



SHIP'S SAFETY BULLETIN

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THE OFFICIAL SAFETY NEWSLETTER OF THE SURFACE COMMUNITY

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The Naval Safety Command's Surface Fleet Assessment Team has subject matter experts in Auxiliaries, Combat Systems, Damage Control, Deck, Electrical, Main Propulsion, SOH, Safety Administration and Weapons.

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The SSB is intended to advise DON personnel of current and emerging safety concerns to enhance their professional development and improve operational readiness. All photos are U.S. Navy unless otherwise noted. Current and past issues are available at <https://intelshare.intelink.gov/sites/nsc/>.

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An example of improper installation, maintenance and construction of lifeline chains.

Stop the chain of mishaps

Adhere to rules on stanchions, guard lines, etc.

By Senior Chief Gunner's Mate Paul Fahrenbach

Every day you step aboard a naval vessel, your life is at risk. However, the Navy puts risk mitigations in place to reduce hazards. One of those mitigations is placing life rail stanchions and chains around openings considered potential fall hazards in order to protect Sailors. However, during recent local area assessments, Naval Safety Command (NAVSAFECOM) continued to witness stanchions, chains, snap hooks, etc., incorrectly used or maintained. Kevlar lifelines, synthetic and chain lifelines and guard lines are one of the single most important and overlooked safety elements aboard ships.

Many Sailors' daily job activities require them to enter vertical trunks, be on platforms, traverse ladders or work topside. All of these areas have some sort of fall protection equipment in place to prevent personnel from falling. While assessing commands around the fleet in 2022, 62 of 87 commands had multiple discrepancies relating to safety chains, lines, rails and safety nets. As about one-third of reported mishaps are slips, trips and falls, our Sailors are finding out the hard way that these preventive measures are not being followed correctly.

Safety guard installation, maintenance and guidance is spelled out in references (a) through (e). Routinely observed noncompliance with guard lines, such as chains, Kevlar and synthetic lines include the following: guard lines not installed at all or installed improperly, wrong fittings, excessive corrosion and incomplete maintenance

checks. Each instance of noncompliance adds unnecessary risk; yet, each of them are well within the ship's capability to self-assess and self-correct.

The best way to mitigate potential falling mishaps is to walk your ship and verify all lifelines and guard lines are in compliance and maintained per references (c) through (e) at a minimum. NAVSAFECOM also recommends the following:

- Ensure lifelines and life rails are installed parallel to the deck along deck edges and walkways, around open hatches, elevator openings and antenna platforms. They should also be installed along other boundaries wherever there is danger of personnel falling overboard, falling to lower levels in the ship or becoming enmeshed with hazardous operating machinery.
- Review requirements for constructing lifelines, chains and guards to ensure compliance with Naval Sea Systems Command drawings and NSTM 600, such as two-course-high life rail systems being spaced 21 inches on centers from the deck or three-course-high life rail systems for heavy traffic areas being spaced 14 inches. Unguarded openings shall be kept to a minimum, no greater than 5 inches of opening gap and not exceed 72 inches in length.
- Reiterate to all Sailors at least monthly the importance

See Chains, page 3

Don't get 'amped up' over energized, critical work

By Senior Chief Electrician's Mate Jarrod Becker

Naval Safety Command (NAVSAFECOM) local area assessments have uncovered a common misconception about exceptions for critical equipment as it relates to pulling fuses on energized equipment, per NSTM 300, paragraph 2.5.3.4. The commanding officer's designation of any equipment as critical (some ships may have an approved critical fuse list) is by itself not authorization to pull a fuse on an energized circuit. Rather, it is merely identifying that equipment as "necessary for safe ship's operation or performance of ship's mission."

Furthermore, per NSTM 300, "the approval of a critical equipment list is not permission to perform energized work. Permission to perform energized work shall be explicitly obtained prior to each evolution." The policy could not be any clearer. If the circuit is over 30 volts and still energized, unless you are just pulling a dead-front fuse (NSTM 300, paragraph 2.5.3.5), you must have the commanding officer's permission to work on the circuit.

Commands should self-monitor their internal process for pulling fuses. A large percentage of equipment requires fuses to be pulled before being properly tagged out for maintenance. It is easy to simply open a fuse panel, reach in and pull the fuses with a fuse puller. It is also wrong, whether it is critical equipment or on the critical fuse list. It is crucial to ensure the workforce understands the need for explicit permission to conduct energized work and all the other precautions required by NSTM 300. Otherwise, you might find yourself on the receiving end of a shocking experience.

