IMCA Safety Flash 13/18

June 2018

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.

1 Lost Time Injury (LTI): Fractured Elbow – Fall Injury

What happened?

The Chief Officer slipped on a smooth section of ramping deck, landing badly and suffering a fractured elbow. The incident took place at crew change, when the Captain, Chief Officer and Engine Cadet joined the vessel. The Chief Officer and Captain walked along the yellow painted walkway to get into the accommodation. It had rained all morning, so the main deck was wet. The Captain walked over the anti-slip bars in the middle of the ramp, while the Chief Officer stepped onto the ramp and did not hold onto the railings on the side of the ramp. The Chief Officer continued walking on the smooth section of the ramp and slipped, heavily falling backwards and landing on his left elbow and buttocks.

Several days later, bruising was apparent around the Chief Officer's left elbow, so he was sent to the hospital for medical examination. An X-ray revealed that he had fractured his elbow and he was sent home for full recovery.

What went wrong?

- Direct cause: improper stepping and handling – the injured person was not holding to the railings. Additionally, he ignored the use of the anti-slip bars that were welded onto the sloping ramp to prevent slips;
- Root cause: personal factors, Inadequate identification and evaluation of hazard or risks – the Chief Officer chose to ignore a safer option of stepping onto the non-slip bars and walked on a slippery deck. He was over-confident and underestimated the risk, leading to a familiarity bias and perceived control.

What actions were taken? What lessons were learned?

Our member used this incident for a timely review of similar slips/trips incidents within their fleet, and identified some personal factors or behavioural-based safety issues:

- *"It's alright, we normally doing this"* – control bias – there will be jobs that are easy to do or easy to understand and can often be regarded as routine. We feel that we are in control and tend to neglect the risk that is actually present. We should keep in mind that even if a job has been done a number of times, there will generally always be some changes, which sometimes may not be obvious or noticeable. We should be more aware of these changes, even if they are deemed to be small;
- *"The area is safe; it is newly painted with anti-skid coating."* – expectation bias – in this instance, the crew tend to overlook the situation and other hazards that lead to an unsafe act/condition. For example: wet surface, ship movement or not holding the railings;
- *"We still have a lot of things to do, this job needs be completed ASAP."* – efficiency bias – due to time pressure, crews work in haste and tend to take shortcuts. Always remember, putting your safety first is always more important than completing the job speedily;
- *"It has always been like this and nothing has ever happened."* – familiarity bias – crew are familiar with the situation onboard as well as its condition, since he/she has been onboard for some time.

Members may wish to review the following incidents:

- Edges and ledges – a slip on deck resulted in injury
- Slips, trips and falls – raising awareness

Members may also wish to view the IMCA short safety video on *Preventing slips and trips.*

2 LTI: Cut to Hand from Protruding Hose Clip (Marine Safety Forum)

The Marine Safety Forum (MSF) has released the below safety alert 18-10.

What happened?

Not long after a vessel departed port, a crew member suffered a serious cut to his hand which led to an LTI. The incident occurred when he was carrying boxes through the galley and caught his hand on the sharp edge of a hose clip protruding in the transit area. First Aid was administered on-board; however, the Master deemed further medical attention was required and the vessel returned to port. The crew member was sent ashore to the local hospital where medication and seven stitches were applied. The crew member was subsequently declared unfit for work for seven days.

What actions were taken?

The offending sharp edge was quickly covered to prevent further injury. The crew member had only been on-board for two days and it is likely that he was not fully appraised or aware of the hazards in his new work area.

The full alert can be found on the MSF website.

This incident is brought to the attention of IMCA members because this was an avoidable injury with costly consequences, in that the vessel had to return to port and the injured person was unfit for work for seven days.

Members may wish to look at the following incident:

- Crewman suffers cut to hand – but gloves prevented it being much worse

Members may also wish to look at the following safety video:

- Watch your hands

3 Two Dropped Object Near Misses

Incident 1 – Wooden block laying in top of main hoist block

During a voyage in good weather conditions, the Captain decided that the vessel would sail with the cranes secured on deck. On the second day of the trip, the Captain was looking at the main hoist block of the forward crane, which was secured at the same height and just behind the bridge, when he noticed a 30cm long piece of 10x10 timber lying on the side of the hook.

The piece of timber was most likely placed there during a re-reeving operation some months previously, although the investigation could not confirm this and it may have been there even longer. The piece of timber was immediately removed.

What lessons were learned?

- Ensure that your work area is suitable for using loose equipment (lying on deck, platforms, gratings);
- Ensure that your work area is checked for loose equipment during your job;
- Ensure that your work area is cleared up after completion of your job;
- It is good practice to use a tool lanyard when working at height with tools.

