

IMCA Safety Flash 19/20

June 2020





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 Fall From a Height into a Ballast Tank

<p>Applicable Life Saving Rules:</p>	 Bypassing Safety Controls	 Confined Spaces	 Work Authorisation	 Working at Height
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What happened?

A worker inside a ballast tank fell from height. The incident happened when a welder and two welder helpers were installing additional stiffeners on the inside of a water ballast tank. Whilst going to the work site inside the tank, one of the welder helpers fell through an opening on the tween deck. The opening is part of the design of the vessel to allow water to pass through.

The crewman was rescued in a medical evacuation. He was taken by helicopter to an intensive care unit and is currently recovering at home.

What were the causes? What went wrong?

- ◆ The work was considered a “small” job. The risks of the route taken to the workplace were not properly assessed. A permit to work was put in place for the confined space entry and the hot work. However, the specifics for the job were not considered;
- ◆ **Stop Work Authority** was not used. On at least one occasion scaffolding or other means to improve access to the worksite was brought up. The last inspection led to a call to the scaffolding foreman, with the request to install scaffolding. However, the welding team was not advised to wait;
- ◆ Due to a last-minute change, the person who fell, joined the team only after the last minute risk assessment for the job was performed;
- ◆ The injured person crossed a barrier (handrail) inside the tank on the way to the work site. It is not known why he took that route and what caused the fall. The surfaces of a tank are slippery when it is empty;
- ◆ The team were not accustomed to working in confined space; they considered it a routine job and did not stay together in the confined space.

What actions were taken?


Immediate actions taken included making the access to the tank safer and holding a Time out for Safety with the whole crew. A presentation with a summary of the investigation was shared with all sites.

- ◆ Updated risk assessment for confined space entry to highlight measures for safe access and the hazard of working at height if applicable;
- ◆ Retraining for crew in last minute risk assessments, focusing on importance of managing change – stop and re-evaluate when anything changes;
- ◆ Further emphasis on Stop Work Authority.

Members may wish to refer to:

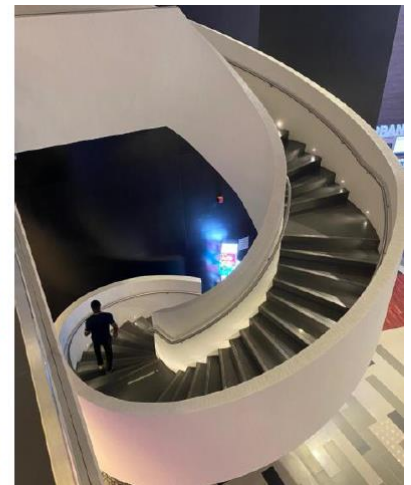
- ◆ [Fatality In Ballast Water Tank – Working At Height In A Confined Space](#)
- ◆ [Fall From Height In A Confined Space](#)

2 Trip and Fall Down Hotel Stairs Causing Serious Wrist Injury

Applicable Life Saving Rule:	 Bypassing Safety Controls
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What happened?

Whilst engaged in business travel, an employee of one of our members slipped and fell when descending a hotel staircase. He sustained multiple fractures and dislocation of the left wrist. He used his left hand to try to 'break' the fall which incurred serious impact injuries. The injured person reported to the company office the following morning before being transferred to hospital where an x-ray confirmed the extent of the injury, which required surgery.



What were the causes? What went wrong?

During the interview about the incident it was confirmed that the injured person had been using his mobile phone while going down the stairs and was not holding the staircase handrail.




What actions were taken?

- ◆ **DON'T use your mobile phone when walking up or down stairs!**
- ◆ Keep your eyes on what you are doing, maintain three points of contact wherever possible when going down the stairs;
- ◆ Always hold the handrail, when ascending or descending stairs;
- ◆ Stay alert to your environmental surroundings and adopt good hazard awareness, even when not in the workplace.