Remember to follow the proper procedures and obtain the necessary permissions before working on critical equipment or conducting energized work. After all, we wouldn't want anyone to get "amped up" over a simple misunderstanding.

Reference: S9086-KC-STM-010/300 NSTM 300, Electric Plant - General

Chains

Continued from page 2

of reinstalling chains and synthetic lifelines that are removed to access areas where personnel are in danger of falling to a lower level. Remember, lost workdays due to the negligence of one Sailor equals increased workloads for others.

As you construct synthetic lifelines and guard lines, always refer back to the NSTM 600 and GSO 612 for proper construction. *Do not* rely on tribal knowledge and the infamous phrase, "This is how we always do it."

Synthetic lines must be made of 5/8-inch line with a 5/16-inch anchor shackle and a 4 5/8-inch snap hook with a weight test of 5,000 pounds. The length of line should be no more than 6 feet, with no more than 3/4-inch slack per linear foot. This will allow the proper catenary or slack for removing the snap hook when required.

References:

- OPNAVINST 5100.19F, Section C, Chapter 2
- OPNAV M-5100.23
- Naval Ships' Technical Manual (NSTM) 600, Volume 3
- General Specifications for Overhaul of Surface Ships (GSO) 612
- Planned Maintenance System, Maintenance Index Page (MIP) 6121



Above: NSN Snap Hook: 5340-01-446-9461; Connecting Link: 4030-00-282-4885.



Above, left: Additional examples of improper installation, maintenance and construction of lifeline chains.

Not your typical fall protection

Slips, trips and falls comprise majority of non aloft-related mishaps

By Senior Chief Boatswain's Mate James Wallen

Talk with any Sailor about the hazards mitigated by a ship's fall protection program and most will be able to draw an immediate connection to working aloft. A fewer number will connect the dots with working at height, and still fewer will associate the hazards with falls from simply walking around the ship, including ascending and descending inclined and vertical ladders.

Based on data pulled from the Risk Management Information safety reporting system since 2017, the Navy has had four fatal falls. Only one of those fatalities was from working aloft. Our fall protection programs are very effective in keeping Sailors safe when conducting traditional aloft work. However, more than 80% of fall mishaps stem from slips, trips and falls not associated with working aloft.

How big of a problem is this?

There have been 657 mishaps since 2017 – that's roughly one slip, trip or fall every 3.3 days. This doesn't include the near-miss incidents where the only injury is a bruised ego from slipping in front of your shipmates. These injuries include dislocated shoulders, sprained ankles and knees, broken legs, and even death. Slip, trip and fall mishaps are roughly equivalent to \$30 million in lost Sailor productivity.

- Falls from brows: 21
- Falls from unguarded edges: 44
- Falls from vertical ladders: 52
- Falls from inclined ladders: 540

These types of mishaps are not discriminatory. The data shows that even those thought to be seasoned Sailors are affected. The causal factors associated with mishaps include:

- **Inadequate real-time risk assessment.** Sailors are misjudging their capabilities with traversing ladders, brows and vertical ladders.
- **Not paying attention or being complacent.** The mundane and routine task of traversing a ladder creates a false sense of security.
- **Rushing or delaying a necessary action.** We've all seen it – Sailors sliding down or running up or down the ladder.

Recommendations

- Enforce the standards of reference (a), Section C, Chapter 1. Always keep one hand on the handrail

and do not carry loads that obstruct movement or sight.

- Reference (b) identifies ladders as items to inspect during zone inspections.



Machinist Mate 1st Class Richard Terry II climbs up a ladder in the main engine room of USS Paul Ignatius (DDG 117), Aug. 5, 2022. (Photo by Mass Communication Specialist 2nd Class Aaron Lau)

- Recommend that ladder wells and vertical ladders be emphasized during training for conducting zone inspections. Specifically look for degraded ladder treads and missing or loose hardware.
- Reference (c) and MIP 6200 MRC A-1 can be used to replace zone inspection of spaces for one of the quarterly inspections. Recommend spaces that have ladder wells or vertical ladders still be inspected for these common hazards during zone inspections.
- Verify damage control petty officer periodic maintenance is being completed as required and ladders are within the parameters of MIP 6641/003 MRCs 18M-4R, 18M-5R and 18M-6R.
- Use the 72-hour egress training requirement as a forum to train on the unique hazards associated with traversing ladder wells.
- Consider adding a section to your annual safety stand-downs to discuss safety involved with these mishaps. Safety officers have the capability to compile the data for your unit. That data can be used to highlight the frequency of mishaps.

