Safety Flash

06/22 – March 2022

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 Fatal fall from collapsing scaffolding on a merchant vessel

Applicable Life Saving Rule(s)

Bypassing Safety Controls

Working at Height

What happened

The Hong Kong Merchant Shipping organisation reports an incident in which a sailor was killed in a fall from collapsing scaffolding. The bosun and AB were assigned to rig a scaffolding to the maintenance platform which was bolted to the gusset plates at the boom of the port side hose handling crane (the boom) on the main deck.

When the bosun and AB were working on the maintenance platform of the boom setting the scaffolding, the platform and the scaffolding suddenly collapsed at the same time. The bosun fell onto the platform railing and he climbed back to the boom safely. Although the AB had worn a safety harness and anchored it to the platform railing in the form of a choker hitch, the lanyard of the safety harness snapped and failed to prevent him from falling from the platform at a height of about 7.9 metres onto the main deck. The AB was declared dead later on the same day.

What was the cause?

Investigation revealed that the securing bolts of the platform support were seriously corroded and failed to support the weight acting on it, resulting in the collapse of the platform;

The investigation also identified other contributory factors:

- Poor risk assessment;
- Poor supervision of scaffolding work being carried out by the crew without training record of scaffolding;
- Non-compliance of the configuration of the scaffolding including the non-compliance of its structural steel rods with a generally recognized standard;
- Insufficient safety instructions or guidelines for scaffolding work provided by the management company of the vessel;
- Inappropriate maintenance of the safety harness;
- Insufficient training on using personal protective equipment.

Members may wish to refer to:

- Near-miss: Scaffolding collapse
- Incidents involving use of scaffolding
- Fall from height during yard visit

2 Non-fatal man overboard incident

Applicable Life Saving Rule(s)

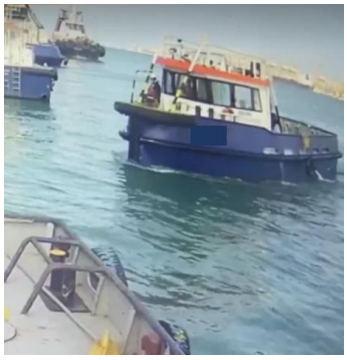
Bypassing Safety Controls

Line of Fire

What happened

After completing work, a small mooring (pilot) boat returned to the jetty. The AB began to secure the forward spring line of the mooring boat. The pilot being transferred on the mooring boat attempted to disembark by jumping across the quayside fender before the vessel, missed the fender and fell into the water between the mooring boat and the jetty.

The pilot was uninjured in the fall; his life jacket inflated and he was able to swim to the jetty ladder and climb up to the quayside.



What went wrong?

- The pilot attempted to disembark the vessel before the vessel was fully and securely moored;
- He was not wearing a helmet and very nearly hit his head on the jetty in the fall; had this occurred the incident may have resulted in a serious injury;
- Falling between the vessel and the quayside, he was fortunate not to be crushed;
- He was lucky: it was noted afterwards that his lifejacket had not been correctly secured; had it slipped off on impact with the water it would have failed to keep him above water.

Actions

- No one should disembark from any vessel until the vessel is completely alongside and securely moored;
- For vessels without gangways, a mandatory “buddy system” during personnel transfer was implemented, whereby another crew member on the shore side supports the crew member transferring from the vessel. Life jackets to be secured and correctly fastened before embarking/disembarking;
- For vessels with gangways, gangways should be securely fastened, and safety nets installed. After installation checks should be conducted to ensure it is secured safely, and the gangway controlled at all times.

Members may wish to refer to:

- MOB: person fell into water during gangway installation
- Double man overboard resulting in one fatality
- Unsafe personnel transfer – man overboard
- MAIB: fatality during transfer from a workboat to a barge
- Wear a life-jacket!! (MAIB)

3 Line of fire: pinched finger between door and frame

Applicable Life Saving Rule(s)

Line of Fire

What happened

An ROV operator suffered a serious injury, after their finger was pinched between the door frame of an ROV control van and the door as it swung closed. The ROV operator was returning to the work area after lunch and made his way to the ROV control van to speak with the supervisor. He opened the door outwards and rested his left hand on door frame as he moved his body inside the control van. The door swung closed, resulting in the door pinching his left index finger against the door frame. He automatically moved his hand away on impact which caused a laceration injury to the fingertip that required a medivac and reconstructive surgery.

