthy Working on Board Ships" – Special Part (PC GT).

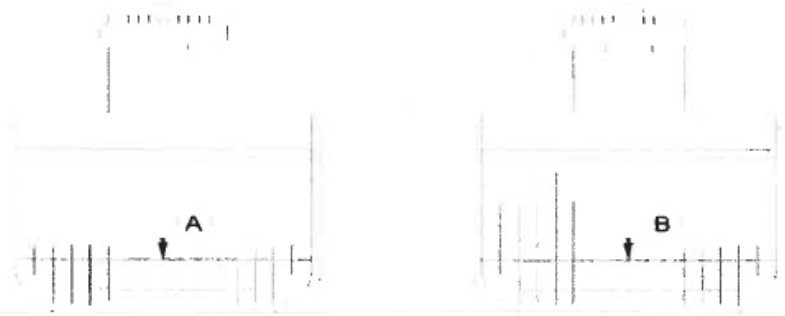
VZD - 14

LUKA KOPER
Port of Koper

**VPRAŠALNIK ZA PREIZKUS USPOSOBLJENOSTI ZA VARNO IN ZDRAVO DELO NA LADJAH – POSEBNI DEL (PC GT)**

| | |
|---|---|
| | **1. DO KAKŠNE GLOBINE POD NIVOJEM NALOŽENEGA TOVORA V LADIJSKEM SKLADIŠČU JE MED RAZKLADANJEM DOVOLJENO VKOPAVANJE MED TOVOR, PAKIRAN V KARTONASTE ŠKATLE, TOVORNE VREČE ALI DRUGO VRSTO EMBALAŽE?** |
| √ | a) Maksimalno do globine v višini človeka, pri čemer je potrebno upoštevati način zloženosti tovora oz. stabilnost zloženega tovora. |
| | b) Do dna zloženega blaga, ne glede na globino. |
| | c) Do globine 3m. |

**2. KATERI NAČIN VKOPAVANJA, KI JE PRIKAZAN NA SLIKI JE DOVOLJEN?**




| | |
|---|---|
| | a) Dovoljen je način prikazan v primeru A in B. |
| | b) Dovoljen je način prikazan v primeru B. |
| √ | c) Dovoljen je način prikazan v primeru A. |

**3. ZAKAJ SE MORA PRED PRIČETKOM PRETOVORA BLAGA ZAVAROVATI PROTI**

## APPENDIX 2 – Certificate of additional training - familiarization of foremen and dispatchers with the technological procedures at PC GT

LUKA KOPER
Port of Koper

Št. SAP: _____

**ZAPISNIK**

**o ponovni seznanitvi z tehnološkim postopkom:**

**Delovodje, Disponenti**

delovno mesto oz. delo

Seznanitve so se udeležili zaposleni navedeni v nadaljevanju.

Seznanitev s postopkom dela in varnostnimi ukrepi skladno s tehnološkim postopkom TP: 10 002 0 in dolžnosti vodenja in izvajanja nadzora.

Seznanitev je dne 13.11.2024 izvedel:

| | |
|---|---|
| Priimek in ime: JANI BANDELJ | Podpis: |
| Priimek in ime: | Podpis: |

Opombe:

Z udeleženci in neposrednimi vodjami je opravljen razgovor, kjer so ponovno seznanjeni z tehnološkimi postopki in praksami za varno in zdravo delo. Redno opozarjanje, povečan nadzor, upoštevanje predpisanih tehnoloških postopkov, so ključni dejavniki za zagotavljanje varnega in zdravega okolja. Posebno pozornost smo posvetili postopku do katerega nivoja je dovoljeno » vkopanje« pri razkladanju tovora. V kolikor je ugotovljeno, da gre za tovor, kateri predstavlja ogroženost oziroma je v nasprotju z ustaljenimi delovnimi praksami, se pred pričetkom razkladanja dogovorimo glede varnega poteka dela.

DN 224 R5 – Sistemi prenosa znanja: Mentorstvo, inštruktorstvo, interni predavatelji

OBR 170

## APPENDIX 2 cont.

**IZJAVA KANDIDATA**

S podpisom potrjujem, da sem se udeležil seznanitve, sem vsebino razumel in jo bom upošteval pri nadaljnjem delu.

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