

Own It: Our Role in Man Overboard Near Deaths



HILE GROUP



Presented at WEDA East Coast Chapter Meeting
October 17-18, 2019
The Dupont Hotel, Wilmington, DE





Your Near Death Falls Overboard

- How many FOBs in 2019?
- What are the most common reasons your colleagues fall overboard?
- What are you doing to prevent FOBs?
- What accountability do you assess for an FOB?

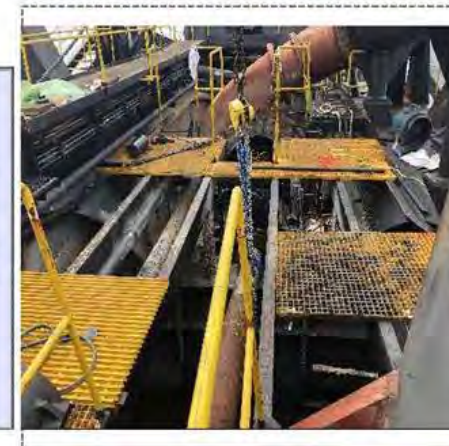
SAFETY ALERT



INCIDENT DATE	INCIDENT TIME	PROJECT #	EQUIPMENT / INCIDENT LOCATION
Jul 13, 2018	1400	72584	Dredge CAROLINA
ALERT TYPE		PROJECT NAME	
INJURY		Charleston Harbor - Contract 2	
SUPERVISOR		INVOLVED JOB TITLE	
Guadalupe Benavides		Deckhand	

INCIDENT DESCRIPTION

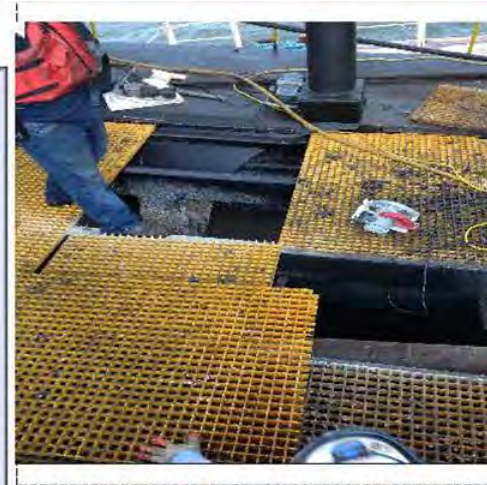
The crew had setup to remove a shaft from the underwater pump. Due to the layout of the grating, 4(four) pieces of grating were removed in order to gain access to allow the shaft to be rigged. Upon removal of the grating, it was not identified that the grating was secured by interlocking with other pieces as compared to independently secured on the supports. As the deckhand was positioning himself to be closer to the chain fall to lift No. 2 shaft, he stepped across from one piece of grating to another that was not secured. The unsecured grating slid from under his feet; as result he went over board. During the incident the deckhand incurred minor scratches / skin irritation.



Corrective Action: Safety Alert

IMMEDIATE ACTION TAKEN

The crew immediately placed all grating back in place and locked/secured them together. The entire crew held a stand down and discussed the incident. Afterwards the crew cut out grating directly above the No. 2 shaft. All grating was back in place except for the portion over the shaft. Axiom was contacted to document the scratches and address any concerns.



TREATMENT REQUIRED

ABRASION

PREPARED BY:

