

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 Update to SF 08/21: fatality - person crushed when secured material fell on him

This is an updated version of the [event published in SF 08/21](#), wherein stored metal plates fell on a crewman causing fatal injuries. It was originally shared with one of our members by a client company, and was public domain news. It does not involve an IMCA member. This updated version has been shared by the company involved.

What happened

An inspection team leader and his assistant were performing loose lifting gear inspections on deck. The task was visually inspecting slings, recording serial numbers and applying the current colour code. During the inspection, the inspection team leader observed two slings rigged up to a load of metal plates which were stacked vertically, resting on dunnage, and secured to a stanchion by a single 5cm ratchet strap. The slings had been left in place on the plates after they were landed by the crane for efficiency and ease of relocation when needed. The plates were all 48 x 96 cm, varying in thickness between 10mm and 25mm, with a combined weight of two tonnes.

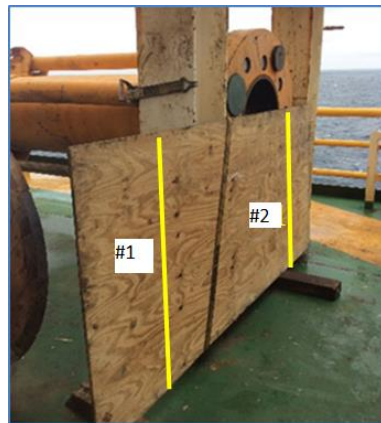


Figure #1: illustration of the position of the plates, using one piece of 4x8 plywood, with the ratchet strap in place and sling position identified



Figure #2: The 5 metal plates, combined weight of approximately 2 T

The inspection team leader attempted to, and was successful in, sliding one of the slings from the plates on the inboard side (#1 represented above in Figure #1), but he discovered the second sling (#2 represented above in Figure #1) was pinched between the rear of the plates and the stanchion, preventing it from being taken off on the outboard side. He then called his assistant to help free the sling, and remove it for inspection.

What went wrong

The inspection team leader then leaned his back against the plates; the reason for this is unknown, but it is assumed the intention was to support the plates in their standing position when the ratchet strap was loosened. When he was standing in this position, directly in front of him was a framework for the drilling bail rack. When the ratchet strap was manipulated by the assistant, the hook (ratchet strap) released, (see Figure #3), allowing the plates to free fall forward (away from the stanchion) under their own weight, fatally trapping the inspection team leader between the plates and the framework of the drilling bail rack (see Figure #4).

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The weight of the falling metal plates overwhelmed the inspection team leader, who was caught in the line of fire and pinned between the plates and the solid frame – and fatally injured. First responders arrived at the scene and attempted to manually remove the plates but were unable to due to their weight.

Lessons Learned

- Reinforce your awareness of the **Line of Fire** – watch out for getting between loads and structures;
- Improve risk perception and situational awareness;
- Remember you are allowed to **STOP THE JOB** if you think it is unsafe!
- Ensure tasks are clear and well planned. Discuss before hand, factors that might make stopping the job necessary;
- Recognise when the nature of a task changes, and manage that change safely. In this case, a low risk task of visually inspecting loose lifting gear changed to a much higher risk task *without the team recognizing they were deviating from their task* – by removing rigged-up slings on sea-fastened cargo, the nature of the task and risk profile had changed;
- Are there sufficient measures in place to prevent unauthorized manipulation of sea-fastenings?
- Look at your housekeeping and sea-fastening:
 - Are materials stored safely?
 - Has the potential for unplanned release of stored energy been minimized as far as practical (e.g. if a strap comes loose, will the stored material fall or tip over?) Can this be mitigated by storing in an alternative location or an alternative orientation (e.g. by lying flat?)
- Ensure third-party sub-contractors and other crew are fully integrated into daily operations management, toolbox talks, risk assessment etc.
- Could this have been designed out? Are deck designs sufficiently robust to take foreseeable equipment configurations – eliminating the need for materials to be required for temporary deck strengthening for specific operations?



Figure #3: illustration of the ratchet strap hook that came free from the stanchion

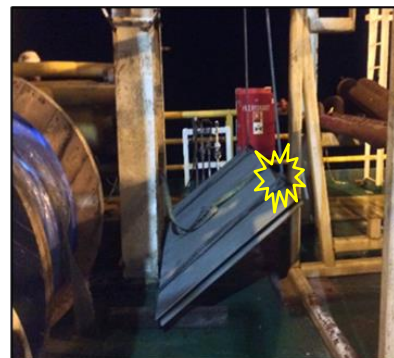


Figure #4: The position of the inspection team leader

2 Only a centimetre – an emergency exit hatch blocked by mooring ropes

What happened

On a vessel alongside in port, an emergency exit hatch was found to be blocked. A team making a daily inspection tour round the vessel found that they could not open an emergency exit hatch providing egress from the engine room to deck on the port side at the stern.

Applicable Life Saving Rule(s)



Bypassing Safety Controls



Line of Fire

What went wrong

It was discovered that the hatch was blocked by mooring ropes applied on the mooring bitts.

Please see the second image with the yellow circle. **Note that the mooring ropes “only just” get in the way by barely a centimetre.** But that centimetre could have been enough to cost someone their life in an emergency.

What was the cause

Our member noted the following causes:

- Failure of engineering design – the operation of the emergency exit hatch was not taken into account during the ship building or modification process;
- Lack of inspection – this latent unsafe condition was not revealed during previous safety rounds on board the vessel.



Recommendations/Corrective Actions

- Check whether or not your hatches or doors could get “only just” blocked - ensure that all emergency exits on board vessels are inspected, kept unobstructed, have good lighting and are well maintained. Report any potential for blockage – and fix it.