The goal is to bring these hazards to the forefront, learn from previous mishaps and ultimately eliminate mishaps by elevating awareness across the fleet. Our overall health and safety is a byproduct of good risk management and helps keep us safe to operate.

References: a) OPNAVINST 5100.19F, b) CNSL/CNSPINST 3120.1, c) Periodic Maintenance System.



USS Tripoli (LHA 7) transfers fuel to USS Paul Hamilton (DDG 60) in the Pacific Ocean, Feb. 23, 2022. (Photo by Mass Communication Specialist 3rd Class Christopher Sybert)

EOSS noncompliance observed on many ships

By Chief Warrant Officer 3 Angel De La Cruz

During recent assessments, Naval Safety Command (NAVSAFECOM) observed non-compliance with the Fuel Oil Quality Management Program on multiple ships. Specifically, ships neglected to perform Engineering Operating Sequencing System (EOSS) procedure Fuel Oil Checklist (FOCL) before conducting refueling/defueling evolutions.

Strict adherence to the EOSS cannot be emphasized enough. EOSS procedures are a primary control to prevent damage to equipment and injury or death of a Sailor. The FOCL is a proven method of preventing fuel spills, and yet, over the last 20 years, surface ships have averaged one significant fuel spill a year that could have been prevented if the command had simply followed the approved procedure.

When conducting a fueling/de-fueling evolution, leadership must ensure all watch standers understand their duties and responsibilities. When questioned by NAVSAFECOM during a ship assessment, two watchstanders did not understand their role or what they were looking for as an overflow watch while the ship was refueling. Do not just have the chief engineer or main propulsion assistant read PowerPoint slides for a brief. The brief is an important step in not just receiving authorization to perform the mission, but just as importantly to ensure all team members understand the totality of the evolution and their part in making it a

success. Are your briefs a check in the block or are they an enabler to excellence?

Recommendations

It takes teamwork to make a fueling/de-fueling evolution successful. All hands involved need to understand their duties and be vigilant during the evolution. Sailors must have a questioning attitude to ensure they completely understand the duties, responsibilities and procedures that must be followed.

- Use reference (c) to assess the health of your command's Fuel Oil Quality Management (FOQM) Program quarterly or as often as necessary. Updated ASA check sheets can be found on the Flankspeed sharepoint for SURFLANT-HQ/ATG toolbox.
- When preparing for any evolution, ensure the brief portion of the PBED process lends itself an informative team discussion that will inspire confidence in the performance of all watchstanders.
- As stated in the Engineering User Guide, strictly adhere to the EOSS. Locally generated refueling procedures must include the entire FOCL.

When was the last time you validated your local procedures?

References: a) OPNAVINST 5100.19F, Section C, Chapter C10, Shipboard Fuels; b) Engineering Operating Sequencing System and c) Afloat Training Group Self-Assessment Check Sheet.

Follow procedures for active alarms and alarms in Cut-Out

By Senior Chief Electronics Technician
Brian McNally

During local area assessments conducted in 2022 and 2023, 38 of the 60 afloat commands assessed had active alarms or alarms in Cut-Out without proper permission and no appropriate corrective action. Per reference (a), the following requires commanding officer and engineering officer approval: "Placing any alarm or safety device in a Cut-Out status, with the exception for PMS. If an alarm is placed in any condition or position that renders it inoperative, it is considered to be in Cut-Out." This process ensures shipboard watchstanders immediately recognize when an abnormal condition exists and can respond promptly.

Recommendations

- Alarm monitoring and reporting is an all-hands effort to maintain deck plate compliance. Assuming an active alarm is a false alarm or that someone is already investigating could lead to a casualty that could have been averted or minimized had prompt action been taken.
- Proper communication between watch stations, particularly between engineer officer of the watch and combat systems officer of the watch, is paramount.
- Using eight o'clock reports to document active alarms

will bring greater awareness across the command and ensure proper prioritization is given.

Recommendations

- Establish a culture to report every alarm up the appropriate chain of command and investigate each one. If an alarm is found to be erroneous, document in the current ship's maintenance report and eight o'clock reports and track corrective action to completion.
- For any alarm that needs to be placed into Cut-Out, get permission from the commanding officer and file at the appropriate watch station, i.e., damage control central and combat system maintenance central. Implement temporary standing orders for personnel working in affected spaces to minimize risks.

