

IMCA Safety Flash 13/17

June 2017

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 info@imca-int.com

Any actions, lessons learnt, recommendations and suggestions in IMCA safety flashes are generated by the submitting organisation. IMCA safety flashes provide, in good faith, safety information for the benefit of members and do not necessarily constitute IMCA guidance, nor represent the official view of the Association or its members.

All five of the following incidents unfortunately involved personal harm (or in the case of the first incident, potential personal harm) to people working offshore. Three lost time injuries (LTIs) are covered – two of them involving injuries to the hands or fingers, one of them a foot injury. In the fifth incident, members' attention is drawn to a report from the Accident Investigation Branch of Norway (AIBN) on a fatal fall of a seafarer on board a Norwegian registered tanker.

The same issues keep emerging, both literally (in the text of members' incident submissions) and implicitly – in the overall trends observed – personal safety culture and personal responsibility for safety.

1 Person Accidentally Drank Hazardous Substance – Unmarked Bottle

What happened?

A third-party agent was on board a vessel during port clearance formalities. On the bridge, there was a mineral water bottle from which this person took a swallow. He immediately spat it out as the taste was different. He subsequently drank a great deal of water; he felt unwell for a time but there were no long-term ill effects and he subsequently left the vessel feeling OK.

What went wrong?

The bottle, *which was not marked as such*, contained a small quantity of diluted bleaching liquid that the bridge staff was using for cleaning the table top.

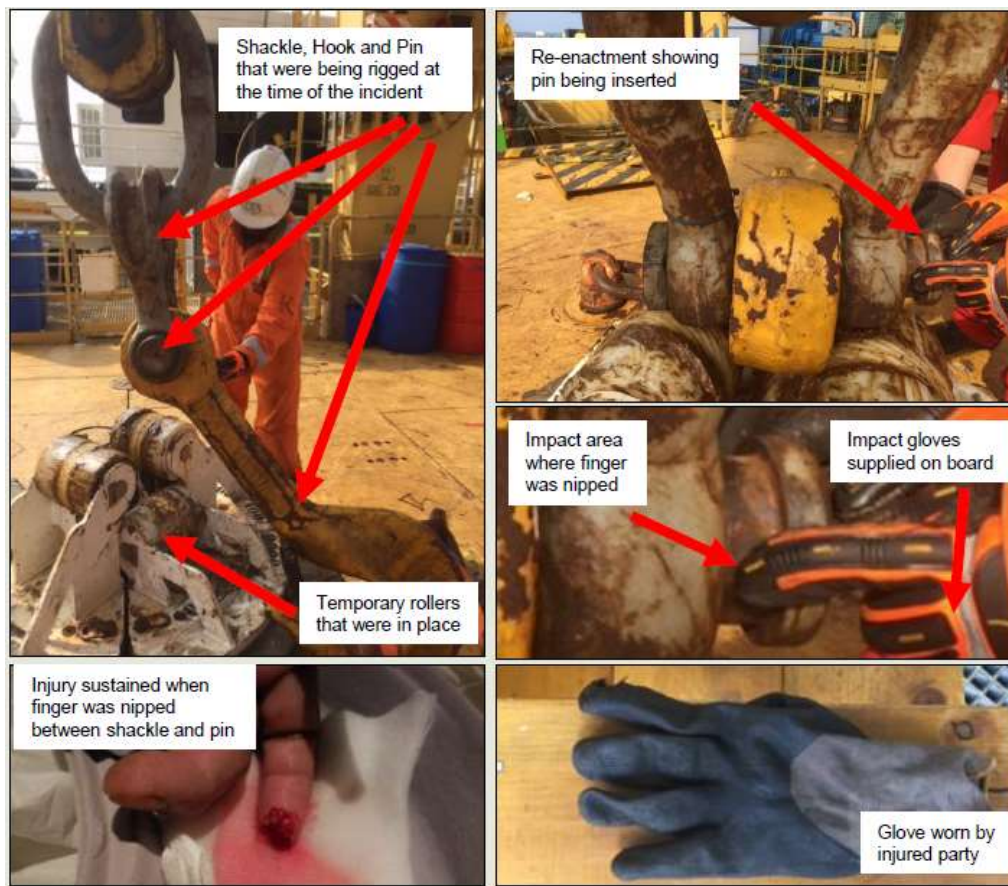
This is brought to members' attention as it is **exactly the same kind of incident** as that recorded in [Person accidentally drank hazardous substance](#).

Members may wish to reiterate some fundamentals of safety awareness to vessel crews in the context of this incident.

2 LTI: Finger Injury Sustained Handling Heavy Shackle Pin

What happened?