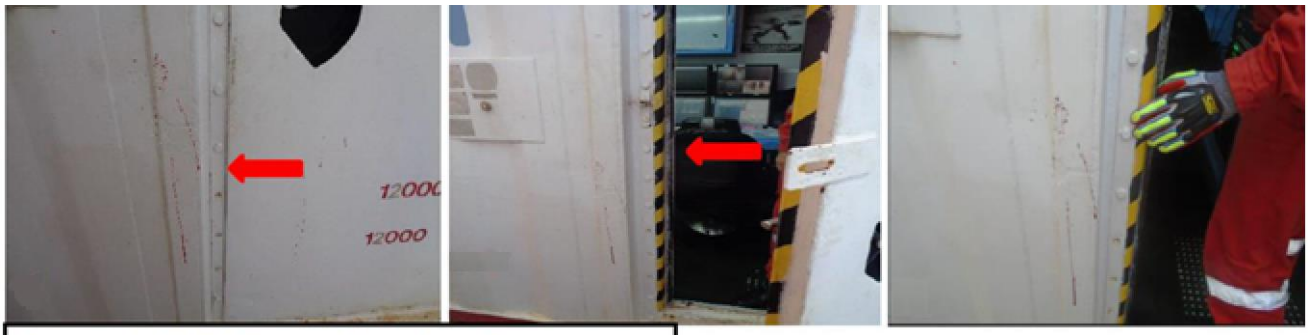


Image 1 - ROV Control Van door frame

What went wrong?

Investigation found that:

- The spring device mechanism to control the speed at which the door closed was faulty and had not been repaired. The ROV team had not identified this hazard nor corrected it before the incident;
- There was a lack of situational awareness in that the ROV operator left his hand in the line of fire;
- The induction/familiarization process had not been effective in identifying hazards associated with the work area;
- This was the first day of the trip for the ROV operator; he had two months experience on the vessel.

Actions

- Ensure that such doors (in this case, to ROV control vans) are fitted with a functioning spring device mechanism to control the speed at which the door closes;
- Ensure these door closing spring device mechanisms are included in the planned maintenance system, and subject to regular inspection;
- Ensure there is suitable induction / familiarization process on site, to safely integrate new workers, and provide them with mentoring and effective supervision.

Members may wish to refer to:

- Finger injury: pinch point
- Hand injury during closing of hatch
- Finger trapped and injured whilst moving hatch covers

4 Get it fixed!! Deteriorated seals on emergency hatch

Applicable Life Saving Rule(s)

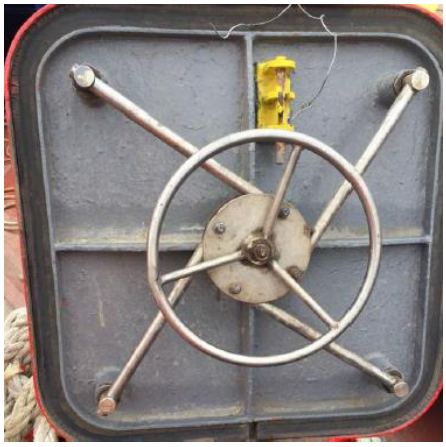
Bypassing Safety Controls

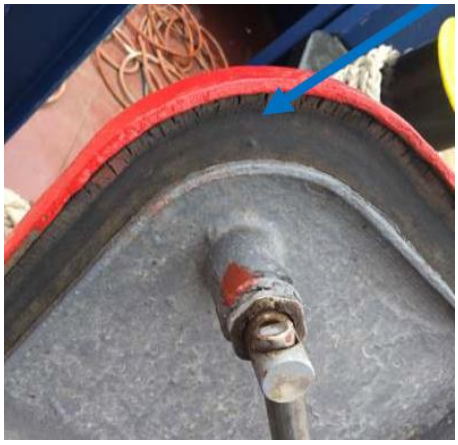
What Happened?

During an inspection of a vessel as a part of the 5-yearly docking, deteriorated seals were found on a number of hatches.

