

IMCA Safety Flash 11/12

October 2012

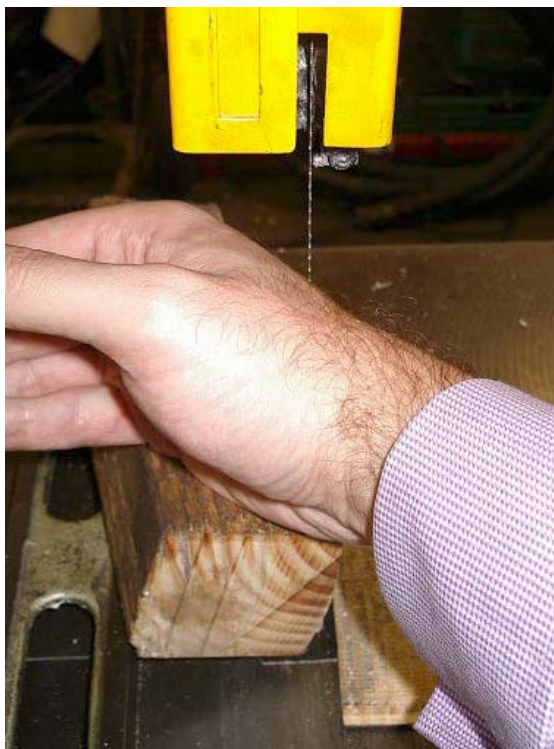
These flashes summarise key safety matters and incidents, allowing wider dissemination of lessons learnt from them. The information below has been provided in good faith by members and should be reviewed individually by recipients, who will determine its relevance to their own operations.

The effectiveness of the IMCA safety flash system depends on receiving reports from members in order to pass on information and avoid repeat incidents. Please consider adding the IMCA secretariat (imca@imca-int.com) to your internal distribution list for safety alerts and/or manually submitting information on specific incidents you consider may be relevant. All information will be anonymised or sanitised, as appropriate.

A number of other organisations issue safety flashes and similar documents which may be of interest to IMCA members. Where these are particularly relevant, these may be summarised or highlighted here. Links to known relevant websites are provided at www.imca-int.com/links. Additional links should be submitted to webmaster@imca-int.com

I LTI: Hand Injury

A member has reported an incident in which a worker sustained a serious injury to his right hand. The incident occurred in an onshore mechanical workshop. The injured person was attempting to cut a small block of wood down to size to use as a spacer. Whilst using the mechanical workshop vertical band-saw his hand came into contact with the moving blade, causing a serious laceration to the back of the hand and resulting in tendon damage.



Position of hand and wood during incident



Band-saw with guard set to lowest position

Our member's investigation revealed the following:

- ◆ Immediate causes:
 - The wood split during cutting due to the application of excessive force to the wood, which was caused by excessive wear on the blade and the incorrect positioning of the wood;
 - A "Push stick" was not used;
 - An adjustable guard was not used.
- ◆ Root causes:
 - Lack of hazard awareness/complacency – the injured person did not identify using the machine as a hazard and did not use the available safety guards and processes whilst operating the saw;
 - Uncondoned behaviour/violation – the injured person identified a fault with the saw but continued to operate it without reporting the fault.

Our member took the following actions:

- ◆ Workshop/Yard Induction form to be reviewed and updated to include specific mention of Safety Observation Card requirements, Stop the Job requirements and section relating to machinery operation and competence;
- ◆ Review of induction frequency requirements and inclusion into site management procedures;
- ◆ Prepare and issue pre-use checklists for each machine with requirements for inspection prior to use, following use and reporting requirements where faults have been identified;
- ◆ Implement locking e-stop system with controlled key access to prevent unauthorised use;
- ◆ Update risk assessment with lessons learned from incident investigation where pertinent.

2 Near Miss: Dropped Object

A member has reported a near miss incident in which a turnbuckle pin weighing approximately 2kg fell more than 12m to deck. The incident occurred on a third party construction support vessel used for pipe laying. The vessel has a gutter to guide the flexible pipe into the vertical tensioner. It is able to slew left and right to allow the flexible pipe to approach from various angles. This gutter was to be held in place using a combination of turnbuckle, chain and shackles (see photographs below.) Whilst installing the turnbuckle securing arrangement, the retaining pin of the turnbuckle was dropped more than 12m to deck. There were no injuries.

