

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.

In this Safety Flash there is an image which may be considered graphic.

1 Serious LTI – Crew member slipped on deck breaking his leg

What happened

Three engineering crew members were involved in the manual handling of a bunker hose from an upper storage area to a lower deck storage area accessed via a spiral staircase. One of the engineers slipped on a greasy area of the deck breaking his right leg (fibula or calf bone) in the fall. A

The spiral ladder did not allow evacuation by stretcher. Fortunately, however, the injured person was conscious and was able to assist the rescue team and go up the stairs. Our member noted that a later drill highlighted that in the case of an unconscious casualty, the safest rescue route would have been to unbolt a vertical hatch leading to the bottom carousel area, which would have proved to have been time consuming.

What went wrong

- The area where the engineer slipped was an isolated spot that did not have any grating installed on the deck. It was also contaminated with grease and water from a previous task;
- The engineers were interrupted in their task by the requirement to conduct another task elsewhere;
- The bunker hose was routed vertically. As a result, residual water from within the hose was able to escape and pool on the deck below where crew accessed the storage area;
- The presence of grating nearly everywhere gives a false perception of a non-slippery surface;
- A Manual Handling Assessment was not considered for the task.

Learnings

- If available, place caps on end of hoses to eliminate water spillage;
- Ensure non-slip deck coating is applied in all exposed areas in storage rooms, and assess all other work and storage areas and apply same coating where required;
- Develop a manual handling assessment for the movement of bunkering hoses, incorporating the use of mechanical lifting aids wherever possible.
- Rescue equipment available onboard for an unconscious casualty – a stretcher - was not suitable for a rescue through the spiral ladders;



Spiral ladder which would not have allowed passage of a stretcher

- Identify all areas onboard the vessel presenting difficult rescue (with limited access/egress) and consider additional rescue drills in all identified areas complete with designated rescues plans.

Members may wish to refer to:

- [Slip on wet surface \(Marine Safety Forum\)](#)
- [Lost time injury – person slipped on the stairs and broke his arm](#)
- [Hose management and chemicals: crew person felt ill \[hose had not been properly flushed afterwards and some of the previous liquid had remained in the hose\]](#)

2 Head injury when crew member fell over in bathroom during heavy weather

What happened

A member of the crew fell over in the bathroom of his cabin while the vessel was rolling violently, and suffered a minor head injury as a result. The incident occurred when the vessel was steaming at full speed during moderate weather conditions, and was rolling in consequence. When the vessel rolled suddenly, the person lost balance, tripped and hit his head against a towel rail. Five stitches were required to close the wound.



Reconstruction!

What was the cause

- The vessel was transiting at full speed across a heavy swell, on the instructions of the client. The high speed was causing the vessel to roll up to 17 degrees;
- The injured person was caught off-balance in a narrow space in the bathroom.

Lessons learned

- Vessel Master to discuss with client the best and safest options for transit across rough seas or during heavy weather;
- Officer of the watch to warn vessel crew to remain aware and be more vigilant of sudden vessel movements, particularly on the stairs, in the galley, in bathrooms, on the open deck, in the engine room and anywhere else where there is risk of injury from overbalancing and falling or tripping over.
- An old saying from the days of sailing ships is: *“One hand for yourself, one hand for the ship”*.

Members may wish to refer to:

- [Slip/trip resulting in lost time injury \(LTI\) \[chief engineer failed to follow instructions not to go on deck during heavy weather\]](#)
- [Crushed finger \[A diver in sat got his fingers trapped in a lock when weather conditions winds were between force 7 and 8 and the vessel was pitching and rolling heavily\]](#)

3 Person slipped when exiting bathroom into cabin

What happened

A crew member stepped out of the bathroom onto the cabin mat, when the mat slipped resulting in the crew member falling backwards, striking his lower back on the base of the bathroom door frame. The medic checked the injured person, identifying some swelling and a small abrasion. In follow up with the medic, the injured person reported feeling a little sore, but with no further symptoms, and returned to normal working duties.

Investigation identified that the cabin mat did not have any anti-slip material on the underside. A check was completed on all cabins which found a number of mats which had the potential to slip due to no anti-slip or rubber material underneath. The assumption had been made that every cabin had an anti-slip type mat.