Incident 2 – Safety pin falls out of lifting beam

Whilst disconnecting lifting gear from a large piece of subsea equipment, which had been loaded onto deck, it was noticed by the crew that a securing pin on the load was more than half out of position. The lifting gear consisted of a large beam and two further spreader beams. The grommets used for these spreader beams were secured with the securing pin, in turn secured with a safety pin. A few minutes later, the securing pin was touched by a steering line attached to the main beam, causing the securing pin to fall out and drop 15m onto deck. No-one was nearby where the pin landed; the loose pin had been spotted and the area cleared beforehand.

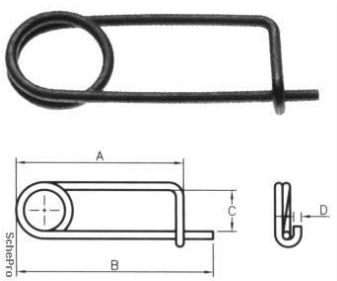
What went wrong? What were the causes

After discussing this incident with the crew, it was clear that the pin was secured with a safety pin of the correct size. What was not known was if the safety pin was still in good shape and not bent open or damaged in any other way. Also not known was if the safety pin fell out of the securing pin by itself (gravity) or if the steering line somehow pulled/pushed the safety pin out.

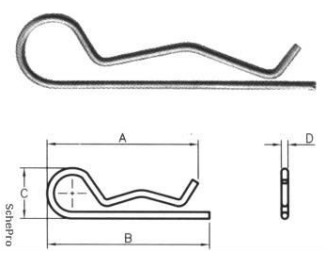
There was no direct force on the securing pin by the grommets. Due to the rigging, the spreader beam was twisted; it was horizontal but twisted some 30 degrees around its axis. This caused the pin to slide out when the safety pin was gone. The safety pin was not found after the incident.

What actions were taken?

A new kind of safety pin was introduced



New pin



Old pin

Members may wish to refer to the following incidents

- Recent near miss incidents involving potential dropped objects
- Dropped object: lay tower adjuster leg pin
- Pin from crane block sheave guard fell 25m

Members may also wish to refer to the following IMCA guidance and safety promotional material:

- Avoiding dropped objects – safety pocket card
- Working at height – video (see also IMCA SEL 009)
- Technip DROPS – video
- Safe lifting (IMCA SEL 030)

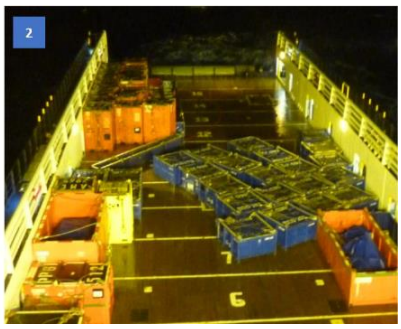
4 MSF: Three Potential Near Misses During Cargo Operations

Three recent safety alerts have been released by the MSF, all relating to high potential near misses during cargo operations. One of the incidents is a dropped object near miss and two relate to cargo moving on deck.

- Safety alert 18-15: Potential Dropped Object

During deck cargo operations at an offshore installation, as a container was received on the installation landing platform the crane operator reported that a potential dropped object had been discovered on top of the container. The object was discovered to be from the supply vessel; the previous day, the supply vessel crew had conducted a fire training drill, which included rigging hoses on the main deck amongst the deck cargo. A lapse in attention by the individual using the tool and a failure in the post-work inspection meant that the tool was left on top of the container on completion of the fire exercise. The photographs show that this object was both conspicuous (red handle against blue coloured container) in appearance and left in a conspicuous position on the container. The object ought to have been discovered and removed post exercise.

- Safety alert 18-13: *Cargo Shifted on Deck - High Potential Near Miss*



Unsecured cargo, including a 24' basket and 20 mud skips, shifted across the deck when a wave, significantly larger than forecast, passed the vessel. The vessel had been alongside a platform working cargo earlier in the day, but owing to the deteriorating weather conditions, the vessel ceased work and departed the 500m zone. The cargo was unsecured to facilitate cargo operations, and was not re-secured on departing the 500m zone. As conditions improved (to Force 6, 2.5m seas) preparation was made for re-entry to the 500m zone, and at this point, the large wave struck.

- Safety alert 18-14: *Deck Cargo Shifted – High Potential Near Miss*

A wave struck the stern of a platform supply vessel (PSV) and caused the cargo to move. The incident occurred whilst the PSV was working both stern to weather and stern towards the rig. Wind was 19 m/s and there was a significant wave height of 3.2m. As the cargo operation was about to start, a large wave hit the stern of the ship and water came over the deck. This resulted in shifting cargo; one crew member was located on the deck in an unsafe position, close to the containers. No personal injuries resulted.