Using the DROPS Calculator as a benchmark in the classification of the potential consequences of a dropped object, our member determined that the outcome of dropping the turnbuckle pin could have resulted in a fatality



Location of turnbuckle pin (L) and where the turnbuckle pin fell from (R)



Securing of shackle pins used at height with wire

Our member investigated the incident and as a result implemented a simple secondary securing method to prevent dropped objects.

Members' attention is drawn to the following IMCA material which may be of assistance:

- ◆ [IMCA SEL 019 Guidelines for lifting operations](#)
- ◆ [IMCA SPP 04 Avoiding dropped objects](#)
- ◆ [IMCA SPC 05 Lifting equipment](#)
- ◆ [IMCA SPC 06 Working at height](#)
- ◆ [IMCA SPC 12 Avoiding dropped objects](#)

Members may also find useful information from www.dropsonline.com

3 LTI: Crush Injury - Arm Trapped by Movement of Crane Block

A member has reported an incident in which a crew member broke his arm. The incident occurred as the vessel was approaching port when a crew member released the securings for the main crane block. The block started to move and inflicted a crush injury resulting in a broken arm and subsequent medical evacuation.

The vessel was rolling due to the sea conditions and vessel manoeuvring. The injured person went to the crane pedestal to remove the sea fastenings from the main block in preparation for crane operations in port. As the injured person loosened the sea fastenings, the ship rolled causing the block to move clear of the bucket, and his right arm was caught between the swinging block and a steel upright. The impact caused lacerations to the inside and back of the upper right arm resulting in bleeding and fracture to the humerus (forearm) bone.



Crane block



Crane block and upright showing how crane block moved

Our member's investigation drew the following conclusions:

- ◆ The movement of the block which caused the injury was directly caused by the removal of sea fastenings too soon before the vessel had actually arrived in port. This allowed the main block to move as the vessel rolled. The main block had been securely fastened up to this time and throughout the vessel transit;
- ◆ The main block bucket had been altered with a section having been removed to house a slightly larger block, this resulted in the block requiring cargo straps to secure it in position;
- ◆ The injured person was working alone at the time of the incident and had neither been requested, nor sought permission to carry out this task.

In addition to internal discussion of the incident, our member took the following actions:

- ◆ To review lone working policy on vessels to ensure all personnel are aware of the dangers and responsibilities of lone working, and to inform others when potentially working alone around the vessel;
- ◆ Ensure active supervision to prevent personnel undertaking tasks without prior notification;
- ◆ To undertake learning and information campaigns to help raise hazard awareness: if personnel can correctly identify hazards then they can take the correct actions to mitigate risks;

Members are encouraged to make use of the following IMCA safety promotional material in relation to this incident:

- ◆ [IMCA SPC 16 Caught between and pinch points: What you should know](#)
- ◆ [IMCA SPP 09 Watch out for pinch points](#)

4 Near Miss: Faulty Lifebuoys Discovered

A member has reported an incident in which defects were discovered on several lifebuoys aboard a company-owned vessel. During routine life-saving appliance checks, it was noted the plug/stopper on one of the lifebuoys was missing. The position where the plug/stopper should have been is shown in the photographs below. These should have been put in place by the manufacturer. In this instance, the lack of the plug had resulted in one lifebuoy being full of water with a resultant loss of buoyancy. A further four lifebuoys were found to have the plugs missing.

The lifebuoy type was **EVAL, E.G. Vallianatos S.P.A Greece, Code 559.**

Members are recommended to conduct a visual check and, where necessary, a weight check on all lifebuoys onboard for this potential issue. It is recommended to amend onboard planned maintenance schedules such that that they include quality control checks and inspection of lifebuoys.



Lifebuoy Plug/stopper insert location covered by retro-reflective tape



Lifebuoy Plug/stopper insert location showing lack of plug when tape removed

5 Able Seaman Injured by Shifting Cargo

The Marine Safety Forum (MSF) has published the following Safety Flash regarding an incident in which a crewman was injured by unstable cargo that shifted when the vessel rolled.

The report can be downloaded from www.marinesafetyforum.org/upload-files//safetyalerts/msf-safety-flash-12.40.pdf