Office of Marine and Aviation Operations

SAFETY NEWS

From the Safety and Environmental Compliance Division

FIRST EDITION NOVEMBER 2011

Welcome to the first edition of Office of Marine and Aviation Operations (OMAO) Safety News. Its purpose is to share the latest safety information and safety news from around the organization. Below is a listing of articles and topics that will be routinely featured.

CONTENTS

POLICY SPOTLIGHT

NOAA Safety Policy, NAO 209-1, requires all supervisors to conduct monthly safety inspections of their respective work areas. Inspection checklists are available via the NOAA Safety and Environmental Compliance Office (SECO) website, www.seco.noaa.gov, and may be customized depending on known risks and common hazards associated with a specific location. Given the variation in work areas throughout the organization, monthly inspections can be accomplished in a variety of ways. For example, ship Commanding Officers typically conduct monthly command inspections, and safety staff or safety committee members at a given facility often inspect common work areas on behalf of supervisors.

It is important to note, NOAA policy states that inspection findings and corrective actions are required to be recorded regardless of how monthly inspections are accomplished. In addition, the status of all open corrective actions is to be reported quarterly up the management chain and to the safety staff at your respective Center or Office to ensure resources, if needed, are allocated or have been requested to accomplish the corrective action.

NOAA Safety Policy also requires reporting of all accidents that occur while on the job or in a duty status. **In addition to accidents resulting in injury and situations leading to work-related illness, reporting is required for near miss incidents, property damage incidents, and environmental incidents**. All incidents, with the exception of shipboard incidents, are to be reported using the NOAA on-line reporting system at http://www.seco.noaa.gov/incident_reporting. Shipboard incidents are to be reported using the NF-57-17-137 fillable pdf form (formerly the MOC-137) and submitted via email to

MOC.Fleet.Accidents@noaa.gov. A copy of the NF-57-17-137 form is available on the Forms page of the Document Management System on the inside OMAO website, http://10.49.29.4/WebDesktop/Binders.aspx.

Regardless of where they occur, **all incidents are to be reported within 24 hours of occurrence**. **Serious incidents**, that is, those resulting in a fatality or hospitalization of three or more employees, those resulting in property damage in excess of one million dollars, and those that pose an imminent threat to public safety and the environment, **are required to be reported within 8 hours of occurrence**.

COMMON INTERESTS

In this section we share information and articles from sister organizations and other agencies having common interests such as Navy, Air Force, Coast Guard, Maritime Administration, University-National Oceanographic Laboratory System (UNOLS), and the Interagency Committee for Aviation Policy (ICAP). Below is an article excerpted from a recent safety newsletter from Military Sealift Command (MSC).

