

IMCA Safety Flash 27/16

October 2016

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.

Focus: Falling into Open Hatches

The focus of this safety flash is the risk of falling into open and unprotected hatches on deck. There are three such incidents with increasing severity of consequence:

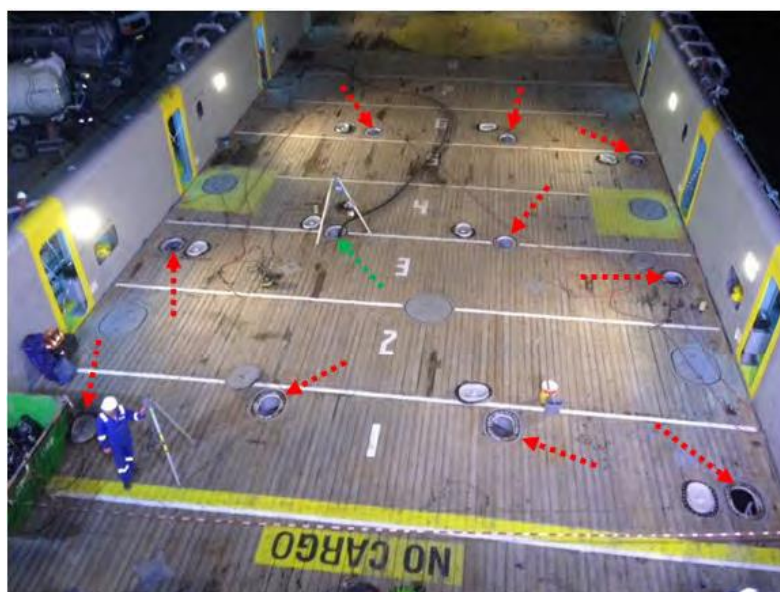
- ♦ In the first incident, a near miss, a number of hatches were left open on deck during tank cleaning. There were no injuries;
- ♦ In the second incident, a crewman did in fact fall into an open hatch on deck, but fortunately managed to grab onto an edge and therefore prevented a more serious fall. He was also uninjured;
- ♦ In the third incident, a person fell into an unprotected manhole and whilst he did catch himself before he took a really serious fall, he did suffer minor lacerations which required medical treatment.

The fourth part of this safety flash deals with the product recall of certain working at height equipment, reproduced by permission of the manufacturer.

1 Near Miss: Open Hatches Left Without Barriers

A member has reported a near miss incident in which a number of hatches on deck were left open without any form of barrier, creating the potential for injury if persons were to fall down the hatches. The incident occurred during routine tank cleaning operations carried out by an authorized tank cleaning contractor on board a supply vessel. During night shift vessel inspection and tank cleaning operation monitoring, 10 tank hatches were observed open and left uncontrolled (potential to fall into the manhole for some employees working near the open hatches).

Initial investigation revealed that 11 diesel tank hatches were opened and gas tested; the 10 hatches were left open for ventilation without any protection/control measures or any barriers for each hatch. The overall area was barricaded off by tape by the tank cleaning contractor with a single standby person allocated on deck.



Our member noted the following:

- ♦ 10 hatches were left open for ventilation without any barriers;
- ♦ There were no additional control measures in place, except a verbal caution during the toolbox talk about the risk of falling into the open hatches;
- ♦ The unsafe condition was neither identified nor challenged by any personnel from the contractor or from the vessel crew.

Our member took the following actions:

- ♦ Tank cleaning operations were stopped for the moment;
- ♦ A safety stand-down was conducted with emphasis on the potential hazards and the requirement to be vigilant and initiate a **stop work** authority for any unsafe conditions identified;
- ♦ Further thorough review of task risk assessment and procedures for tank cleaning and other dangerous space entry activities – with consideration of better management of the open hatches;
- ♦ Further clarification of roles and responsibilities during simultaneous operations (SIMOPS) and during tank cleaning;
- ♦ Barriers and vented grating ordered for all vessels in fleet.

2 Near Miss: Person Almost Fell from Height During Anchor Chain Preparations

The Marine Safety Forum (MSF) has published the following safety alert regarding a near miss during preparation to load anchor chain into a moon pool chain locker. One person almost fell into the chain locker. The hatch cover had been temporarily removed before the installation of the chain guide. The hatch had an opening of 155cm x 85cm. The depth of the locker was approximately 10m and there was 1–1.5m of water at the bottom.

