Marine Safety Forum – Safety Flash 11-01

Issued: 5th January 2011

Subject: Eye Injury – Compressed Air Line

An Incident occurred where a crewmember suffered a serious injury to his eye. The particular incident was caused due to a task being carried out which was not planned correctly and also, did not, have sufficient precautions put in place to protect everyone in the work area from the potential hazards that went along with the task.

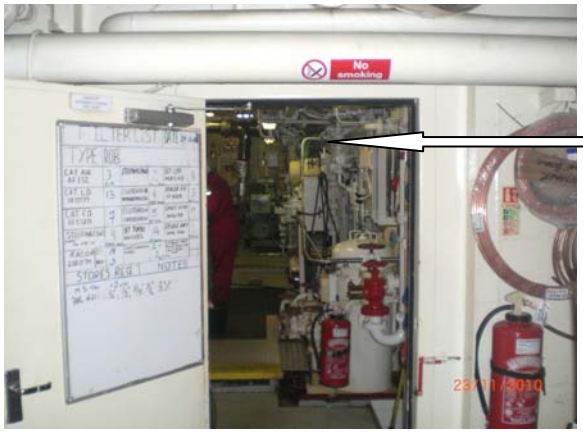
An Engineer decided he needed to try and unblock a small section of pipe work within the vessels Anti-Foulant system using the compressed air line.

The Engineer working on the Anti-Foulant system removed a vertical section of pipe from a 'T' junction which was approximately 6 feet from the deck plates and covered the exposed pipe with a rag, which was tie wrapped in place; this was located adjacent to the doorway leading from the Cement room to the Engine room.

The compressed air line was attached to the pipe work in a position where the detached pipe was not visible, this meant that the Engineer who would be operating the in-line valve to regulate the air pressure being blown through the pipe, would not be able to see where the blockage remnants would be expelled due to the position of 2 workbenches. At this point, barriers or barrier tape should have been put in place to prevent anyone entering the area.

Position of the doorway between Cement room and Engine room.

Location of removed vertical pipe.



The view the IP had as he walked through the Cement room / Engine room doorway. (The detached vertical pipe is located through the doorway and immediately to the left)

The Engineer then opened the valve slightly to allow the air to flow through the pipe work, at exactly the same time the IP walked through the doorway from the Cement room to the Engine room as the blockage was expelled, pushing off the tie wrapped rag where some of the spray and debris hit him on the left side of the forehead. The residue of the Anti-Foulant chemical which was blown out, ran down the IP's face and entered his left eye. The IP was treated with several Saline eye washes, whilst arrangements were made for his transfer ashore to have his eye checked by a Specialist.

Findings / Lessons learnt

- A Permit to Work had not been opened by the Engineer to control the Use of Compressed Air and Use of Chemicals.
- As the Engineer could not see either the location of the removed pipe or anybody approaching the doorway adjacent to it due to the 2 workbenches, it was found that this job should have been deemed a 2 man job rather than a 1 person job.
- The Risk Assessment did not include the use of barriers or tape.