Members may wish to refer to:

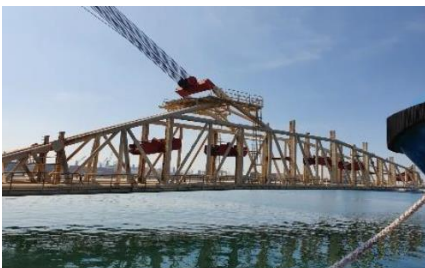
- ♦ IMCA “Are you prepared” video *Preventing slips and trips*
- ♦ IMCA poster *Take care on the stairs*
- ♦ *Person Injured By Mooring Lines* [trying to step from one vessel to another **whilst talking on a mobile**. This anonymous person is now immortalised in IMCA video SEL 038 *Mooring incidents*]
- ♦ *Recent Slips, Trips And Falls Involving Stairs*
- ♦ *Lost Time Injury – Person Slipped On The Stairs And Broke His Arm*

3 Man Overboard from Stinger

Applicable Life Saving Rules:	 Bypassing Safety Controls	 Work Authorisation	 Working at Height
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What happened?

A member of the crew fell overboard through an opening in the stinger. The incident occurred with the vessel alongside in port. A team of three electricians were conducting function checks on a new roller box camera on the stinger. One of the team fell about 2 metres into the water through an opening in the stinger floor grating. The person remained conscious and was able to swim to a lifebuoy that had been pre-deployed as part of the task. He was recovered via the quayside ladder and was given first aid treatment for minor scratches on his neck and ear.



Stinger as seen from the quay



Opening through which person fell



A view of the rescue of the person

What were the causes? What went wrong?

- ♦ A requirement to move the vessel prevented the work on the stinger being completed on the quayside, which would have removed the fall potential;
- ♦ Two weeks before the incident, a management inspection of the stinger had identified damage to handrails and walkway grating including the section from which the fall occurred. Repair was considered low priority because this area was not one that was normally accessed, and remedial work was neither planned nor immediately actioned;
- ♦ The controls identified in the risk assessment were not verified by the supervising persons at the site;
- ♦ The Permit to Work (PTW) was authorised without review or confirmation of control measures;
- ♦ “Task seen as routine”- there was no task-specific Toolbox Talk (TBT) conducted; a ‘pre-shift’ briefing was considered adequate. The persons involved saw the task as “routine and simple”;
- ♦ The work team involved in the incident observed unsafe conditions, including openings in walkways and missing handrails, *but did not stop the job* to re-assess, or apply any Management of Change procedure.

What actions were taken?

- ◆ Adequate planning and risk assessment before starting work;
- ◆ Appropriate review of work area before start to ensure the specified controls provide safe working conditions;
- ◆ Stop work authority should be re-emphasised as an obligation and responsibility for all;
- ◆ Specific risk of falling overboard should be considered not only for work over the side but also for work near the side.

Members may wish to refer to:

- ◆ [Near Miss: Man Overboard](#)
- ◆ [Lost Time Injury \(LTI\): Fall Overboard/Fall From Height](#)
- ◆ [Near-Miss: Mooring Without Port Assistance](#)

4 Crewman Fatally Injured While Stood on Stern Ramp of *Seatruck Progress*

What happened?

The UK Marine Accident Investigation Branch (MAIB) has published [Accident Investigation Report 10/2020](#) into the death of the Third Officer of *Seatruck Progress*, when he was struck and fatally injured by a freight vehicle semi-trailer while standing on the vessel's stern ramp.

What went wrong?

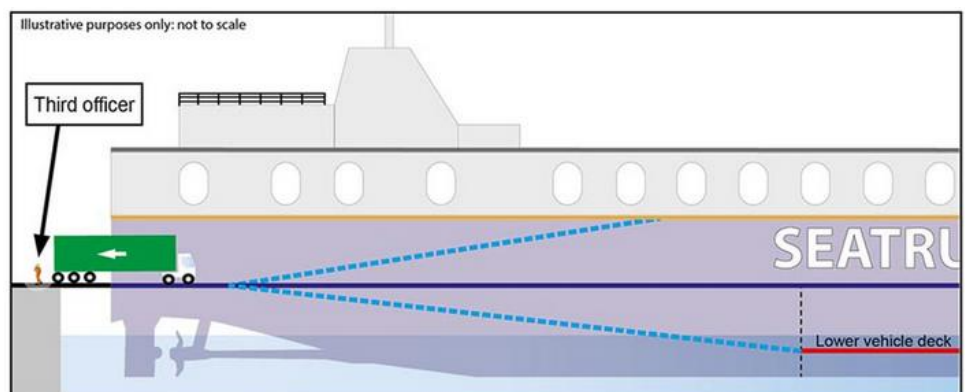
- ◆ The semi-trailer was being pushed ashore by one of the port's tractor units;
- ◆ The third officer was facing down the ramp and talking on his mobile telephone when he was struck;
- ◆ He was unaware of the trailer approaching from behind;
- ◆ The driver of the tractor unit was not expecting any pedestrians to be on the stern ramp and could not see the third officer due to the trailer blocking his view ahead.



