Safety Flash 16/19

July 2019

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 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.

1 LTI: Foot Injury After Standing on Rotating Winch Drum

What happened?

An AB was taking part in a task to re-spool a wire onto an aft deck tugger winch, when he climbed onto the side of the tugger winch and, whilst stood there, the rotating winch drum trapped both his feet. His injuries include a fractured foot and severe abrasions.

His boots (proper personal protective equipment (PPE)) prevented a much more serious injury.

What went wrong?

- The crewman failed to identify the hazards associated with the tugger winch;
- None of his colleagues intervened or told him to stop when they might easily have **STOPPED** the job' when he put himself in the line of fire;
- The risk assessment was inadequate – it did not include this particular hazard associated with the tugger winch.

What actions were taken? What lessons were learned?

- "Hazard hunt" focusing on winches and the hazards associated with them;
- Review of risk assessments related to deck operations to ensure that the hazards associated with winches are captured;
- Someone was injured because no-one intervened or stopped the job; remind all that it's OK to **STOP** the job if it's unsafe.

Members may wish to refer to:

- Hydraulic umbilical winch operation – trapped thumb
- LTI: Tugger Winch Incident (MSF)
- Winching Equipment (2000)