"A Second Chance" – from MSC Newsletter, *Safety on Ships, Volume 5, Issue 3*

> Most of us don't know when a mishap is coming. We don't intentionally put ourselves in harm's way. But when safety procedures are not followed we increase our chances of a mishap occurring.
>
> Recently, a mariner was given an assignment to remove dead-ended wiring from the overhead of a compartment. He found the wiring coiled up in the overhead with an identification tag attached. For safety reasons, a fiberglass ladder was used to access the wires, but many other safety precautions were overlooked. In order to get a better look at the tag, the mariner grabbed the coiled wire in the area of the wire's protective coating and lowered it down from the overhead. As the wire was lowered from the overhead, it swung in a way that enabled the exposed end of the wire to make contact with his bare hand, causing an electric shock. The other end of the wire was connected to an electrical panel charging the wire with 440 volts. Fortunately, the mariner was able to drop the wiring and only a minor injury occurred.
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> As part of the follow-up to the investigation, safety procedures were reviewed and discussed with the mariner. Two basic safety precautions were not followed when dealing with this electrical wiring incident: the wire was not tested prior to handling, and proper hand protections (gloves) were not used. A major principal of dealing with electrical wires is ALWAYS ASSUME THE WIRE IS LIVE UNLESS PROVEN OTHERWISE.
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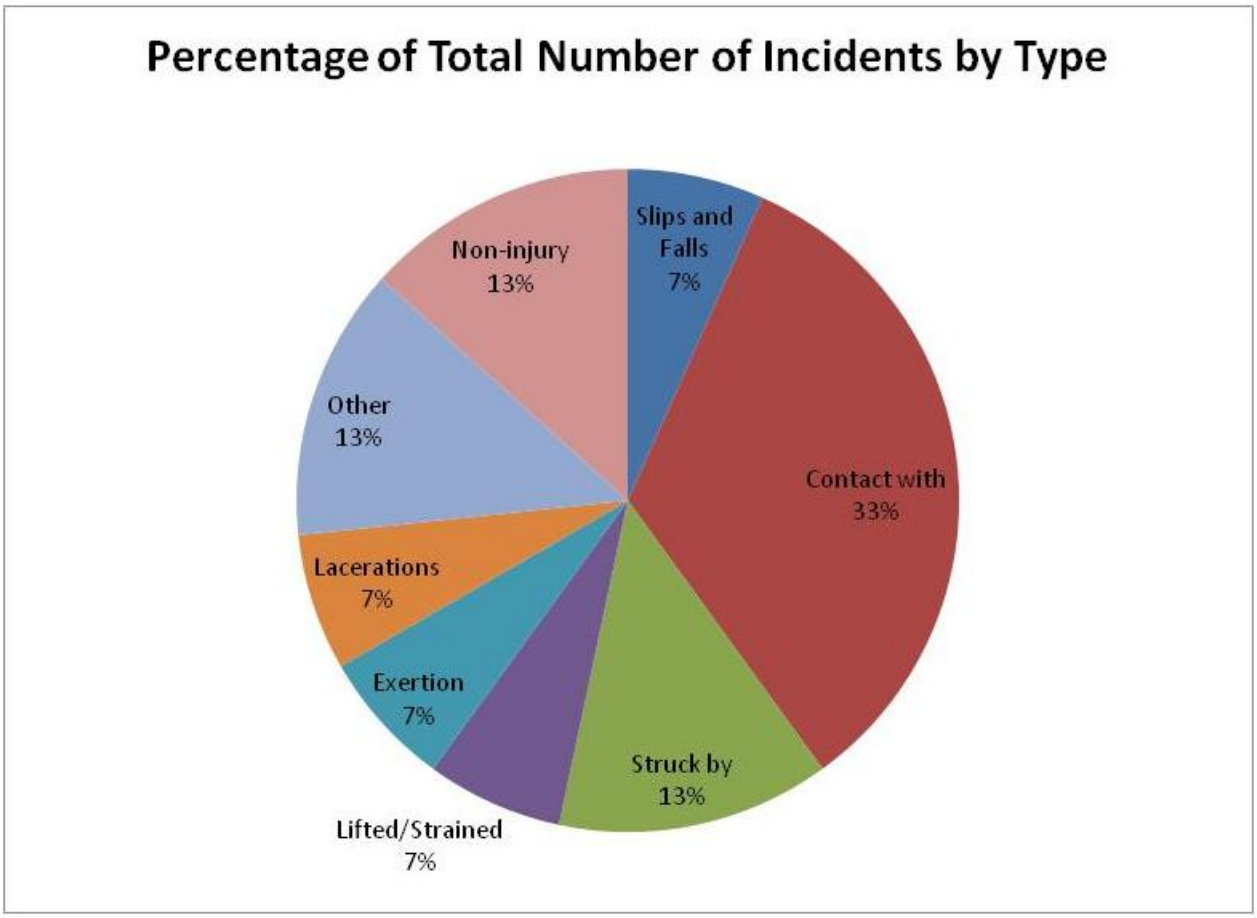
> When mishaps occur on ships, it is important that "lessons learned" are shared. This ship immediately held a safety stand-down with the entire crew to show how the mishap occurred in order to prevent it from happening again. When the mariner who grabbed the live wire was asked what he would do differently in the future when working with electrical wires, he replied, "Always test the wires before touching and wear proper PPE (personnel protective equipment)." No one should wait for an accident to happen to prompt them to follow safety precautions, because not everyone gets a second chance.

