Marine Safety Flash A15-32 (15th December)

Crushed Hand

Incident Overview

On the completion of anchor handling operations, two crew members were tasked with stowing a wire and chain buoy catcher against the starboard (stbd) crash rail using a ships crane. Two crew members were involved in this lifting operation, one operating the stbd rail crane and the other connecting/disconnecting the crane hook. The crew member operating the stbd rail crane positioned the crane load (buoy catcher) in the intended position. In an attempt to manipulate the buoy catchers landing position tight against the crash rail, the second crew member (Injured Party - IP) placed his left hand on the crane wire termination swage.

Figure 1: Crane weight assembly caught on Dacon Frame

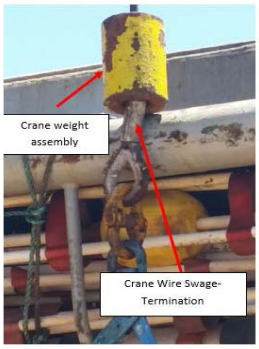

Figure 2: Weight Assembly and Wire Swage Termination

Figure 3: Hand Placement

The IP began guiding the buoy catchers landing position tight against the crash rail. The vessels rail crane hook and crane weight assembly separated due to the crane weight assembly becoming lodged in the Dacon rescue frame assembly directly above the lift. The dislodged weight assembly dropped from a height of 1.5m. The weight assembly (20kg) crushed the IP's hand, which was placed on the termination swage.

Key Findings

Familiarity Completing a Routine Task Leading To Lack of Situational Awareness. The deck team had just completed anchor handling operations and were completing deck clean up duties. Both crew members became complacent due to the routine nature of the task and failed to identify that the weight assembly was not in place as they were focused on completing the task and did not step back to assess the hazards and risks associated.

Weight Assembly – Hazard Identification. Crane hook assembly was supplied to the vessel on delivery and is a common arrangement on various vessels, the weight assembly is free moving allowing it to slide up and down the wire. This had not been identified as a hazard previously.

Recommendations

1. The incident to be discussed during next Safety Meeting to highlight the risk of complacency during routine tasks and the importance of hazard identification and risk assessment throughout all tasks onboard.
2. Safety Officers and Safety Representatives to conduct "Hazard Rounds" with a comprehensive focus on "Caught in / on between" associated hazards and update hazard register as necessary.
3. All Vessels to review crane hook assembly on board and identify any potential hazards that could arise during operations.