IMCA Safety Flashes summarise key safety matters and incidents, allowing lessons to be more easily learnt for the benefit of all. The effectiveness of the IMCA Safety Flash system depends on Members sharing information and so avoiding repeat incidents. Please consider adding safetyreports@imca-int.com to your internal distribution list for safety alerts or manually submitting information on incidents you consider may be relevant. All information is anonymised or sanitised, as appropriate.

## 1 UK MAIB: Safety Digest – lessons from marine accident reports 1/2021

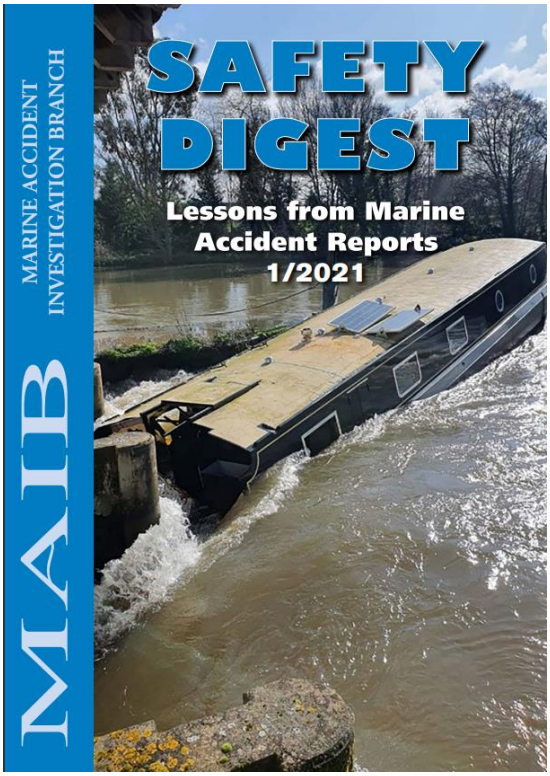
The United Kingdom Marine Accident Investigation Branch (MAIB) has published its Safety Digest 1/2021 *"which draws the attention of the marine community to some of the lessons arising from investigations into recent accidents and incidents. It contains information which has been determined up to the time of issue."*

The information is published by the MAIB – and recirculated by IMCA - to provide information on the general circumstances of marine accidents and to draw out the lessons to be learned, with the sole purpose of preventing similar accidents happening again.

Section 1 on Merchant vessels will be of primary interest to our members (though there may also be learnings for our members from the other sections on fishing vessels and recreational craft.)

The headings in Section 1 include:





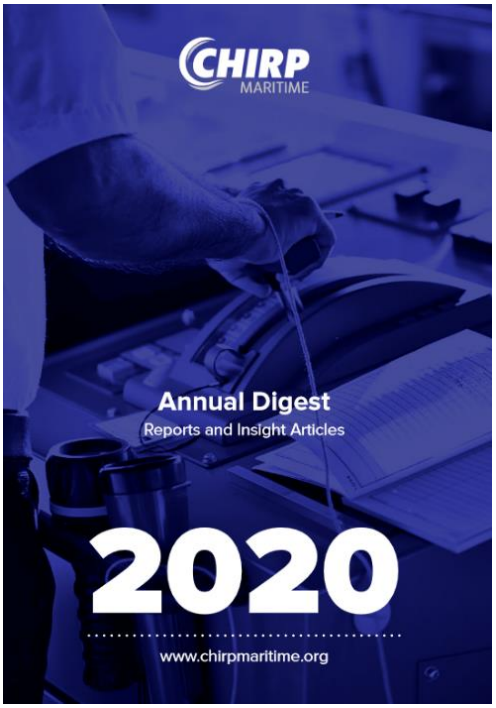
## 2 CHIRP Maritime – annual digest for 2020

CHIRP stands for *Confidential Human Factors Incident Reporting Programme.* One of the aims of the organisation is to contribute to the enhancement of maritime safety worldwide, by providing a totally independent confidential (not anonymous) reporting system for all individuals employed in or associated with these industries.

CHIRP welcomes safety-related reports from people in the international maritime sector, including the shipping industry, fishing industry and leisure users. Reporters' identities are kept confidential. The information provided is made available, with the approval of the reporter and in a disidentified form to those who can take action to remedy the problem. Important information gained through reports; after being disidentified, is also made as widely available as possible through appropriate publication with the aim of improving safety standards.

This then, is CHIRP Maritime. https://www.chirpmaritime.org/

**CHIRP Maritime has published its Annual Digest 2020.** It is a flagship publication and contains all the published reports of the previous 12 months as well as various technical articles. This year, amongst these articles is a paper by CHIRP member Dr.Clare Pekcan *"Seafarer wellbeing during the COVID-19 pandemic"* highlighting the psychological impact on seafarer's trapped at sea unable to return home at the end of their tour of duty.




The annual digest has headings as follows:

- Health and seafarer welfare;
- Fishing, tugs, yachting and recreation;
- Engineering, technical, environment and regulation;
- Deck safety, deck operations, and cargo operations;
- Collision regulations and navigation;
- Safety culture;
- Pilot boarding and pilotage.

The CHIRP Maritime Annual Digest is available here.

## 3 Leg injury when struck by rebounding hammer

### What happened

A crew member was struck on the right lower leg (the shin) by a rebounding hammer. The incident occurred when he was using the hammer to remove a stainless steel securing pin on the brake band drum of a tugger winch. He was using the hammer and other equipment to remove a stainless steel securing pin, which was positioned at knee height on the brake band drum. The pin was moving both ways a little, but required more lubrication. Spray lubricant was applied and was working through the pin mounts. The crew member was striking the pin out using the hammer; one blow missed the pin, rebounded back and struck his right lower leg, causing a small cut and bruising above the ankle.

