IMCA Safety Flash 19/16

July 2016

Summary

All the incidents in this safety flash involve personnel actually injured in the workplace.

1 Injury Caused by Shifting Load Of Pipes

The Marine Safety Forum (MSF) has published a safety alert regarding an incident in which a crewman suffered a broken leg. The injury occurred when the crewman got his leg caught under a bundle of pipes that shifted whilst preparing them for a lift. It took fifteen minutes to free the injured crewman, and helicopter medevac ashore was necessary.

Before **After**

Further information is available from www.marinesafetyforum.org/images/msf-safety-alert-16.07.pdf.

Members may wish to refer to the following incidents (search words: *hose*):

- IMCA SF 08/06 – Incident 2 – *Serious injury during pipestalk rolling operations;*
- IMCA SF 05/14 – Incident 2 – *RWC: Injury to foot caused by moving roller.*

2 Lost Time Injury (LTI) – Loss of End of Thumb

The MSF has published a safety alert regarding an incident in which a crew member lost the end of his thumb. The incident occurred during the installation of an additional security gate at the top of the gangway. The injured person was holding the gate in position while a second crew member located the bolts. To access one of the securing bolts,

the second crew member closed the pilot door without warning, trapping the injured person's finger between the gate and the pilot door. As a consequence, the injured person lost the top of his right thumb above the first knuckle.

The **immediate causes** were observed to be:

- Inadequate work planning or programming – the work was viewed as everyday which resulted in an inadequate risk assessment;
- The lack of guards or barriers;
- Lack of communication between the two parties involved in the task – a basic and simple warning that something was going to change would have sufficed and an accident would have been avoided – "*watch out, I'm closing the door*".

Further information is available from www.marinesafetyforum.org/images/msf-safety-alert-16.01.pdf.

Members may wish to refer to the following incidents (search words: *finger*):

- IMCA SF 03/09 – Incident 3 – *Crushed finger* [in a dive chamber door];
- IMCA SF 04/16 – Incident 4 – *Finger injury during maintenance work – restricted work case.*

3 "Routine" Task, Non-Routine Result: A Fall from A Crane Ladder Leads to an LTI

A member has reported an incident in which a crewman fell from a fixed ladder injuring himself. The incident occurred when, after familiarising the shore-side crane operator, an Able Seaman (AB) was descending the crane ladder. His right foot slipped on the second rung of the ladder from bottom. He lost his hand grip on the ladder and fell down backward from a height of half a meter, with his buttocks touching the floor first resulting in lower back pain. He was referred to hospital for further examination of the injury and was declared unfit for duties for seven days.

Our member's investigation noted the following:

- The ladder steps were free from oil/grease and clean;
- Correct and clean personal protective equipment (PPE) was being worn:
  - the injured person's safety shoes were in good condition with no traces of oil/grease on the soles
  - the cotton gloves he was wearing were also free of any oil/grease;
- The injured person was not firmly holding onto the ladder with his hands while descending the ladder;
- He was sufficiently rested before the incident;
- The **immediate cause** was carelessness – right foot slipping off from crane ladder rung, a loose hand grip on the ladder while descending;
- A **causal factor** was improper motivation – lack of focus towards the task in hand;
- The **root cause** was that the risk was seen as tolerable – this was a routine and recurring task.

The following preventative actions were identified:

- All crew to be reminded to be more safety conscious especially while going down ladders – ensure footing is secure and that there is no rush or hurry when on ladders;
- Care to be taken to ensure safety shoes and gloves are free from oil/grease stains;
- Care to be taken when conducting routine work, especially by less experienced crew.

Members may wish to refer to the following incidents:

- IMCA SF 09/15 – Incident 1 – "*Routine" task – non-routine result: batteries stored sideways leak battery acid;*
- IMCA SF 09/15 – Incident 2 – "*Routine" activities –non-routine result: finger injury during welding;*
- IMCA SF 20/15 – Incident 1 – *Recent slips, trips and falls involving stairs.*

4 Restricted Work Case (RWC): Injury to Eye During Deck Washing

A member has reported an incident in which a crew member was injured while washing down the main deck. While washing, the hose had developed a twist. The crew member, an Ordinary Seaman, wedged the nozzle between his left hand and chest and tried to remove the twist with the other hand. He lost control of the nozzle which resulted in the water jetting onto his face. The impact was directly onto his goggles, which were blown off by the sudden release of water pressure, allowing water to enter directly impact his right eye. He suffered corneal abrasion and slight bleeding. First aid was given on board.

Our member's findings were as follows:

- There was a lack of situational awareness;
- There were inadequate resources for the job in hand – no-one was there to assist;
- The correct PPE was being worn;
- **Immediate cause**: clearing twist(s) in a pressurized water hose without first securing it to prevent uncontrolled movement due to the rapid increase of water pressure;
- **Causal factor**: inadequate resources and inadequate supervision;
- **Root cause**: The risk was seen as tolerable, as this (cleaning the deck with pressurised hoses) was a routine recurring task. Also there was a lack of situational awareness and a failure to reassess potential safety hazards and thus consider a different course of action.

Our member took the following preventative actions:

- Further on board training for crew in safe handling of hoses under pressure;
- Ensured adequate resources stationed where required;
- Ensured better supervision by heads of department;
- Consideration of visored safety helmets, which will act as additional protection;
- Tie a tail rope near the nozzle that will help secure a pressurized hose to the ship's structure before clearing twists or operating the main valve.

Members may wish to refer to the following incident (search word: *stored*):

- IMCA SF 18/15 – Incident 4 – *Lost time injury (LTI) following stored energy release and subsequent serious infection of wound;*
  - Whilst this is a subsea incident involving a diver, it is similar in that injury was caused by unplanned release of stored pressure, with consequent risk of infection from water getting into the wound, as might have occurred here in slightly different circumstances.

5 Worker Seriously Injured When 1 Tonne Load Fell on Him

The UK Health and Safety Executive (UKHSE) has successfully prosecuted a cargo handling company after an employee suffered serious injury when a sheet of marble weighing one tonne fell on him. The incident occurred when the worker was assisting a fork lift truck operator to move a one tonne sheet of marble from a container. The marble sheet fell on him, causing him serious and extensive crush injuries to his legs as well as a fractured sternum and severe lacerations to the back of his head.

The HSE investigation found that there was an unsafe system of work being used to move the load.

Further information can be found on the UK HSE's website here.

IMCA will continue to draw to members' attention to onshore incidents such as this involving the movement or lifting of heavy loads, working at height, dropped objects, etc. where it is considered that there are lessons to be learned.