Marine Safety Flash A15-33 (15th December)

IP Sprains Ankle Removing Chain from Drum

Incident Overview

Photos 1: The view of looking down on chain storage drum

While the vessel was inside the 500m zone repositioning itself for cargo operations, the Injured Person (IP) and the Trainee Integrated Rating were removing lashing chain from a 44 gallon drum, for the purpose of securing a 65ft section of riser. The TIR gathered one end of chain/hook from the drum and proceeded to move away from the drum pulling out the chain as he went, the IP was assisting in feeding the chain out of the drum.

The IP positioned himself with his right knee resting on a section of old coiled mooring rope next to the 44 gallon drum and his left foot lay flat on the deck grating. When the IP stood upright with the chain in both hands, he felt a twinge / pain in his left ankle / foot region. The left ankle was not rolled and there were no uneven protrusions on the deck in the immediate work area. The injury was later diagnosed as a sprain with no bone, tissue or ligament damage.

Key Findings

- Poor Posture – Due to the posture of the IP when removing the chain from the drum and transferring his weight to his left leg, it caused over exertion in the left ankle.
- Poor housekeeping – Due to the mooring rope been used previously it was coiled and stored at the most convenient location. If the mooring rope was not there the IP would not have knelt down to retrieve the chain.
- Accessibility to the lashing chain was poor in that it was not readily accessible due to the mooring rope not providing appropriate access to the lashing chain in the drum.
- Poor Task Planning – the work being done was not adequately planned in terms of retrieving the chain from the drum.
- Not stopping the job – when the IP first felt the discomfort in the ankle, the job was not stopped as it was not considered to be of a concern. IP continued working and approx. 45 minutes later the ankle was found to be swollen and First Aid was applied.
- The IP was wearing full PPE but the safety boots did not provide ankle protection. Safety boots that provide full support would have made a difference in reducing the severity of the injury.

Recommendations

1. Review and discuss this incident with all crew on board at next Safety Meeting.
2. Reinforce good housekeeping practices.
3. Reinforce in risk assessment/toolbox meeting, the correct manual handling techniques to be used for the task.
4. Inspection to be carried out on board where any mooring rope that is used on the deck to prevent steel on steel contact should be hung up/secured in a suitable location on deck e.g. on the outside of the crash rails.
5. Crew to be reminded to Stopping the Job when an injury occurs during a task to seek treatment at the earliest opportunity.
6. PPE Matrix to be reviewed by HSEQ department to identify the correct type of safety boots to be worn to ensure that they have adequate ankle protection.