What were the causes?

The MAIB comments:

- ◆ This is one of several similar accidents in recent years where both maritime and land-based industry best practice guidance have not been met: there was no physical barrier on the stern ramp to segregate vehicles and pedestrians and there were no controls in place to monitor the stern ramp and stop vehicles when pedestrians needed to walk across it;
- ◆ The use of mobile telephones and other communications media is an increasing source of distraction on working decks and in other hazardous workspaces on board ships, for which formal guidance is currently lacking;
- ◆ This was the second work-related death in 15 months to have occurred on board ferries operated by Seatruck Ferries Ltd and berthed in Liverpool.



Members may wish to refer to:

- ◆ [Safety lessons: staying alert to hazards on ship working decks](#) – A safety message to the shipping industry about mobile phone distraction and the importance of providing a safe means of segregating vehicles and pedestrians.
- ◆ [Worker Trapped and injured by reversing vehicle](#)
- ◆ [Fatality: Crew Member Struck By Forklift During Quayside Operations](#)

5 USCG: Automatic Identification System (AIS) Inaccuracies Led to Fatalities

The United States Coastguard (USCG) has published [Safety Alert 04-20](#) relating to an incident where a causal factor in a number of fatalities was incorrect information entered into vessel AIS (Automatic Identification Systems). **Accurate AIS data entry and display is essential to safe navigation.**

What happened?

During the hours of darkness, two towing vessels were approaching a bend on the Mississippi River. Neither vessel was broadcasting the total length overall of their tow to other AIS users.

- ◆ The first vessel's AIS broadcast showed its length at 72 feet, but the overall length of the vessel and its two-barge tow was 672 feet.
- ◆ The second vessel's AIS broadcast showed the length at 200 feet, but the overall length of the vessel and its 40-barge tow was 1,600 feet.

Without the information regarding the total length of the other vessel and its tow, the operators did not have a full understanding of the pending passing situation.

As the vessels rounded the bend and completed their turns, they collided, causing the down bound towing vessel to capsize and sink with several fatalities.

The US Coast Guard notes:

The AIS is a valuable tool which broadcasts critical vessel information to other vessels. However, proper function of the AIS is dependent on accurate vessel data entry, including entering the proper ship type code and the full length of a vessel and its tow. The accurate display of a vessel's full length becomes particularly important in situations that prevent vessels from seeing each other until they are in very close proximity.

Members may wish to refer to:

- ◆ [IMO Guidelines For The Installation Of A Shipborne Automatic Identification System \(AIS\)](#)
- ◆ [IMO page on AIS transponders](#), outlined more fully here:

Regulation 19 of SOLAS Chapter V - *Carriage requirements for shipborne navigational systems and equipment* - sets out navigational equipment to be carried on board ships. In 2000, IMO adopted a new requirement for all ships to carry automatic identification systems (AISs) capable of providing information about the ship to other ships and to coastal authorities automatically.

The regulation requires AIS to be fitted aboard all ships of 300 gross tonnage and upwards engaged on international voyages, cargo ships of 500 gross tonnage and upwards not engaged on international voyages and all passenger ships irrespective of size. The requirement became effective for all ships by 31 December 2004.

Ships fitted with AIS shall maintain AIS in operation at all times except where international agreements, rules or standards provide for the protection of navigational information.

The regulation requires that AIS shall:

- ◆ provide information - including the ship's identity, type, position, course, speed, navigational status and other safety-related information - automatically to appropriately equipped shore stations, other ships and aircraft;
- ◆ receive automatically such information from similarly fitted ships; · monitor and track ships;

Automatic Identification Systems (AIS) are designed to be capable of providing information about the ship to other ships and to coastal authorities. IMO regulations mandate the use of AIS.

- ♦ exchange data with shore-based facilities.

The regulation applies to all ships built on or after 1 July 2002 and to ships engaged on international voyages constructed before 1 July 2002.