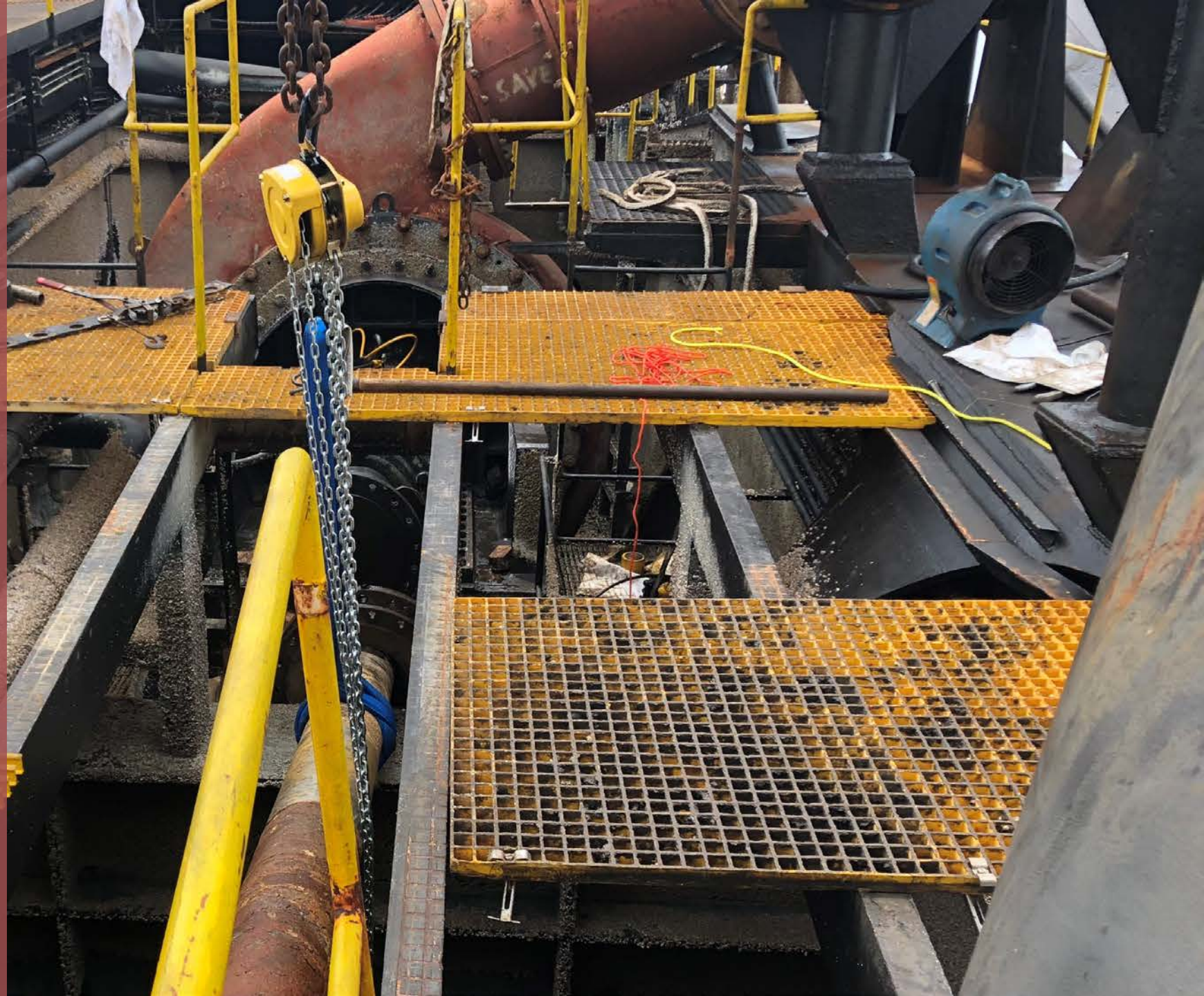
SSHO Mike Jimenez

DATE

Jul 13, 2018

Corrective Action: Safety Alert


Replacing
Dredge
Carolina
No. 2
pump shaft













Multiple Cause Incident Analysis

- Active engagement
- Cross-stakeholder team
- Collect pre-cursor data



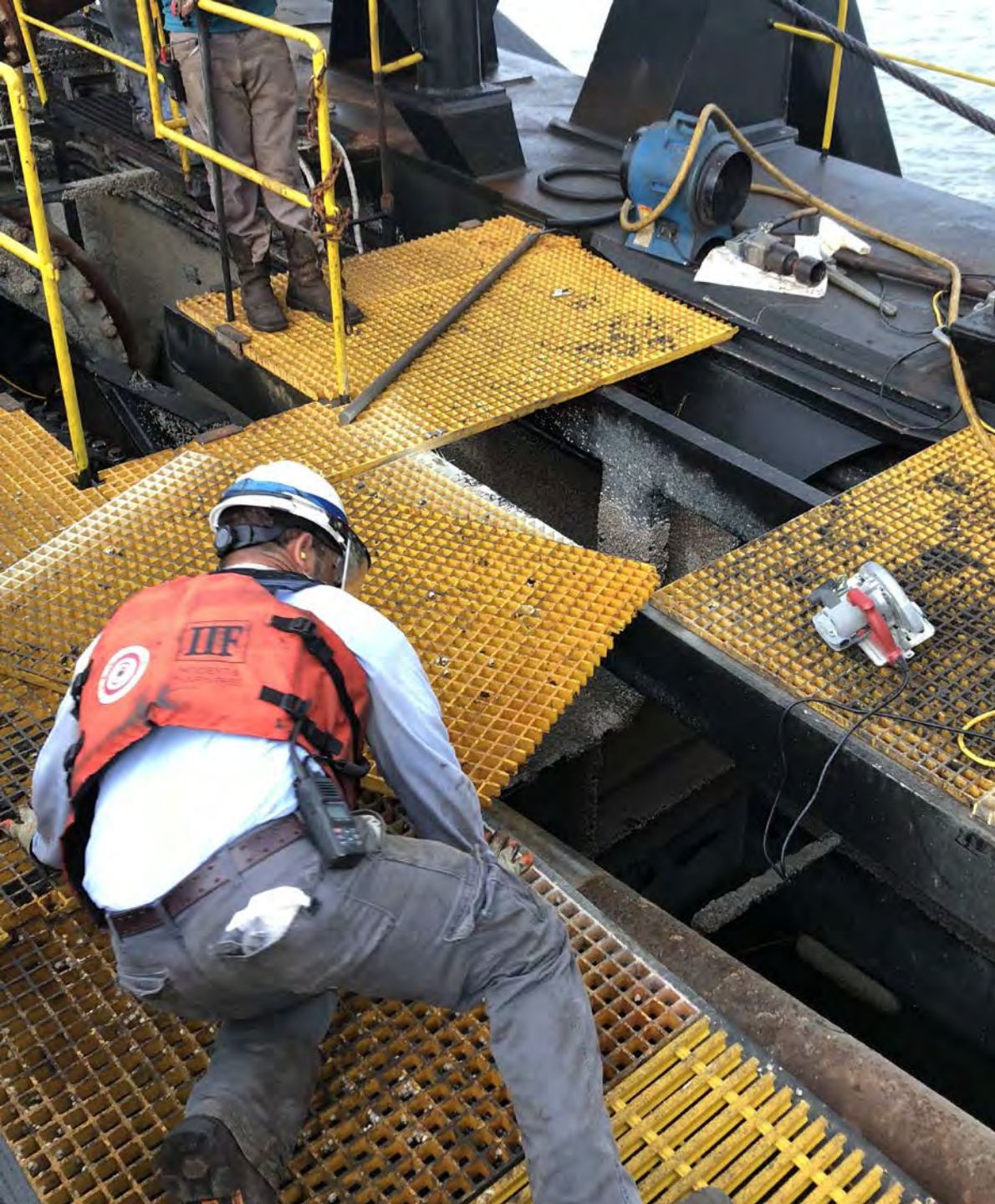
Multiple Cause Incident Analysis

- Prospective Contributing Factors
 - Operator/Individual
 - Work Group
 - Supervision
 - Equipment/Tools/Materials
 - Work Space/Environment
 - Organization
 - Outside Association



Multiple Cause Incident Analysis

- Five Why's analysis
- Executive team review
- Document and track Corrective
Actions



Corrective Action:
Grating Cut and
Reinstalled



Corrective Action:
Grating Cut and
Reinstalled

Step 7. Verify Corrective Actions

This Step...

Concluding your Analysis

↳ See more

Training to be provided to Carolina crew about fall protection and available techniques.

Show History

Schedule and conduct fall protection training with the entire dredge crew highlighting areas of confusion.

Show History

Design grating connecting system for individual pieces

Show History

Cut and reinstall grating so that the only area without grating is directly above the shaft.