Leadership should know alarm state conditions and tour control watch stations with a questioning attitude regarding program compliance.

Reference: COMNAVSURFPAC/
COMNAVSURFLANTINST 3540.3B, Chapter 3,
Section 3, Commanding Officer and Engineer Officer
Approval Requirements.

Boatswain's Mate 3rd Class
Jeremiah Walton tests the
ship's alarms on the bridge of
USS Harry S. Truman
(CVN 75), May 15, 2022.
(Photo by Mass Communication
Specialist Seaman
Anthony Robledo)



Follow RM principles during high-risk training

By Senior Chief Fire Controlman Dan Allred

In the last decade, the Navy reported 39 injuries as a result of anti-terrorism and force protection training. Of those injuries, five occurred during drills, eight happened while practicing baton strikes and mock takedowns and 26 occurred while “practice-fighting” during the Ship’s Reaction Force-Basic (SRF-B) course. Some of the injuries included: fractured legs, fractured hands, concussions and shoulder and knee injuries.

While it is true that SRF-B is high-risk training due to the risk of injury associated with it, most, if not all of these injuries could have been prevented by applying risk management (RM) principles. According to reference (a) planning and executing high-risk training will incorporate RM program elements and principles. While the goal is zero mishaps in training, it is understood that mitigating all risk can reduce training value. This, however, does not relieve instructors and safety observers of their responsibility to provide a safe training environment.

Overzealous students as well as other training participants appear to be the leading cause of injuries occurring during SRF-B. Reference (b) stresses the importance of using the “light hands” concept when performing training elements that require physical contact. The “light hands” concept is defined as using less than 100% force, using only enough force to maintain the hold or properly execute a technique, and ensuring students don’t apply so much force as to hurt each other.

Many of the injuries were reported as a result of tackling, kicking or striking with enough force to fracture and break bones. Other injuries were sustained from unmitigated hazards in the training area, such as chairs and sandbags, or from running through shipboard passageways. Each of these would have been preventable by applying RM principles and conducting an appropriate risk assessment per reference (b).

There are many factors and considerations that must be taken into account when conducting any form of contact-related training. The following guidelines and procedures must be complied with to ensure a reasonable safe training environment:

- Comply with the “light hands” concept. Instructors and safety observers must be engaged and involved in all aspects of high-risk training to ensure students are not unnecessarily injured due to excessive force in the training environment. Only the force necessary to properly demonstrate a

Conduct a deliberate risk assessment before participating in high-risk training events

technique should be applied. Other participants should also be reminded to use only the force necessary to provide a realistic and practical training environment.

Comply with JITTS, an acronym for:

- Jewelry - Ensure students remove all jewelry before conducting contact-related training.
- Injuries - Identify students with existing or previous injuries that may be aggravated by performing the training techniques and make sure other participants know to avoid unnecessary stress on injured body parts.
- Tap-out rule - Students should be reminded and encouraged to “tap out” if they are feeling excessive pain or pressure due to a technique being performed.
- Training area - Students and instructors should inspect the training area to ensure it is free from objects or obstacles that may cause harm.
- Stretching - Stretching pertinent muscle groups before physical contact training will reduce the possibility of muscle injuries.

Use the crawl, walk, run methodology to avoid injuries caused by improper technique execution. It is imperative instructors progress slowly to ensure trainee understanding before advancing the pace of application. Conduct a deliberate risk assessment before participating in high-risk training events as required by references (b) and (c).

References:

- a. OPNAVINST 1500.75D, “Policy and Governance for Conducting High-Risk Training”
- b. Navy Security Force Sentry (A-830-2216C) Instructor Guide
- c. OPNAVINST 3500.39D, “Operational Risk Management”

Keep eye on sight protection guidelines

By Senior Chief Hospital Corpsman
Jennifer Nolen

The Sight Conservation Program is a key component to everyday life aboard naval vessels. As the Naval Safety Command conducted local area assessments at Naval Station Mayport, Florida, in Hawaii, Pacific Northwest and onboard Naval Station Norfolk, Virginia, there were no less than 68 instances where proper sight protection was not adhered to or the program was ineffective.

Many may think of sight conservation as it relates to eyewash stations; however, there are other aspects to consider. Imagine working with a drill, grinder, sand blaster or even a welding tool, and dust or debris gets in your eye because you are not wearing approved eye protection or using designed equipment shields and shrouds.

