

IMCA Safety Flash 16/18

July 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): Ankle Injuries During Loading Operations

What happened?

An experienced AB suffered serious ankle injuries during offloading operations. A vessel was delivering drill pipe casings to a jack-up rig when he was hit by the casing bundle being discharged. The casing involved in the incident was being lifted when it was observed that the Tag Line was entangled in the sling. The crane operator lowered the casing to around 1m above the vessel deck. The AB was instructed by the Duty Officer to untangle the tag line. Whilst he was doing this, the crane operator lowered the casing bundle without warning, causing it to swing towards the AB. He was struck by the casing bundle, lost balance and fell onto the adjacent casings lying on the deck. The movement of the crane did not stop, and the casing bundle was lowered further, coming to rest partly on the AB's legs and partly on other casings on the main deck.

The Duty Officer immediately notified the crane operator to lift the casing and transfer it to a safe area. The AB was carried from the main deck and shifted to the ships hospital for inspection and first aid.



Our member noted the following:

- ◆ The incident occurred in daylight, good weather and calm seas;
- ◆ The AB was experienced, wearing full personal protective equipment (PPE) and was fresh on shift in the last hour and adequately rested;
- ◆ The crane operator was approximately 35m above the vessel deck and had clear line of sight to the working area;
- ◆ This incident occurred during the 13th lift of 29 loads. 12 bundles of casings had already been safely picked up by the rig using the same crane;
- ◆ No inappropriate, unsafe or reckless use of crane by the operator was observed during these previous 12 lifts which might have warranted stoppage of operations.

What went wrong? What were the causes

- ◆ There was a lack of situational awareness/risk perception/risk awareness on the part of the crane operator of the rig;
- ◆ There was inadequate communication or transfer of information and intent from the rig crane operator to the vessel.

Members may wish to review the following incidents:

- ◆ [Incidents involving poor crane operations](#)
- ◆ [High Potential Near Miss: slip on tag line during crane operations](#)

Members may also wish to refer to the following guidelines:

- ◆ [Guidelines for lifting operations](#) (IMCA SEL 019)

2 Injured Finger during Cargo Operations

What happened?

During cargo operations, a crewman got his finger stuck between the cargo and the lifting chain. The incident occurred when a vessel was discharging modules with a weight of 220 tonnes direct from the vessel to a trailer on the quay. One hook of a chain tackle which was connected to the cargo, fell off. The other hook was still connected to the trailer. When reconnecting the hook that fell off, a sudden movement of the module meant that one finger got stuck between the module and the chain. When the module swung back the crewmember was able to remove his hand. His finger was seriously damaged, and he had to be sent to hospital for X-ray and stitches. He came back onboard some hours later.

Our member noted:

- ◆ The lifting was taking place at a relatively unsheltered location; there was some vessel movement from swell, but this was considered to be within acceptable limits;
- ◆ The crew were experienced in this discharge operation; it was second time the ship was discharging in this port.

What went wrong? What were the causes?

- ◆ There had been a change of plan, for which there had been insufficient management of change (MoC). The company has a technique for use in exposed harbours where swell is an issue. It was felt that there was



insufficient equipment available for that technique to be used safely, so the decision was made to land the cargo straight on the trailer, using chain tackles to reduce the horizontal motion;

- ◆ No job hazard analysis or toolbox talk took place for the alternative lifting technique; this is considered to be the cause of the incident.

What actions were taken?

- ◆ New technique was to be developed for landing cargo in a swell port, based on tools/equipment the company used in another product group (cross learning).

Members may wish to review the following incidents, both of which have management of change (MoC) as a causal factor:

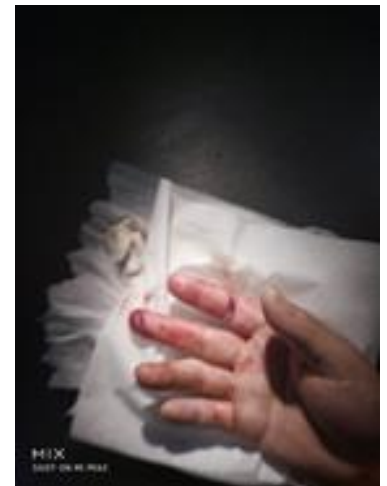
- ◆ [Line of fire LTI: Finger injury during lifting operations](#)
- ◆ [Serious hand injury](#)

See also [Guidelines For Management Of Change](#) (IMCA SEL 001).

3 Finger Injury Caused by Falling Wire Wedge

What happened?

A crewman suffered a crushed finger during an operation to replace a winch wire on a large crane. Two crew members were installing a wire wedge into the eye of the wire in order to prevent the wire coming loose from the winch drum. They held the wedge in place by hand whilst other crew tightened the wire. Unfortunately, the wedge – which weighed 15kg – fell. The crew were unable to support the weight of it and one person had his right hand crushed between the wedge and the deck. He was taken to the on-board clinic immediately. The on-board doctor treated him for injuries to his forefinger and middle finger.



What went wrong? What were the causes?

Our member noted the following:

- ◆ There was no proper holding point on the wedge;
- ◆ Workers' gloves were contaminated by the wire grease during operation making them slippery;
- ◆ When the wedge fell, one person attempted to hold or stop its fall, but failed due to the 15kg weight;
- ◆ The operation was not conducted in the safest or easiest manner.



What lessons were learned?

A better technique would have been to rotate the drum until the wire eye was upward. Then the wedge could be laid on the eye, and the wire tightened up until the wedge was suitably secured.

Members may wish to review the following incidents (both hand injuries caused by unplanned falling of heavy objects during repair or maintenance):

- ◆ [Lost Time Injury \(LTI\): finger injury whilst working in engine room](#)
- ◆ [Finger injury during maintenance work – restricted work case](#)

4 There's Something in my Eye!

What happened?

After shift, a member of the crew took a shower and felt that there was something in his eye. The next day he asked for help to remove it, but without success. He had to leave the vessel at the next port to have the debris removed.



What went wrong?

During the early part of the previous shift, this person had worked on deck wearing proper PPE and later in the shift, was working on the bridge. During the day, the debris had settled in his hair and washed into his eyes during the shower.

What lessons were learned?

There was a lack of awareness of this mechanism of transmission of debris into the eyes.

Be aware that debris can be still present after removal of all PPE, and of the risk of debris being transferred into the eyes from PPE or from the hair at a later time or when showering.

Members may wish to refer to the following incidents:

- ◆ [Eye Injury: crewman got something in his eye when removing his PPE](#)
- ◆ [Loss of sight in right eye: misdiagnosis of illness](#)