IMCA Safety Flash 30/17

December 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.

Summary

The UK Health & Safety Executive (UK HSE) publishes regular news bulletins on recent safety incidents. Many of these are worth bringing to your attention. This safety flash consists of press releases relating to prosecutions by UK HSE following incidents, that we consider will be of interest and information to IMCA members and their offshore crews.

See UK HSE news page: http://www.hse.gov.uk/news/index.htm for further details.

1 Self-Employed Diver Sentenced for Falsifying Diving Medical Certificate

What happened?

A man has been sentenced after supplying falsified diving medical certificates to a diving company in 2016. A Magistrates' Court heard that this individual did not hold a valid medical certificate of fitness to dive. See http://press.hse.gov.uk/2017/self-employed-diver-sentenced-for-falsifying-diving-medical-certificate/

What went wrong?

Investigation showed that in 2016 the defendant was in possession of a certificate closely resembling a genuine certificate but which had been altered to display a false expiry date. The defendant subsequently produced the falsified certificate to enter into a contract to provide his services as a commercial diver.

The defendant pleaded guilty to six breaches of Regulation 12 (1)(b) of the UK Diving at Work Regulations 1997 and one breach of Section 33 (1)(m) of the Health and Safety at Work Act 1974. He was sentenced to 32 weeks imprisonment suspended for 12 months, 150 hours community service and ordered to pay costs of £12,000.

The HSE inspector commented that the UK HSE will not hesitate to take appropriate enforcement action against persons in possession of or using a falsified fitness to dive certificate.

Contractors are reminded that it is their responsibility to check the validity of their diver's medical certificates of fitness to dive, especially, when the doctor and diver are unknow to them. Divers, who may be unfit for employment not only put themselves at risk but also others who may have deal with the consequences.

Members may wish to refer to the following recent incident:

- Counterfeit Training Certificates

2 Worker Suffers Life Changing Injury After Pressure Test Failure

What happened?

The UK HSE advises that three companies were sentenced after an employee suffered serious fractures to his leg. An employee of one company was taking part in a pressure test of a boiler at the site of a second company. A third company were assisting in the pressure test. The injured person was there to verify the test.

What went wrong?

A valve on a pressure test rig was pressurised above the safe working limit and failed, causing the hose and metal fitting assembly to whip round, striking the employee on the right leg, causing serious compound fractures.

As a result of the incident, the injured person had his leg amputated from the knee down. The HSE's principal inspector noted that *all three companies had failed the injured person*. If appropriate pressure relief had been fitted and the companies had put in place a system of work that was safe, then this person would not have been exposed to the harm he suffered.

IMCA notes that particularly close attention to responsibility for safety should be taken where different companies or organisations are working together at the same site.

Members may wish to refer to the following similar incident:

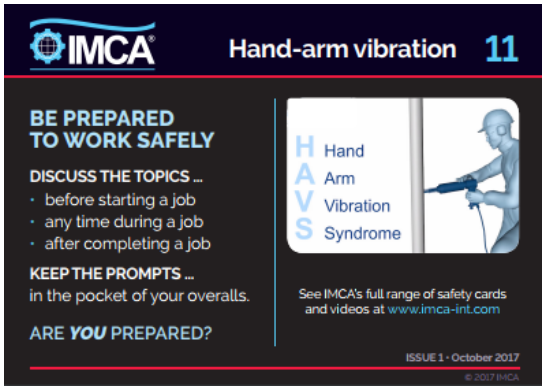
- Failure Of High Pressure Fitting

3 Four Hand and Finger Injury Incidents

Incident 1 - Company fined after exposing workers to Hand Arm Vibration Syndrome (HAVS)

What happened?

The HSE is reminding companies of the necessity of monitoring workers' health after an organisation was fined for exposing six maintenance team workers to Hand Arm Vibration Syndrome (HAVS). This was discovered following a health surveillance programme.



What went wrong? What were the causes?

Investigation found:

- The six workers' conditions were likely to have been caused or worsened by the use of vibratory power tools. Staff in the maintenance and refurbishment departments experienced significant exposure to hand arm vibration in their daily work which put them at risk of developing or exacerbating existing HAVS;
- The company neither adequately planned its working methods nor trained or informed employees on the risks to their health;
- The company did not limit the duration and magnitude of exposure to vibration and failed to put in place suitable health surveillance to identify problems at an early stage.

Hand Arm Vibration Syndrome (HAVS) is a serious and permanent condition caused by regular and frequent exposure to hand-arm vibration. HAVS results in tingling, numbness, pain and loss of strength in the hands which may affect the ability to do work safely and cause pain, distress and sleep disturbance.

