IMCA Safety Flash 02/17

January 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.

Two Entirely Avoidable Fatalities

The below fatal incidents, information on which has been published by regulatory and safety organisations, demonstrate the need for continued attention to maintaining an effective safety culture.

- The first incident concerns a fatal fall during cargo operations, where the Chief Mate was standing on the load as it was being lifted, fell, and was fatally injured.
- The second relates to an unfortunate and entirely avoidable man overboard incident where a seaman painting the hull fell into the sea. This incident was wrong on every level. Proper plans were made and communicated to the crew but were not followed – an inadequately maintained Bosun's Chair collapsed and dropped him into the sea and he was not wearing a life-jacket or personal flotation device. Finally, the rescue boat failed to start. The seaman drowned.

1 Fatal Fall from Height During Cargo Operations - *Johanna C*

The UK Marine Accident Investigation Branch (MAIB) has published Report 1/2017 regarding a fatal fall from height during cargo operations. The Chief Officer on board the UK registered general cargo ship *Johanna C* fell from a large steel cargo unit that was being repositioned in the vessel's forward hold. The chief officer was moved ashore and taken to a local hospital by ambulance, but he died shortly after arrival.

The investigation identified that:

- It was inherently unsafe and unnecessary for a person to stand on top of the cargo while it was being lifted – the risks of standing on a load under tension were not recognised;
- The fatally injured party lost his balance and fell onto the deck following a sudden and unexpected movement of the cargo and/or its lifting slings as the cargo was lifted;
- The sudden and unexpected movement of the cargo and/or its slings was possibly due to the slings slipping from their intended positions;
- The crew's response following the chief officer's fall was immediate and positive.

Actions taken:

- Vessel crews have been prohibited from standing on loads under tension;
- The UK Maritime and Coastguard Agency (MCA) has also taken action to include the dangers of standing on loads being lifted in its Code of Safe Working Practices.

The full report can be found here. Members may wish to refer to the following almost identical incident (search words: *height, cargo*);

- IMCA SF 02/16 – Incident 2 – *Fatal fall during cargo loading operations.*

2 Man Overboard Fatality – Tragic Consequences of Failing to Follow Safety Procedures

The United States Coastguard (USCG) has published Marine Safety Alert 01-17 relating to a man overboard fatality. Whilst a vessel was at anchor off the coast, a crewmember that could not swim was working over the side in a 'Bosun's Chair' to paint the vessel's mid-ship draft marks and load lines. Unfortunately, when his shipmates on deck started to haul him back up, the Bosun's Chair rope parted and he fell into the water. He survived the fall and attempted to swim towards a life ring that had been thrown to him, but he ultimately submerged and was lost. Other crewmembers attempted to launch a rescue craft, but it failed to operate.

This terrible incident is an example of where following safety management system procedures could have prevented a death or injury. Investigators found that the Captain and Chief Mate had met and developed a suitable work plan. This plan was later communicated to the crew involved. The plan had several important elements, including inspecting the Bosun's Chair and manila rope rigging, and requiring that the crewmember going over the rail wear a personal floatation device (PFD) and use a safety harness and lifeline.

However, the plan was not implemented. Crew members failed to adequately check the strength of the Bosun's Chair rope, instead simply pulling on it. Also, the deceased crew member had not been not wearing a PFD, and, even though he wore a safety harness along with a lifeline, the lifeline went untended and was not tied off to the vessel. The vessel's Bosun was not present, and it remains unknown as to who was supervising the operation. Finally, months before this tragedy, the Chief Mate had placed a requisition request for new manila rope and for PFD work vests that were designed to be worn with the vessel's safety harness; however, the request went unfilled.

As a result of this casualty, the USCG strongly reminds vessel owners and/or operators and all personnel on board vessels everywhere to do the following:

- Properly use safety equipment;
- Ensure adequate supervision of work teams;
- Develop workplace mind-sets that properly develop and execute plans, including those for worst case scenarios;
- Implement barriers to prevent such scenarios;
- Fully implement and adhere to Safety Management System requirements.

The full report can be found here. Members may wish to refer to the following incident (search words: *over board*):

- IMCA SF 10-15 – Incident 5 – *Daughter craft man overboard incident;*
  - The main conclusion drawn was that the boatman did not secure his safety harness to the harness point and did not convey this to the deck crew. Also, the deck crew lowered the davit wire without confirmation that the boatman was secure. Causes: failure of communication, failure to be aware of safety responsibilities, failure to use personal protective equipment (PPE) appropriately.