



An Engineer Falls

Description

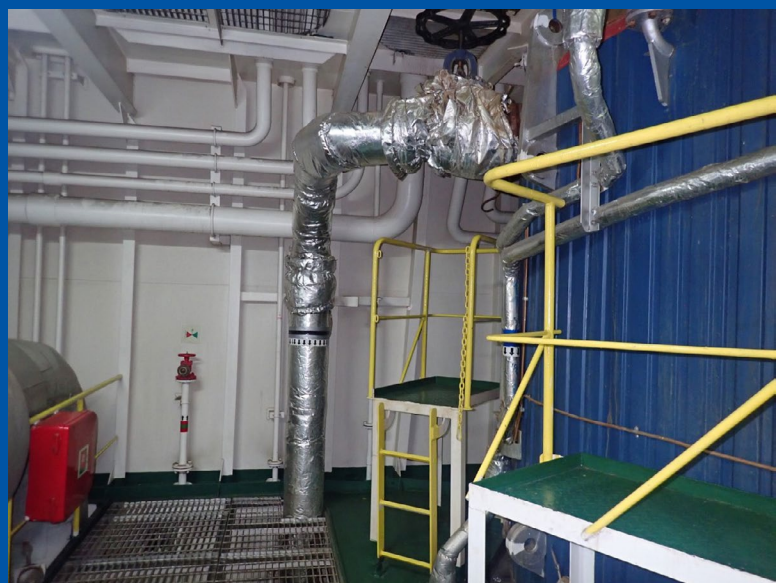
The engineers on a general cargo vessel had just completed some preventive maintenance on the exhaust gas boiler when they noticed a gasket between a valve body and the valve bonnet appeared to be leaking steam.

The Chief Engineer quickly was notified, and he authorized shutting down the exhaust gas boiler and making the repair. Thereafter, a work permit was completed to repair the leak and signed off by the Chief Engineer. He reminded them of the lock out/tag out procedures and – due to risk of injury from the steam – specifically requested for them to conduct a toolbox meeting.

This was not a system they were very familiar with, so they consulted the drawings, reviewed the piping arrangement, and discussed available safety precautions. After evaluating the risks, they decided to completely isolate the valve to ensure no steam or hot water could reach that valve while the new gasket was being installed. They used the lock out/tag out system and recorded the valves that were secured and the locations.

The work went according to plan and the new gasket was installed. However, they had difficulty correctly aligning the valve bonnet with the valve body just using one chain fall. So, the Third Engineer climbed onto the first rung of the railing to manually guide the valve bonnet into place. As he pushed the hanging valve bonnet into position, he was giving directions to the engineer working the chain fall. At the last second, the Third Engineer had to pull his hand back to keep his fingers from getting caught under the valve bonnet. When he did so, he lost his balance and his foot slipped off the railing. He landed hard on the deck and injured his back.

He was carried to the hospital space on a stretcher for evaluation. The injury appeared sufficiently serious that the vessel diverted towards the nearest port. When within range, a helicopter flew out to the vessel and transported him to the hospital.



Actual Injury

The Third Engineer injured his back when he fell. He was treated at the hospital and eventually sent home to recuperate. He was unable to work for almost six months.

Potential Injury

The injuries to the Third Engineer could have been substantially worse. He could have hit his head as he fell or when he landed. He could have broken one or more bones as well. He was lucky that his injuries were not permanent.

Prevention

- ★ What else could have been discussed at the toolbox meeting? Did the toolbox meeting address all safety concerns associated with upcoming work, or just the most serious safety concerns?
- ★ When the Third Engineer stepped up onto the railing, should someone have identified and said something about the potential safety hazard or risk? Do you have a system in place that allows for anyone to call a stop to the work when there is a safety concern?
- ★ What could have been done instead of someone trying to stand on the railing?

When you identify a hazard before something goes wrong...

it's a Good Catch.

When you stop an operation before something bad happens...

it's a Good Catch.

When an unsafe act is stopped even if it is well intentioned...

that's a Good Catch, too!



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