**Applicable Life Saving Rule(s)**

Line of Fire

### What went wrong?

- He was in the line of fire – his leg was so positioned as to be hit when the hammer rebounded;

- The arc / swing of the hammer onto the pin required precision to avoid striking to the side, which resulted in uncontrolled rebound of the hammer in an undesired direction.

**What went right**

- A Toolbox Talk and Operational Risk assessments had taken place before starting work;
- All correct PPE was being worn at the time of the incident occurring

**What were the causes?**

- Immediate causes
  - He hit the pin in such as way as to cause the hammer to rebound in an uncontrolled direction;
  - His leg was in the way.
- Root Causes
  - Inadequate continuous risk assessment
    - The crew member did not identify the potential hammer miss-hit and rebound direction of the hammer during the activity;
    - The risk assessment did not identify the required body position to ensure it was not in the line of fire.
  - STOP Work Authority
    - No "Stop Work" and review the activity was undertaken during the tasks to evaluate the controls being implemented and the possible requirement to improve (by the individual or others).

**Lessons learned**

- Deeper and more thorough consideration of what "Line of Fire" can mean – are you in ***your own*** line of fire?
- Check with your colleagues before starting – *is this safe, could I do this in a better way?*
- **STOP the job** if you think it is unsafe, and put the right controls in place to make sure no-one is harmed.

Members may wish to refer to:

- Lacerated chin caused by flying wedge

## 4 Swedish Club: Lessons learned - crew member loses leg in mooring injury

**Applicable Life Saving Rule(s)**

Line of Fire

The Swedish [P&I] Club has recently released a "casebook" containing safety lessons learned from maritime incidents. This useful resource document can be found here: www.swedishclub.com/loss-prevention/cases/case-studies/.

One of the case studies describes a very serious injury of a crew member during mooring operations.

**What happened**

During mooring operations, a member of the crew was caught between a mooring line and the fairlead as the mooring line paid out very fast, resulting in his leg being cut off. A first aid team from shoreside came onboard, and thirty minutes later an ambulance arrived and took him to hospital. He survived but is now disabled.

**What went wrong?**

The mooring lines were let out very fast, sank, and got caught in the propellor.

**Lessons learned**

- The vessel had a risk assessment for the mooring operation, but this did not include the risk of the mooring line getting stuck in the propeller, as the mooring line should be floating in normal circumstances;
- In addition, the mooring line was partly around the bollard, with a bight and a right angle to the normal pull direction. This arrangement caused the snapback zone to cover the entire area between the bollard and railing. When the rope ran out rapidly and got caught in the propeller it snapped back to where the Third Officer was standing, even though he was not inside the normal snapback zone;
- This shows the importance of everybody involved in the operation being aware of the risks of potential snap-back zones. Mooring a vessel is a normal operation, but the **risks need to be re-evaluated every time**. (IMCA emphasis).

Members may wish to refer to

- 6 tips for safe mooring operations - SAFETY4SEA
- HSSE 038 *Mooring incidents* video
- HSSE 029 *Mooring practice safety guidance for offshore vessels when alongside in ports and harbours*
- Lost time injury (LTI): Hand severed during mooring operations
- Lost time injury (LTI): Hand injury during mooring operations

## 5 Two injuries

A member reports two injuries during operations, highlighting the need for continued vigilance and care in everyday activities.

### Incident 1: Crew member injured head on girder

#### What happened

Around eight hours into their shift, a crew member was stowing tools and equipment in the port side aft engine room stowage, and as he bent down to open the lid of the toolbox, he hit the corner of a girder and gashed the top left-hand side of his scalp. He was attended to with first aid treatment to stop the bleeding, clean and dress the wound.


#### What went wrong?

- The crew member was a very tall person in relation to the limited working space;
- The crew member was complacent and lacked situational awareness;
- He was not wearing proper PPE (a bump cap);
- There was no protective material on the girder, nor were there warning signs or hazard ID tapes on the girder;
- There was a lack of viable and safe stowage space in the Engine Room.

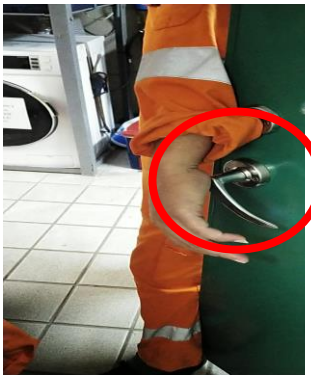
#### Actions

- Follow your company rules for PPE;
- Develop a higher level of situational awareness;
- Impact protection (high density foam) wrapped on the edge of the girder, also, safety warning signs, and hazard tapes to indicate line of fire.

### Incident 2: Finger injury when heavy door closed

#### What happened

During a routine inspection of the air conditioning plant room, the engineer caught his sleeve on the latch of the AC room door and due to the lower pressure within the room, the door closed and slammed shut catching the tip of his finger. He was immediately given first aid, and subsequently transferred to another company vessel for transit to port for further medical check-up including an X-ray.



*Crew Member Caught Overalls On Door*

*Door Closed On Finger*

#### What went wrong?

- He had his sleeves rolled up making snagging more likely;
- There was no indication that the AC room door would slam shut because the room was at a lower pressure than elsewhere;
- The spring loaded self-closing device on the door was set to slam the door shut due to the lower pressure in the AC room, as it would not close properly under any other setting.

#### Actions

- A sign was posted indicating that the door was a pinch point owing to its tendency to be pulled shut by the lower pressure in the AC room.