ACCIDENT STATISTICS

The total number of OMAO near miss, minor/first aid, medical treatment, lost time, and

environmental incidents reported in October and November 2011 is listed in the table below and is shown as a percentage by incident type, on the pie chart that follows.

Near Miss – 0		
None reported		
Minor/First Aid – 7		
Contact with - 4	Lifted/Strained - 1	Other – 2
Medical Treatment – 4		
Struck by - 2	Exertion - 1	Laceration – 1
Lost Time – 2		
Contact with - 1	Slip, trip, fall - 1	
Environmental – 2		
Non-injury - 2		



The pie chart above shows “contact with” and “struck by” incidents combined to be a significant cause of accidents in October and November 2011. Increased awareness and care is needed to ensure all employees stay clear of structural components, equipment, and other obstructions including moving objects, while performing tasks and moving about the workplace. It is worthwhile to note that “slip, trip, and fall” incidents contributed a smaller percentage of the total when compared to previous time periods. Let’s work to continue that trend by ensuring appropriate foot ware is worn at all times and walking surfaces are properly maintained especially in stairwells and on ladders, and in areas that are typically wet or slippery.

RECENT INCIDENTS: CAUSES AND LESSONS LEARNED

This section provides a description of some recent incidents that have occurred in OMAO. In many cases, more thorough follow-up investigations have been conducted and more comprehensive lessons learned have been disseminated to targeted audiences within OMAO. The information below is intended to remind us of the importance of staying safe.

Description: While test operating a crane that had been recently repaired, a shipboard employee was shocked upon handling the crane’s emergency stop button. Lock-out/tag-out of the crane had been cleared when the repair was completed, however, at some point during the course of the repair, the crane’s emergency stop button had been removed because it was in the way of a painting job and had been left unsecured and dangling from the ship’s rail.

Causal Factors: In its unsecured position, the metal enclosure housing the wiring for the emergency stop button became exposed to the elements. While the stop button was left in its unsecured position, moisture had entered the enclosure increasing the likelihood and intensity of an electrical shock. The metal box became electrically energized by the wiring, and caused the operator to be shocked when the box was handled to stop the crane.

Lessons Learned: Do not clear lock-out/tag-out of equipment until it has been fully restored to its original condition. Do not attempt to operate equipment that is not in a fully operational condition. Communicate changes in equipment status and equipment modifications across all potentially affected departments, even if they are temporary and

Description: A crewmember was returning to the ship’s house from the weather deck after taking out the trash. While attempting to open the aft door leading to the main internal passageway, the crewmember slipped off the stair leading from the main deck, fell, and landed awkwardly resulting in an ankle injury requiring medical attention and lost time.

Causal Factors: Not yet fully investigated and reported. See lessons learned below as it relates to potential causes.

Lessons Learned: Considerations include performing general housekeeping to prevent slipping and tripping hazards; wearing appropriate foot ware; maintaining non-slip coatings; and installing anti-slip nosing on stairs and ladders. In addition, assistance should be sought when carrying loads on stairways and through hatches and companionways as needed. As always, keep one hand for you and one hand in contact with the ship. Also, remember when descending steep stairways and ladders, grasp the hand rail in a way that your hand grasps the underside of the handrail at a height above your head so that you can catch yourself from falling should you slip or lose your balance.

appear to be minor. Ensure lock-out tag-out procedures are maintained and implemented.	