Members may wish to refer to:

- [Inadequate maintenance and securing arrangements of emergency exit hatches](#)
- [Engine room emergency hatch damage](#)
- [An error with fire flaps led to engine space flooding, causing costly damage](#)

3 Potential Dropped object from Container

What happened

Before backloading a container from rig to vessel, it was noted that there were two metal blocks in the top corner pockets of the container.

What went wrong

Findings: the blocks were loose metal blocks size of approximately 12 cm by 5 cm weighing between 1.6 and 2kg each. The container had undergone two lifts coming to the rig and was just about to be lifted off the rig when the blocks were noticed whilst carrying out pre-load out checks. The blocks were found to be stacking guides used in the yard when stacking containers.



Before

There was potential for serious injury had the blocks had become dislodged during a lift, and also potential for severe injury to personnel in surrounding vehicles and/or pedestrians if the blocks had become dislodged and fallen during transit on the public highway from the yard to the quayside.

Lessons learned

- Stacking pins now painted in contrasting **visible colour** for easy identification;
- Additional spot checks and verification checks on all containers before load-out;
- Use twistlocks such as that illustrated here:



Members may wish to review:

- Standard Club *Master's guide to container securing*, 2nd edition
- Potential dropped objects left on loaded cargo
- Two potential dropped objects (Marine Safety Forum)
- Quayside dropped object



After

4 MSF: wearing and storage of eye protection

The Marine Safety Forum has published [Safety Alert 21-05](#) relating to a recent incident involving safety equipment and its storage.

What happened

Someone engaged in grinding operations got something in his eye. But the foreign body he got in his eye was either already within the safety visor or flew up beneath the full-face protection and under his own glasses. He immediately stopped the job, washed out his eye, and reported to the Master. His eye was examined; no object was found, and he no longer had any eye pain or discomfort.

What went wrong

- At the time, he had been wearing a full-face visor, and his own prescription glasses. He made the natural assumption that his eyes would be fully protected. Unfortunately, this was not the case, the foreign object could have fallen into his eye from within the visor or flew up under his full-face protection;
- In Figure 1 goggles can be seen stored in an unsuitable position next to drilling and cutting machinery within the workshop, where there was a very good chance that particles could land within the protective gear, and therefore could fall into an operator's eyes.



Fig. 1 Blue goggles stored unprotected



Fig. 2 Goggles stored in plastic protective bags

This incident shows the importance of using the correct eye protection and of storing it correctly.

Actions/recommendations

- Eye protection PPE was relocated and enhanced by placing it in clear plastic bags to ensure it remains clean and free from foreign objects before use;
- Risk Assessments for use of Power Tools, Hot Work and Grinding were adjusted to state that “Goggles MUST be worn” as opposed to “Correct PPE should be used”.

Members may wish to refer to:

- [Eye injury: Crewman got something in his eye when removing his PPE](#)
- [There's something in my eye!](#)
- [Are YOU prepared to work safely? *Protect your eyes*](#) short video

5 Malaria hasn't gone away

A member reports that in February 2021 one of their personnel had been admitted to the Intensive Care Unit of their local hospital, with confirmed malaria. The individual had recently travelled back from work in a malaria-risk country, had developed flu-like symptoms and *had assumed this may be due to COVID-19*. Following two negative COVID-19 tests and onset of confusion, the individual was admitted to hospital. (*IMCA italics*)

This flash highlights the symptoms of malaria and the process which should be implemented by persons working in a malaria-risk country.

Key facts about malaria

Malaria is a life-threatening disease caused by parasites that are transmitted to people through the bites of infected female Anopheles mosquitoes.

- The mosquitoes which spread malaria are most likely to bite at dusk or at dawn;
- The main symptoms of malaria are:
 - Fever
 - Headache
 - Chills
 - Multi-organ failure (if treatment not received quickly)
- The initial symptoms of malaria are similar to those of flu or of COVID-19 – if you experience these after having been in a malaria-risk country you should first assume that it may be malaria.

Preventing Malaria Infection

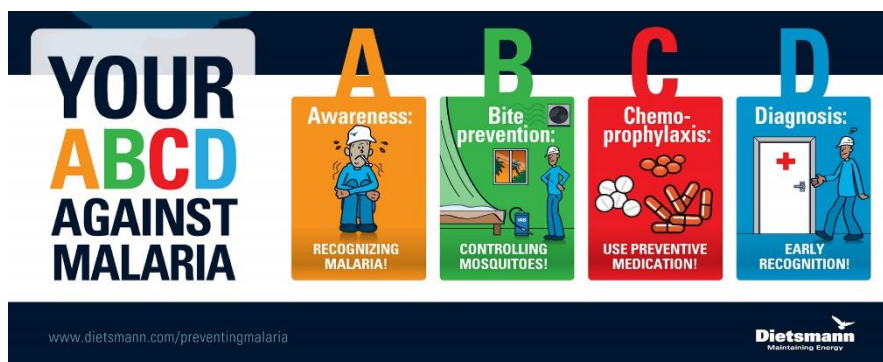
Prevention is better than cure. Take the following measures to avoid being bitten:

- Wear long sleeved and long leg clothing to keep skin covered;
- Use an appropriately effective mosquito repellent;
- Sleep under a mosquito net, where provided;
- Take anti-malaria medication (chemoprophylaxis) to reduce the effects if you are bitten. This is not 100% effective, so anyone displaying symptoms whilst taking the medication **should still seek medical advice**.

Diagnosis and Treatment



Early diagnosis and treatment reduce disease and prevent death. Being aware of symptoms and ensuring family & friends are also aware of these may help reduce delay in diagnosis. If you experience flu-like symptoms after being to a malaria-risk country, contact your doctor urgently and advise them that you should be checked for malaria so that you can receive treatment quickly.



Malaria: Know the symptoms and get checked immediately if you display them.