# Marine Safety Flash

# A16-14(12th April 2016)

## Foot Injury - Steel beam insecure

### Incident Overview

A crewmember was painting in the ROV Hanger. Chipping and painting was completed in stages due to equipment having to be moved from one side of the deck to the other. Two Steel “H” Beams were stored underneath the ROV Umbilical and were moved from Portside to Starboard side; both beams were secured to the Gypsy Storage Rack using webbing straps (Figure 1). Both steel beams were stowed in an upright position to make it easier to lash to the gypsy storage rack (Figure 2), both are approximately two meters in length and weigh 150-200kg.

Crew Member 1 (CM1) began preparations for the days planned tasks. As CM1 prepared the worksite, he unlashed the two steel beams, on completion the crew commenced their morning break.

During the morning break, CM1 met by chance with the Crew Member 2 (CM2) accommodation stairs; CM2 was not on watch at the time nor completing any work. As they were at the location, CM1 and CM2 proceeded to the ROV Hanger to discuss the next stage of chipping and painting. CM2 was standing near the gypsy storage rack as he was talking to the CM1 (see Figure 1). As the crew were talking, the vessel pitched forward resulting in one of the steel beams rolling onto CM2’s foot. The Injured Party (IP) sustained bruising to his foot.

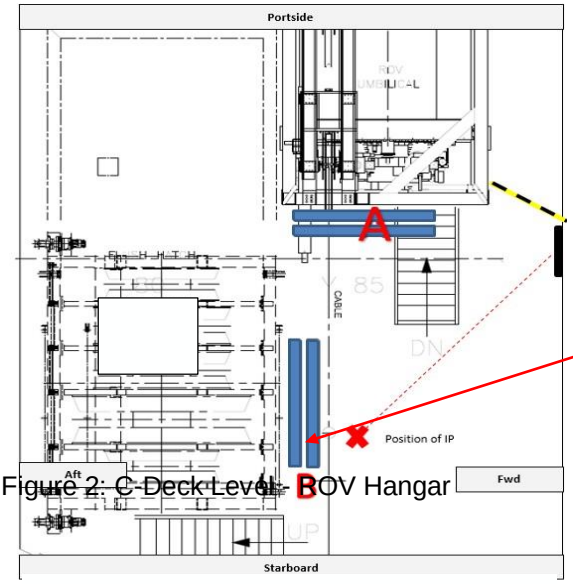


Figure 2: C-Deck Level – ROV Hangar

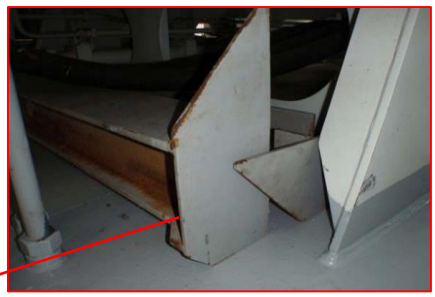

Figure 1: Steel Beam in Upright Position

# Marine Safety Flash

# A16-14(12th April 2016)

## Key Findings

1. Placement of Steel “H” Beams

The deck steel beams were sitting on a raised uneven surface, The combination of the upright placement of the unlashed steel beam, the raised uneven surface and the slight vessel movement rendered it likely that that beam would roll forward. It was not identified in the Risk assessment that the placement of the steel beams presented a hazard.

2. Worksite Left Unsecure

The worksite was left in an unsecure state; anyone transiting the area was unknowingly exposed to the hazard. The steel beams should not have been unlashed until the beams were required to be relocated, and until the task of moving the steel beams was thoroughly risk assessed.

3. Personal Protective Equipment (PPE) Not Worn

At the time of the incident, the IP was wearing Crocs (rubber sandal type footwear). The IP was transiting the internal accommodation stairs and entered the ROV Hangar to discuss the work. The ROV Hangar is also utilised a recreational area when no operations are conducted within the area.

Once maintenance within the area commenced, the area should have been classified as a “worksite”. As such, all crew transiting the area are required to comply with the company PPE requirements. PPE would not have prevented the incident; however, steel cap boots would have reduced the impact to the IP’s foot.

## Recommendations

• Masters to discuss the incident with on board personnel during Safety Committee Meeting and highlight the risk of leaving a worksite unsecure. To be documented in accordance with instruction from regional HSEQ.

• Safety Officer and Safety Representatives to conduct Hazard Hunt with a focus placed on unsecured items and this activity should also be documented.