Preliminary investigation was conducted and after crew feedback, it was revealed that the crew had observed this unsafe condition some while ago, ordered and received new seals, but had continued to operate with no action, waiting for docking in order to replace deteriorated seals etc.

Hatch seals perform a vital role in a wide variety of marine applications. The hatch seal ensures that no liquid or gas is able to enter the vessel. After a period of use seals can deteriorate and become worn which reduces potential sealing properties. In this case, there was the risk of potential seawater leakage to the engine room had no action been taken.





What went wrong? What was the cause?

- Lack of risk perception and lack of timely action by vessel crew after identifying deteriorated seals - continuing to operate in an unsafe condition, considering waiting until the vessel was docked.

Actions

- *"If it isn't broken, don't fix it"* is a call to inaction – if something needs dealing with, deal with it now, not later.

Members may wish to refer to

- Only a centimetre – an emergency exit hatch blocked by mooring ropes
- Failure of chamber door hydraulic actuator *[All the seals inside the actuator were found to be completely perished inside.]*
- Near miss/positive: Internal O-ring seal found damaged on fuel system *["It always pays to check. O-ring seals are small but vitally important components which should be treated with the greatest of respect.]*
- Diving bell TUP O-ring seal damage

5 MSF: Foreign object in eye

What happened

The Marine Safety Forum reports in Safety Alert 21-20 that a worker got debris in his eye whilst paint chipping. A few hours after the job was completed, he reported a pain in his eye to the Master. Subsequent examination indicated that he had a small piece of debris in his left eye. Medical assistance was attempted onboard to flush the object out, but this was unsuccessful. The seafarer had to visit hospital to remove the object from his eye. He then returned to the vessel with no further treatment required.

What went wrong

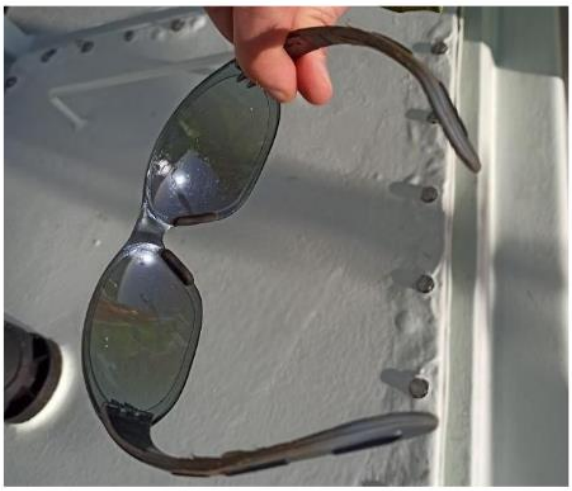
The MSF's member notes:

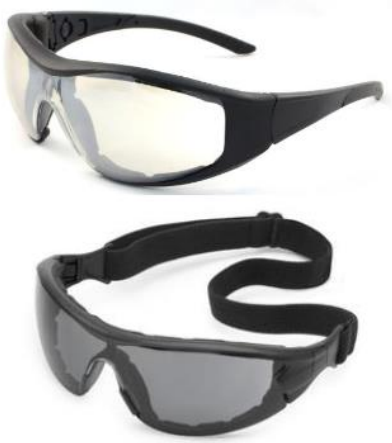
- The seafarer was wearing safety glasses that were relevant to the routine maintenance task, however the change of task to chipping would have required a change of safety eyewear to googles.
- Though the circumstances of the job changed, the job was not stopped nor appropriate risk assessment reviewed;
- There was insufficient planning for the job and the risk assessment in use was generic without adequately addressing all hazards and controls.

What was changed as a result?

- All onboard Risk Assessments were reviewed to ensure that the correct eyewear is mentioned as per the company PPE requirements;
- There was a renewed focus on eye safety;
- Following review and discussion with the crew, better safety glasses – "Spoggles" – were sourced, which meet the requirement of safety glasses and safety googles.

Left picture shows Safety Glasses in use, right shows 2 x examples of Spoggles





Members may wish to refer to:

- Are YOU prepared to work safely? *Protect your eyes* (short video)
- De-Rusting Incident Resulting In Eye Injury
- There's something in my eye!
- Eye injury: Crewman got something in his eye when removing his PPE