Show History

Because the ladder position cannot be changed while personnel are working on it, cut and reinstall grating so that the only area without grating is directly above the shaft.

Show History

Chief, Relief Captain & Deck Captain to be given performance accountabilities for not recognizing potential hazards during the task. Crew members involved with the task to be given coaching sessions by GLDD management to cover incident.

Show History

Return to Dashboard



DISCUSSION





VESSEL TRANSFERS



3-Points



Red Zone



Comms



Trip



Weather



PPE



Pinch

1. **FOLLOW** ORDERS OF PERSON IN CHARGE
2. **IDENTIFY** WEATHER AND SEA CONDITIONS
3. **ENSURE** A CREW MEMBER ASSISTS YOU
4. **COMMUNICATE** WITH ALL PARTIES
5. **VERIFY** CLEAR ACCESS TO TRANSFER POINT
6. **KEEP** HANDS FREE OF OBJECTS DURING TRANSFER
7. **MAINTAIN** THREE POINTS OF CONTACT
8. **TRANSFER** ONE PERSON AT A TIME
9. **RECOGNIZE** AND AVOID PINCH POINTS
10. **DO NOT** TRANSFER IF YOU ARE UNCOMFORTABLE
11. **DO NOT** TRANSFER UNTIL INSTRUCTED
12. **DO NOT** JUMP OR OVEREXTEND DURING TRANSFER
13. **DO NOT** LINGER IN THE TRANSFER ZONE





HILE GROUP



Julie Hile

hile@hilegroup.com

309.888.4453

Dave Johanson

DJJohanson@gldd.com

843.737.6445