IMCA Safety Flash 14/08

September 2008

These flashes summarise key safety matters and incidents, allowing wider dissemination of lessons learned 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

1 Serious Injury Incident During Routine Crane Maintenance

A member has reported a serious injury incident which took place recently during planned routine crane maintenance operations onboard a third party vessel.

Access to the crane cab level was via a stairway from the main deck, leading to a vertical ladder which then gave access to the upper crane platform. At the time of the incident, routine planned maintenance was being carried out on the crane winch pumps on the upper crane cab level, as shown below:

The Incident

A crew member was carrying out routine maintenance on the upper crane platform, checking gearbox and pump oil levels, of which there were twelve to be checked. The oil check involved manually removing a plug. The crew member's gloves and boot soles became contaminated with hydraulic oil and, when descending the vertical ladder, the crew member slipped on the ladder rungs and fell approximately two metres to the crane cab platform below. During the fall the crew member's left leg became trapped in one of the lower rungs, causing injury.

Following immediate assistance from the onboard medic and consultation with medical advisers, the crew member was medevaced ashore. It was later confirmed that the person had suffered a fracture of the left tibia.

Lessons Learnt

Working on the upper crane platform was considered to be a routine activity and consequently there were no permit to work (PTW) or other working at height (WAH) controls in place.

There were no task procedures in place for the activity and the method of checking the oil levels by removing a plug to bleed the oil was deemed to be unacceptable. Hazards and controls were not properly identified.

The task was seen purely as 'routine' maintenance and there was an unchallenged acceptance of the method of carrying it out.

Perception and awareness of the potential risk involved in this task was low. There was:

- no risk assessment in place;
- no toolbox talk held prior to the job;
- lack of active supervision.

A ladder access survey did not fully recognise the potential risks around safe access/egress from the upper crane platform. The design of the vertical ladder and its location/position was considered to be inadequate and unsuitable:

- 'Backscratcher' was considered to be ineffective and did not provide adequate fall protection;
- there was no suitable handrail fitted;
- there was no anti-slip to the ladder rungs;
- the ladder's position relative to the upper crane platform meant that it was only possible to step on to it in a 'backwards' position.

Actions

This incident clearly had the potential for much more serious consequences and was classified as a HIPO (high potential event). The investigation revealed a number of key learning points which should be shared by IMCA members to raise awareness and help eliminate any similar incidents in the future.

- Routine planned maintenance activities should be reviewed to assess if there are any similar ones which may fall under the WAH category and should include a PTW;
- Risk assessments should be in place and be reviewed for routine tasks;
- Vessel supervisory staff should actively involve themselves in toolbox talks for marine routine activities and ensure that, where appropriate, they are recorded;
- The design and location/position of the existing ladders should be reviewed to ensure/improve safe access/egress.

2 Failure of Fall Arresters

A member has reported several incidents onboard vessels where fall arresters have been found to be defective. Although the incidents have not resulted in any injuries to personnel they may have had very serious consequences.

It is believed that the failure of the equipment was lack of inspection and/or maintenance. It is of utmost importance that appropriate maintenance and inspection of fall arrest equipment is carried out in accordance with the manufacturer's instructions.

Members are recommended to remind vessel crews to go through the inspection and maintenance regime to ensure fall arrest equipment is maintained to a safe standard.

Below are pictures from one of the failed equipment: