

## IMCA Safety Flash 28/19

December 2019

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](mailto: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](http://www.imca-int.com/links). Additional links should be submitted to [info@imca-int.com](mailto: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 Man Overboard – Fall from Pilot Ladder

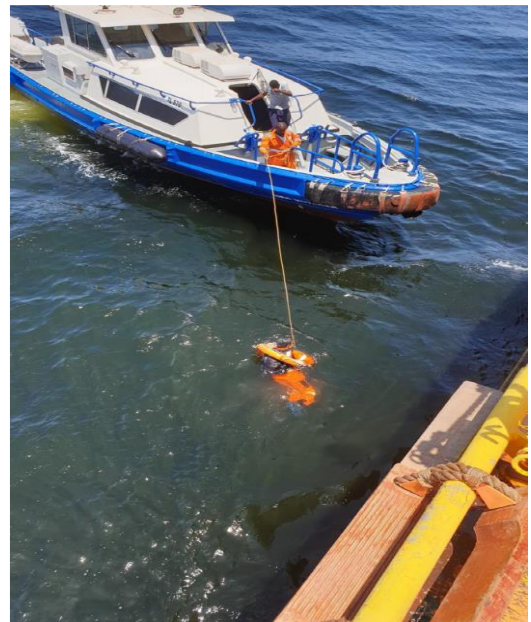
#### What happened?

During boarding a vessel via pilot ladder from a service boat, an IT service technician lost his footing and fell from the second step of pilot ladder into the sea. He was carrying a backpack with IT equipment and documents. He was rescued with the assistance of the crew of the service boat. First aid was rendered, and no injuries were reported. The IT equipment carried was damaged as a result of flooding with seawater.

#### What went wrong?

While he was climbing the pilot ladder with his right foot on the 2nd step of the ladder and his left foot just off the service boat deck, the boat lurched backwards, causing the bottom part of the ladder to sway slightly.

This resulted in the IT service technician losing his balance and he fell into the water from a height of approximately 1.0 to 1.2 meters. He was not wearing a lifejacket.



#### What actions were taken?

- ◆ Ensure that ALL persons embarking or disembarking through the pilot ladder wear SOLAS approved lifejackets;
- ◆ No bags, back packs or any other luggage should be carried – all luggage should be sent on-board separately;
- ◆ Brief all crew on ‘**stop work authority**’ – this should have been stopped before it happened.

Members may wish to refer to:

- ◆ [Near Miss: Man Overboard](#)
- ◆ [Near Miss: Non-Fatal Man Overboard Incident](#)
- ◆ [OCIMF: Pilot Ladder Side Rope Failure: Unsafe Pilot Transfer](#)

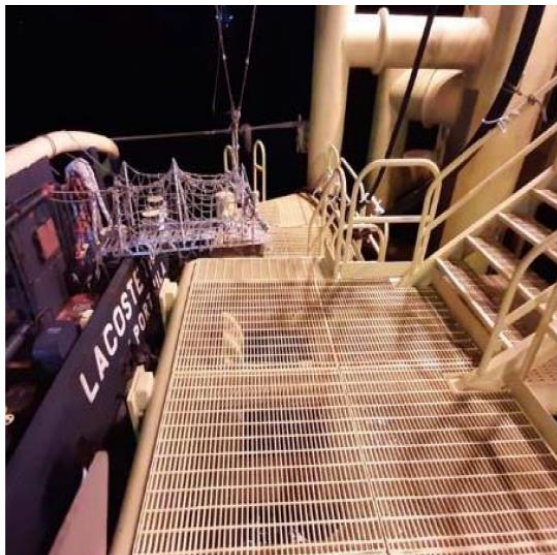
## 2 High Potential Incident – Man Injured While Falling Overboard (MOB)

### What happened?

Whilst descending stairs to a boat-landing area on an offshore platform, a sub-contracted employee of one of our members tripped on a 2-inch discharge hose that had been laid across the base of a stairway. He fell forward onto the boat landing, momentarily arresting his forward movement, before tumbling into the gap between the boat landing and a moored workboat. He was able to break his fall by grabbing a fender chain attached to the workboat. The fall injured him (it was a restricted work case) however it is clear that there was potential for the outcome to be more severe.



Position of temporary hoses at incident scene



Reinstated work area, free of trip hazards - post incident event



Offshore platform where incident occurred, with workboat alongside (moored to boat-landing)

The officer on watch witnessed the incident from the vessel bridge and raised the alarm; a deck AB responded by manually recovering the partially submerged person to deck. He was wearing a three-piece foam flotation device, and all required personal protective equipment (PPE) including a helmet with chinstrap correctly worn.

He suffered bruising to the left wrist and a minor cut to the right ear. Follow up medical examination indicated that he also suffered a fractured wrist.

### What went wrong? What were the causes?

- ◆ The incident was the result of poor/inadequate hose management practices; Hoses were laid across the platform boat-landing causing a trip hazard;
- ◆ Control measures as per the approved risk assessment were not implemented; specifically, the requirement to route hoses in a safe manner. This resulted in poor worksite preparation and insufficient inspection;
- ◆ Poor custom and practice – laying hoses on platform walkways had been common practice during the current campaign; they had been temporarily set up four days prior to incident and they were not identified or highlighted as causing a trip hazard;
- ◆ Failure to recognise and report hazards – individuals involved in the operations at the time of the incident had previously accessed the platform's boat landing and had failed to recognise and report the hazards presented from hoses laid across walkways.

### What actions were taken?

- ◆ Ensure all work tasks are adequately planned and risk assessed before starting work activities, including review of access, egress and escape routes;
- ◆ Where temporary hoses are placed at access ways/work areas always, consider additional controls to eliminate the possibility for trip hazards, such as use of cable racks or hose covers;

- ◆ Increase focus on critical safety behaviours such as ‘eyes on path’ when accessing unfamiliar worksites. **When hazards and/or unsafe conditions are observed, intervene and report.**

Members may wish to refer to:

- ◆ [Lost Time Injury \(LTI\): Trip Incident During Routine Task](#)
- ◆ [Hand Injury Caused When Worker Tripped Over Hazard](#)
- ◆ [Lost Time Injury \(LTI\): Trip Incident](#)

### 3 Unsafe Boarding During Unmooring Operation

#### What happened?

A vessel was departing from port when crew found it necessary to remove the mooring lines from the shoreside bollards with no safe un-boarding/boarding arrangements in place – instead clambering over the side (CCTV capture shown adjacent). A standard unmooring process (using shore-based support) had been discussed with the team involved during the pre-task briefing/toolbox talk.



#### What went wrong?

Immediately before starting the unmooring operation, the port authorities informed the vessel that the ‘shoreside linesmen’ were not available. As a further consequence, the mooring lines were not recovered quickly enough, resulting in an entanglement into a stern thruster.

#### What were the causes?

- ◆ Failure to follow company operating procedures and internal HSSE rules;
- ◆ Ineffective assessment of risks before starting work;
- ◆ Failure to effectively recognise and manage the safety risks associated with the change to the planned activity (failure to manage change);
- ◆ No-one stopped the job (**stop work authority**).

#### What actions were taken?

- ◆ The fouled mooring line was removed/cleared from the thruster;
- ◆ Reinforcement and raising awareness of:
  - existing company rules on safety including the obligation of all employees to ‘speak up/step in’ if they see an unsafe act and/or condition
  - the importance of dynamic risk assessment and management of change (MoC)
  - the relevant sections of Code of Safe Working Practices for Merchant Seafarers (COSWP)
  - fleet level risk assessment and management procedures
  - fleet level vessel mooring/unmooring procedures;
- ◆ There was a visit by senior management and discussion with the team involved.

#### What lessons were learned?

- ◆ Vessel crew should not act as linesmen for their own vessel;
- ◆ Contingency plans should be developed in advance for this type of routine activity;
- ◆ Changes to any activity should be effectively risk assessed and managed using the MoC process.

Members may wish to refer to:

- ♦ [Man drowned after falling into dock when disembarking through pilot-gate](#) [The crewman disembarked the vessel through the pilot-gate at the side of the vessel instead of using the designated and secure gangway and lost his footing whilst doing so]
- ♦ [Unsafe Boarding Of Vessels \(MSF\)](#)
- ♦ [Near Miss: Non-Fatal Man Overboard Incident](#)
- ♦ [Near Miss: Man Overboard](#)

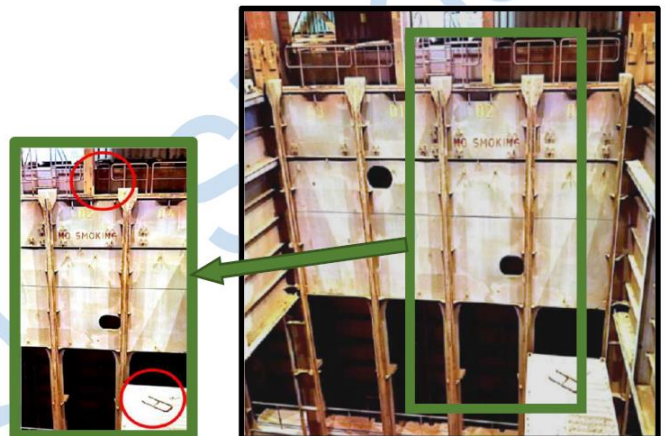
#### 4 Raising Awareness on Safety Barriers such as Railings and Gratings

##### What happened?

The Transport Safety Investigation Bureau (TSIB) of Singapore has released [Safety Flyer 2019/02](#) entitled *The importance of ensuring proper inspection and maintenance regime*. It is intended raise awareness on the importance of carrying out comprehensive inspection of safety barriers such as railings and gratings, and to encourage timely preventive maintenance and implementation of adequate safeguards in place to ensure safety of personnel on board ships.

##### What went wrong? Some recent occurrences

- ♦ **A stevedore was fatally injured** by falling into the cargo hold of a container ship; investigation revealed that a safety railing, which was in poor condition and badly corroded, could have contributed to the fall of the stevedore from a height of about 20 metres. Although the corroded safety railing had been identified to be one of the tasks to be carried out on-board, there were no safeguards or warning signs put in place to warn personnel in the vicinity of its condition.
- ♦ **A crew member of a container ship had a fatal fall from a height of almost 20 metres**, when the base plate of the crane cabin he had just entered gave way, and he died at the hospital.



##### Corrosion fatigue on-board ships?

The TSIB notes the following:

- ♦ Most forms of corrosion on-board ships occurs due to oxidation, which implies the presence of oxygen or oxidisers, for the metallic reaction to form rust;
- ♦ Atmospheric conditions at sea typically accelerates this corrosion and the severity is commonly caused by airborne (sea) salt spray, temperature and moisture. Generally, moisture when combined with elevated temperatures and salt, intensifies the corrosion process;
- ♦ In spite of the requirement for steel to be galvanized when used for shipbuilding, comprehensive preventive measures for inspections and maintenance form the crucial safeguard against deterioration of the metal's strength and thickness integrity.

The TSIB recommended the following practices:

- ♦ A comprehensive inspection regime of areas which could pose a threat to the safety of personnel should be in place so as to facilitate appropriate intervention and priority for carrying out appropriate repairs in a timely manner;

- ◆ Safety barriers/gratings are meant to protect personnel from potential hazards, such as prevention of falling from height. Where safety barriers/gratings are found to be corroded such that their main role of providing functions could be compromised and pose a threat to personnel, shipboard staff should take appropriate mitigating measures by putting up warning signs and cordoning off such areas to the extent practicable and make such observations known to the company;
- ◆ Inspections of areas which are covered by anti-slip mats or any other similar concealments of metallic surfaces, should be carried out in detail especially where the chance of moisture being trapped is high.

## 5 Welder at Work Injured During Close SIMOPS

### What happened?

A welder was hit and slightly injured by a lashing wire during lashing operations being conducted close by. Whilst all the deck crew were lashing reels, a welder was busy welding lashing eyes. The duty officer marked out the position for the lashing eyes. The welder had to weld the lashing eyes to the deck very close to the lashing crew. Whilst he was welding, he was hit in the neck by a lashing wire. He did not pay much attention to it and continued welding.

This incident was not seen or noticed by anyone else except the welder. He reported it two days after when he felt a stiff and swollen neck. He was given first aid treatment and returned to work.

### What went wrong?

- ◆ Simultaneous operations were not properly or safely managed:
  - no proper safety meeting when several persons and operations were going on/doing job in the same area
  - there was inadequate supervision
  - there was inadequate awareness on surroundings
  - there was inadequate job preparation. Pulling wires through small openings might occasionally slip from one man's hands.

### What lessons were learned?

- ◆ Persons in supervisory roles should ensure that there is adequate pre-task preparation, toolbox talks etc, and that these are clearly understood by the crew members;
- ◆ Designate someone to keep watch and monitor the operations – particularly during hot work;
- ◆ Be aware of your surroundings, especially when there are a number of jobs taking place in the same area.

Members may wish to refer to:

- ◆ [Toolbox talks](#) (Be prepared to work safely short promotional video)
- ◆ [Risk Assessment](#) (IMCA SEL 021, video)
- ◆ [Crewman Falls Down Open Hatchway During Simultaneous Operations](#)
- ◆ [Management of simultaneous operations during demobilisation](#) [*A similar incident from 2008 in which a member of the crew undertaking 'routine' disconnection of cables on deck was hit by a steel beam dislodged by operations that were taking place overhead on a higher deck*]