Description: Ship was conducting oily waste transfer to a truck on the pier when the waste oil hauler increased pressure and flow in the transfer hose. The hose blew out at a weak spot causing approximately three gallons of oily waste to spew out on the pier, into the water, and onto the deck of the ship. **Casual Factors**: The primary cause of the spill was the condition of the transfer hose exacerbated by the actions of the operator. In addition, a Declaration of Inspection form had not been completed in advance of the oily waste transfer. **Lessons Learned**: Treat oily waste transfer as seriously as any fueling operation and follow like procedures, including procedures for completing a Declaration of Inspection form. Ensure oil transfer procedures are current and oil transfer checklists are followed. In addition, ensure oil pollution emergency plans are maintained and exercised regularly.	**Description**: During a security round at night in heavy seas, an Able Seaman (AB) stopped to secure a strap holding a mooring in place on the trawl deck. After securing the strap, the AB rose to a standing position and turned in one motion striking his head on the mooring gear causing a three inch laceration above his eye. **Casual Factors**: Heavy seas, lack of personal protective equipment (PPE), a lapse in situational awareness, and inadequate lighting combined to contribute to the cause of this accident. **Lessons Learned**: Those making security rounds are reminded to notify the watch prior to attempting to correct any deficiencies found during rounds so that the situation can be assessed and hazards can be reduced. Measures taken may include providing additional crewmember assistance, adding increased lighting, and ensuring additional safety precautions are followed including use of PPE as the situation may warrant.

BEST PRACTICES

In this section of the newsletter, we plan to share a best safety practice from around the organization that we have seen, or that has been brought to our attention.

In this issue, especially as it relates to “contact with” incidents, we note that there was discussion among safety staff regarding use of hard hats during shipboard rounds and other situations where head hazards exist. Doug Smith of Marine Operations Center (MOC) Safety, Training, Environmental, and Management (STEM) reports, “We had several lacerations to the head that could have been prevented by a hard hat. Another option [as it relates to “contact with” incidents] is not performing rounds as frequently in inclement weather, or modifying rounds for rough weather to reduce risk of injury. *Ferdinand R. Hassler* may be an example of a best practice, where they have minimized descending vertical ladders during rounds and plan to install cameras for remote monitoring.”

The best ideas for improving safety come from the field. Do you have an idea to help prevent injuries? Please send it to the SECD Chief (omao.secd@noaa.gov) and we will plan to share it throughout OMAO.

NEWS AND NOTES

A Marine Operations Center (MOC) Fall Protection Program has been developed and implemented. The Fall Protection Procedures document was signed by RDML Devany on November 7, 2011, and is effective as of that date. The MOC Fall Protection Program requires that adequate measures are in place aboard ship and at shore-side facilities in accordance with maritime industry standards and OSHA regulations to prevent falls from heights greater than four feet and to reduce the impacts from falls should they occur. The document is available for review on the OMAO Document Management System website, http://10.49.29.4/WebDesktop/Binders.aspx, document number 1701-15. Training required to meet fall protection program requirements is being coordinated by Kevin Fleming. Kevin can be contacted by email kevin.j.fleming@noaa.gov or by phone at 757-441-6800.

All employees are required to complete the annual NOAA Safety, Environmental, and Sustainability Awareness Online Training by December 30, 2011. The course can be accessed via the Commerce Learning Center NOAA web site: https://doc.learn.com/noaa. To date, approximately sixty-eight percent of OMAO employees have completed the course.

There will be Shipboard Environmental Compliance Officer (ECO) training this winter. To help minimize travel and maximize training quality. Two 3-day workshops are scheduled. ECOs may attend either: Pascagoula: December 7-9, 2011, or Newport: January 31-February 2, 2012. For more information, contact Julie Wagner by email julie.n.wagner@noaa.gov or by phone at 541-867-8808.

TERM OF THE MONTH

Near Miss Incident - An unplanned event that did not result in injury, illness, or damage – but had the potential to do so. Only a fortunate break in the chain of events prevented the actual injury or damage from occurring.

OMAO employees are expected and in some cases required by law to report near miss incidents. Reporting near misses are important for several reasons. Lessons learned from an investigation of a near miss can be used to prevent a future accident. In addition, statistically speaking, for every accident that does occur, there are ten times the number of near misses that have already occurred. In other words, based on statistics, there are more near misses happening in the workplace than there are actual accidents. As a result, recognizing near misses and reporting them will be a proactive way to reduce the number of accidents that actually occur.

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Safety . . . our mission depends on it