During re-rigging of heavy lifting gear, two riggers were holding the crane hook upright, another three were holding the shackle, and a sixth crewman was holding the shackle pin ready for insertion. As he pushed the shackle pin home, his left index finger was nipped between the head of the shackle and the body of the shackle. This resulted in a serious injury to the index finger of the left hand.



What were the causes of the incident?

- ◆ Our member identified the following **immediate** causes:
 - not paying attention – lack of awareness of hazards; this was due to the routine nature of the activity
 - inadequate personal protective equipment (PPE) – impact resistant gloves not worn; these could have reduced the severity of the incident;
- ◆ The following **underlying** causes were identified:
 - complacency – due to the repetitive nature of this routine activity
 - prescribed PPE was not worn due in part to poor communication and poor enforcement of the requirements
 - poor design of the shackle pin and the method used for rigging may have contributed to the incident – the size and shape of the pin head left little room for the fingers to hold
 - environment – the work area was restricted and cramped.

What lessons were learnt? And what were the actions?

- ◆ Easier rigging arrangements involving less manual handling would be investigated, including the possible use of mechanical aids.

Members may wish to refer to the following incident:

- ◆ [Finger injury during maintenance work – restricted work case.](#)

3 Drill Bit Snapped: Finger Injury Sustained

What happened?

A crewman was in the process of using an electric drill to fix a broom head to a broom stick. The broom stick was held in the vice. The crewman was holding the drill with his right hand, and holding the broom head with his left. The drill bit snapped off which caused the drill to slip and as a result it penetrated the crewman's safety gloves and came in contact with the nail of his left thumb. This slightly dislodged the nail from the thumb. The injury required first aid treatment only.



What were the causes of the incident?

The **root causes** identified by our member were misperception of risk and improper handling of tools. Appropriate precautions were not taken in proper work techniques. Even though the vice was used, he still held the job with one hand. This could have resulted in a more serious injury.

What lessons were learnt? And what were the actions?

- ◆ Briefing and training sessions to be conducted for vessel crew regarding safe working practices with hand tools;
- ◆ Greater involvement of vessel crew in identifying hazards and risks for each part of their job.

IMCA has published a short video and pocket card on hand safety – [Watch your hands](#). Members may also wish to refer to the following incident:

- ◆ [Care using hand tools](#).

4 LTI: Tugger Winch Incident (MSF)

What happened?

The Marine Safety Forum (MSF) reports an incident involving a platform supply vessel which had completed loading operations and the deck crew were securing the cargo for sea with assistance from the tugger winch. The AB who was operating the tugger winch was well experienced and had carried out this operation many times. The AB stood

at the tugger winch with his right foot resting on the winch support plate and started heaving up the wire using the control handle which was located above the winch.

As the winch barrel rotated, the wire securing bar trapped the AB's foot between the winch support plate and the rotating barrel crushing his foot as it rotated.



Actions to prevent recurrence?

Following the incident, a protective frame was built around the tugger winch to prevent a similar incident from happening again.

- ◆ Could this occur on your vessel?
- ◆ Are your winches and rotating machinery suitably protected?

This incident was first published as [Marine Safety Forum incident 17-01](#).

Members may wish to refer to the following incidents:

- ◆ [Winching Equipment](#) [covering the exact same issue];
- ◆ [Hydraulic Umbilical Winch Operation – Trapped Thumb](#).

5 Fatal Fall Aboard Tanker *Marinor*

The Accident Investigation Branch of Norway (AIBN) has published incident 17-04 on the fatal fall of a seafarer on board a Norwegian registered tanker. Whilst the vessel was at sea preparing for an inspection, the crew found that one lashing turnbuckle for the free-fall lifeboat had corroded. The chief mate explained to the Able Seaman (AB) who was to carry out the work that the job only involved rust removal and painting of the turnbuckle. No work permit was issued for this maintenance job, since the work would take place at a height of only just over one metre and in an area secured by railings.

The AB who carried out the maintenance work told the bosun that, while carrying out the work, he had observed that the forward hook for the free-fall lifeboat was in need of lubrication and he asked the bosun for help to steady the ladder he had erected in the position of the forward hook in the davit.

When the AB had climbed part of the way up the ladder, it suddenly slipped on the deck without the bosun being able to keep it steady or stop it from slipping. The AB fell along with the ladder and ended up motionless on the deck next to the ladder. He died three hours later from injuries he sustained.



Ladder as positioned by the AB to reach the forward hook



Ladder was unstable, both feet were not in firm contact with the deck

The full report can be found on the [Accident Investigation Branch of Norway website](#).