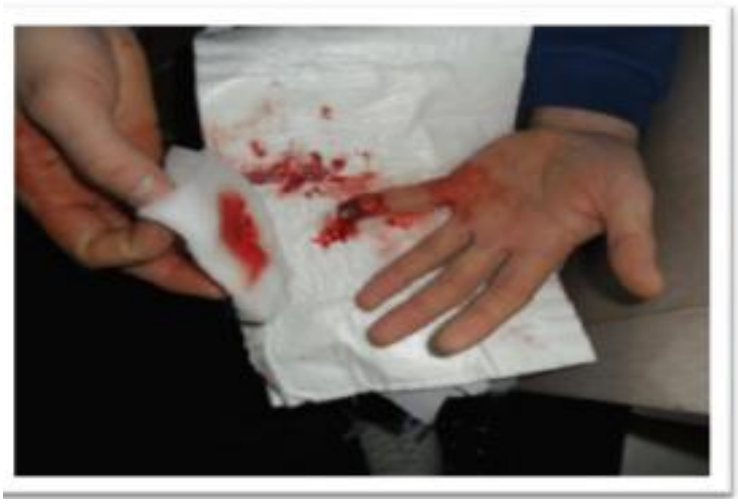
Marine Safety Forum – Safety Flash 12-16

Issued: 28th March 2012

Subject: Gangway Finger Injury

When putting the gangway in storage position for sea passage, the gangway was picked up, and the gangway moved to the left causing a finger to get trapped in between gangway and fire hydrant manifold. All safety measures were taken and toolbox / Risk Assessment were made.

During preparation for departure 2 ABs and the Second Officer were tasked with removing and stowing the ship's gangway. The gangway was lifted onboard and whilst it was being slid along the deck for stowage, one AB had his finger pinched between the gangway frame and an isolation valve on deck resulting in a deep cut to his finger. The Chief Officer started to carry out first aid to stop the bleeding. The Captain contacted the agent to arrange transportation for the Injured Person to hospital and informed the office (ERT) of the accident. The AB was transferred to hospital where he received further treatment before returning to the ship. On his return, the Captain made the decision that the AB would not be fit for duty and that he should return home to recover fully. The AB was off duty for 5 weeks.



Technical Findings

The Store crane was out of order and awaiting repairs. Therefore a smaller gangway was being used that allowed for crew members to manually handle it into position.

The gangway was normally stored on cargo deck but this was in the way during cargo operations. This was reported as a near miss. The Technical department was looking at getting a rack for the gangway to store it.

Procedural and / or Organisational Findings

The Risk assessment for gangway did not adequately cover manual handling of gangway.

The Risk Assessment did not identify any pinch areas, nor had the isolation valve been highlighted as a potential danger.

A Toolbox meeting was held, but did not identify the additional risks involved with the manual handling of the gangway.

No management of change was carried out for the change of gangway.

Human Factor Findings

During toolbox talk the (additional) hazards involved were not identified.

Task was not fully planned because the valve was not identified as a potential pinch point.

Corrective actions

- Vessel RA to be re-assessed to identify all risks involved in manually handling gangway
- Rotate valve so will not be possible to pinch finger
- Investigate alternative gangway storage facility one deck higher than the main deck on the aft of the accommodation. The gangway will be positioned as far possible to port side to establish easy handling and positioning of the gangway by the crane
- Management of Change procedure and forms to be rolled out and emphasized
- Report to be discussed with master in respect of use of toolbox and Risk Assessments

Preventive actions

- Reminding crew of the need to re-assess any Risk Assessment if the task has been changed.
- Time Out for Safety to be held across the fleet, consisting of “hands & fingers” safety campaign and discussion.
- Use of Management of Change procedure to be discussed at briefing and debriefings of masters and on board during visits from Safety Coach.
- Risk Assessment training for fleet to continue and be revised with lessons learnt.