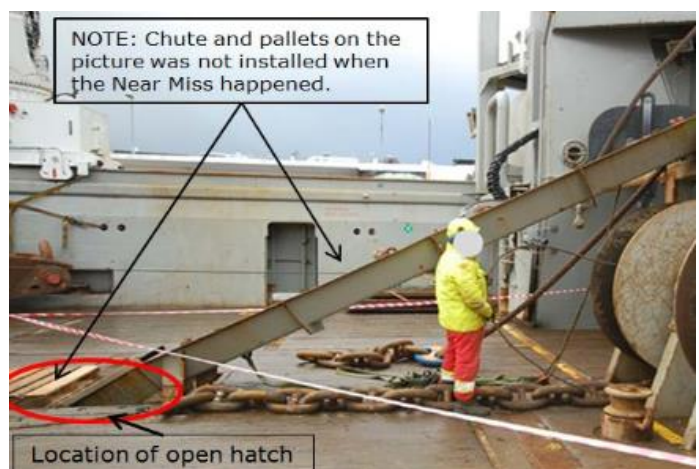
The person fell backwards, with the upper part of his body towards the opening of the hatch. He managed to turn slightly over to his right side and grab onto the edge around the hatch opening with both hands. His ankles and the lower part of his feet were also above the edge of the hatch opening. He managed to get his right elbow over the edge. He shouted for help twice before getting the attention of his colleagues.

The MSF notes that the near miss occurred because:

- ♦ The hatch had been left open without a barrier;
- ♦ The fact that the hatch had been opened was not sufficiently communicated;
- ♦ Risk assessment and planning for the work, given the risks involved, was neither suitable nor sufficient.



A similar hatch



Reconstruction of area of near miss

The MSF safety alert can be found [here](#).

3 Medical Treatment: Person Fell Down Unprotected Hatch

The MSF has published safety alert number 16-17 regarding an incident in which a shore-side foreman walked into the "safe haven" area of a supply vessel and stepped into an open manhole. Whilst he managed to catch himself and prevent a free fall of 5m into the tank, he nonetheless suffered a laceration on his shin requiring 3 stitches and bruising to the forearm.



The MSF noted the following **causes**:

- ♦ Lack of barriers to open manholes;
- ♦ Several different activities all occurring at once;
- ♦ Lack of coordination of those simultaneous activities.

The following corrective actions were taken:

- ♦ Covering of manholes with gratings during work;
- ♦ Ensuring that ongoing work is coordinated between the work parties in the same area, through toolbox talks.

The full report can be found [here](#).

Members may wish to refer to the following incidents (search words: *hatch, open*):

- ♦ [IMCA SF 08/08](#) – Incident 1 – *Fall through open hatch in walkway*;
- ♦ [IMCA SF 20/15](#) – Incident 2 – *Crewman falls down open hatchway during simultaneous operations*;
- ♦ [IMCA SF 17/16](#) – Incident 5 – *Near miss: bilge cover left open*.

4 DBI-SALA® Lad-Saf™ Sleeve – Stop Use and Voluntary Recall/Replacement

A member has drawn IMCA's attention to problems with certain safety equipment used in work at heights. The equipment is the DBI-SALA® Lad-Saf™ Sleeve. The manufacturer of this equipment reiterates that customer safety and confidence are their highest priorities, and confirms that in light of reported incidents and potential misuse scenarios involving the equipment, its sale has been discontinued.

Original Lad-Saf sleeves are being voluntarily recalled for replacement. Users of such equipment are asked by the manufacturer to:

"immediately stop using and quarantine all original Lad-Saf sleeves. Affected part numbers are:

6100016, 6116500, 6116501, 6116502, 6116503, 6116504, 6116505, 6116506, 6116507, 6116509, 6116512, 6116535, 6116540, 6116541, 6116542, 6116500C, 6116500SM, 6116507/A, 6116540b, 6160031, KC36116502, KC36116506 = 6116506, KC3PL3330, KC3L3330/O, KC3L3330ED, KC3SC2020

Contact 3M Customer Services at +33 4 97 10 00 10 or email us at LADSAFEMEA@mmm.com, to discuss the replacement of your returned units with an X2 sleeve, depending on your needs, at no cost to you."

Further information is available at <http://en.capitalsafety.eu/Pages/News-Lad-Saf-Sleeve-Voluntary-Recall.aspx>

PRODUCT STOP USE AND RECALL / REPLACEMENT NOTICE
IMMEDIATE ACTION REQUIRED

DBI-SALA Lad-Saf™ Sleeve