Our member noted that this incident could have resulted in a far more serious injury.



What went wrong/what was the cause

Cloth based mats were being used instead of rubberised (anti-slip) mats. There were not sufficient rubberised mats to supply each cabin. Cloth based cabin mats do not offer any anti-slip properties.

What went right

- The accident was promptly reported to the medic by the injured person;
- Most of the cabins were found to have the correct anti-slip mats fitted.

Learnings

- The immediate corrective action was to apply deck grip tape, until suitable anti-slip mats were available;
- An adequate stock of rubberised matting should be maintained onboard;
- If there's a temporary need to use cloth based mats, some form of anti-slip material should be used to prevent the mats from slipping;
- Inspections of accommodation areas should highlight where anti-slip mats are not present or not available.

Members may wish to refer to:

- [Fall from Height Leading to Injury](#) [there was no non-slip coating, and an uneven surface, in a hazardous area. This had not been identified.]
- [Lost time injury \(LTI\): fractured elbow – fall injury](#) [The Chief Officer slipped on a smooth section of ramping deck, landing badly and suffering a fractured elbow]

4 Leak of oil-based mud

What happened?

There was a spillage of oil-based mud from a vessel alongside. The leak occurred when a vessel was preparing to transfer oil-based mud to the shore base. Just prior to transfer starting, the shore base team was about to conduct a pressure test to ensure there was no leakage on their hose. The pressure test was carried out with the objective of maintaining 5 (five) bars pressure at manifold using a dry-break fluid connection. Unfortunately, during the test, about 20-25 litres of the mud came out of the tank ventilation.

The officer on duty immediately instructed the crew on deck to contain the spillage to avoid the mud going overboard. The vessel reported the occurrence to the DPA.

What went right

Before starting the job, the crew and the shore base team conducted a toolbox meeting. After that, the crew prepared to close all valves that needed to be closed and also placed scupper plugs on deck to avoid any spill overboard.

What went wrong

- Before starting the pressure test no-one ensured the valve seals were well-maintained and in good condition;
- During the pressure test, 5 (five) bars pressure could not be maintained, which indicated internal leakage;
- The officer on duty was informed about the overflow by the shore base lifting crew, not by the AB on duty;

What was the cause

The valve seal was damaged, causing the valve's failure to be fully closed even when the valve's handle was in a full closed position. The oil-based mud cargo had mixed with certain chemicals remaining at the valve seat leaving the valve surface and seal deteriorated.

Actions taken

- Replaced the damaged valve;
- Arranged regular monthly cleaning on manifold valve;
- Ensured that after carrying out loading/discharge cargo, all lines were blown out to ensure there is no residual chemicals or mud at line and manifold.

Members may wish to refer to:

- [Low pressure mud hose parted \(2011\)](#)
- [MSF: water based mud spill on deck](#)
- [MSF: Tank corrosion](#)



Showing damage on valve surface and seal

5 Life raft secured incorrectly on cradle

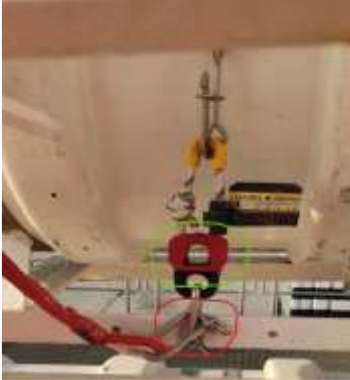
What happened

During an onshore visit to a vessel, it was observed that a life raft was attached/connected incorrectly to the life raft cradle. The life raft painter rope was connected to the cradle instead of to the weak link on the Hydrostatic Release Unit.

Applicable
Life Saving
Rule(s)



Bypassing
Safety
Controls



incorrect connection point in red and correct one in green



Correct life raft securing arrangement

What went wrong?

It was installed incorrectly and there was no post-installation check carried out. What inspection there had been, had been a visual check of condition with no check of whether the life raft was or was not correctly installed and secured.

Actions taken

Post-installation checks and life-raft weekly inspections added to planned maintenance system.

Members may wish to refer to:

- [Life raft self-activates and falls to the quayside](#)
- [Life raft dropped to the jetty](#)
- [Two incidents relating to life rafts/life boats](#)