Members may wish to refer to the following similar incidents:

- Uncontrolled Exposure To Hand-Arm Vibration (HAVS)
- Two Cases Of Hand Injuries – UK HSE

Incident 2 - Welder loses two fingers when manual lift goes wrong

An engineering company was fined after a worker suffered injuries to three fingers when they were crushed by a metal frame he was attempting to lift with colleagues. A worker suffered crushed fingers when a metal frame weighing approximately 250 kilograms fell whilst it was being lifted manually to carry out welding. Two fingers were partially amputated later as a result of his injuries.

What went wrong? What were the causes?

Investigation found:

- Manual lifting and turning of these frames was not an isolated occurrence and a number of the frames had been made in this manner over the three years that the company has been in existence;
- No steps had been taken to avoid the manual handling or to assess the manual handling operation and take steps to reduce the likelihood of injury.

Members may wish to refer to the following incident:

- Lack Of Safety Awareness: Crush Injury During Lifting Operations

Incident 3 – worker's fingers severed

What happened?

A worker had four fingers amputated while operating a metalworking lathe. An employee had been using emery cloth to clean steel shafts on a metalworking lathe. He was holding the emery cloth by hand when his gloves became entangled in the lathe. He lost four fingers on his right hand, broke several bones in his left arm and dislocated his wrist as a result.

What went wrong?

Investigation found that the company had failed to ensure the work to clean the metal shafts was carried out safely. It wasn't an isolated incident and their employees had been applying emery cloth directly by hand on the lathe for several years prior to the accident.

The HSE Inspector said that this employee "*suffered life changing injuries in an accident that could have easily been prevented. The risks involved with applying emery cloth by hand on metalworking lathes are widely known and the company should have done more to ensure that they carried out the work in a safe manner."*

This incident is identical – save only the outcome which was worse in this case to the August 2017 incident:

- Two Cases Of Hand Injuries – UK HSE.

Incident 4 – worker suffers crush injuries

What happened?

A worker suffered crush injuries from trapping his hand in an unguarded printing machine. An employee was injured when his hand was drawn into the print rollers while he was attempting to clean the running machine resulting in partial amputation of two fingers.

What went wrong?

Investigation found that the lack of guarding on the machine was the root cause of this incident together with a lack of training and supervision.

The HSE inspector said "*This case serves as a reminder to industry that planning and guarding of machinery requires regular reviews and monitoring to ensure workplace safety. The need to review machinery guarding is a positive benefit to improving workplace safety".*

Members may wish to review the following incident:

- Lost Time Injury (LTI): Incident With Circular Saw Leads To Loss Of Thumb

Members are encouraged to bring to the attention of their crews, the IMCA safety promotional materials on hand safety and other topics, available free to members here.

4 Two Industrial Vehicle Incidents

Though these two incidents do not pertain to the marine environment, the underlying issues involved – traffic management and separation, planning and safe systems of work, risk assessment, work at height etc. – are of relevance and interest to IMCA members.

Incident 1 – Driver fatally crushed

What happened?

A visiting HGV (Heavy Goods Vehicle) driver was delivering materials to a site when he was crushed to death as a forklift truck overturned whilst lifting a load from the trailer of the HGV.

What went wrong?

Investigation revealed that the forklift truck had been overloaded and that visiting delivery drivers were not kept at a safe distance from the loading and unloading operations.

The company was fined £1.2 million. The HSE inspector said: *"Standing too close to where loading or unloading work is being carried out can put people in harm's way so people, such as delivery drivers, should be in a position of safety when forklift trucks are operating. This tragic incident could have been avoided if the company had implemented a safe procedure to ensure that pedestrians were kept at a safe distance during loading and unloading work."*

Incident 2 - Employee falls from bonnet of vehicle

What happened?

An employee fell from the bonnet of a tar laying machine. He was standing on the bonnet of the machine to cut the branches of overhanging trees when he fell from the bonnet into the tar hopper. He sustained a fractured back and damaged spinal cord causing permanent paralysis from the waist down.

What went wrong?

Investigation found that the company had failed to plan the task in hand, resulting in an employee using the bonnet of the tar laying machine which was not a safe place to work.

Serious and life changing injuries could have easily been prevented had the company planned the work at height, including an assessment of the risks and either avoidance of working at height using long reach tools or measures being put in place to prevent a fall.

Members may wish to review the following incident:

- Fatal Fall From Height During Cargo Operations – Johanna C