OPNAVINST 5100.19 Series directs the requirement of each commanding officer to establish Sight Conservation Programs for afloat units. Per 5100.19, the safety officer must do the following:

- Evaluate areas, processes and equipment for sight hazards. Determine appropriate sight protection equipment per the industrial hygiene (IH) survey.
- Conduct training during command indoctrination and annually thereafter.
- Evaluate the effectiveness of the program annually.
- Ensure safety eyewear obtained meets American National Standards Institute (ANSI) test requirements.

All safety glasses, chipper goggles, welding goggles, chemical goggles and face shields must be approved by the ANSI and are allowed to be issued. All eyewear must be labeled “Z87” or “Z87+.”

Eye protection is mandated when directed by the IH survey or the planned maintenance system.

Recommendations

- Conduct initial training during command indoctrination on when and where to wear eye protection.
- Conduct annual refresher training during safety stand-downs.

- 5100.19 will assist units with ensuring sight conservation areas are marked properly.

References: ANSI Z87.1-2015 and ANSI Z358.1-2014.

Beware heat stress in port

By Senior Chief Gas Turbine Systems
Technician Casey Barnes

Heat stress is often discussed during training and safety awareness events throughout the naval enterprise. When we think of heat stress, we often think of being underway and operating in hot conditions.

But what about in port?

As we operate in the warmer season, physical exertion activities, such as repairing equipment and loading or off-loading ammo, tools or equipment will place our bodies in a heat stress condition. This condition can be met while you are outdoors or within the skin of the ship. Over the past three years, 48% of heat-related injuries have resulted directly from the activities listed above. Sailors failing to recognize the task at hand and their own physiological state are a recipe for a casualty.

Any time you conduct strenuous tasks that are physically demanding, whether inside or outside, take the time to assess whether a heat stress survey is warranted. Heavy work is the least favorable, coming in at physiological heat exposure limit (PHEL) curve VI. Ensure controls are implemented to mitigate the risk of a heat stress casualty. Ensure Sailors are physically prepared.

Heavy work is sometimes unplanned and Sailors may not have been given the opportunity to eat or hydrate as appropriate. Hard controls are artificial or natural ventilation, available water, cool-down periods and the cycling of personnel.

Personnel conducting heavy repairs or other strenuous work must have their stay time determined by using PHEL curve VI guidance, per OPNAVINST 5100.19F.

RIB ops require training, safety emphasis

By Lt. Cmdr. J. Ray Norris

In the past, we have experienced significant mishaps while conducting small-boat operations, ranging from high-speed impacts to man overboard. The aftermath of these aforementioned mishaps have resulted in the loss of assets, injury to personnel and loss of life. The following information will enhance the level of knowledge regarding the safety and operational requirements for rigid inflatable boats (RIB) with an emphasis on shipboard operations.

Training and Qualification

NAVEDTRA 43152-M Watch Stations 302 (7MRB) and 303 (11MRB) identify the Seven-Meter RIB Coxswain Course (CIN: K-062-0625) as a required course before Sailors obtain their final qualification as a coxswain. Graduating from this course alone does not automatically qualify the Sailor as a coxswain; the Sailor is still required to complete the related personnel qualification standards aboard their ship and if deemed ready, may be qualified by the commanding officer.

In addition to the 7MRB coxswain course, there is now an 11M RIB Coxswain Course (CIN: K-062-0626) available in Mayport, Florida (CDP 24KW); Joint Expeditionary Base Little Creek-Fort Story, Virginia, (CDP 24KX) and San Diego (CDP 24KY).

Operations

The most common employment of the 7M RIB is in that of search and rescue (SAR) and visit board search and seizure (VBSS) operations. It is critical that forces are familiar with the operating limits and requirements while executing these missions using their small boats.

According to NSTM 583, paragraph 4.1.3, the maximum carrying capacity for VBSS/MIO is 2,970 pounds, which includes fuel and hoisting equipment.

Additionally, NSTM 583, paragraph 4.1.3.3 states the maximum number of personnel during launch and recovery shall not exceed five. The boat shall be launched with a boat crew consisting of four personnel, allowing space in the RIB for the rescued individual to be recovered by the boat davit. The boat crew should be comprised of:

1. Coxswain
2. Bow hook/SAR swimmer

3. Stern hook/engineer
4. Boat officer
5. Rescued individual

Note: One item to consider is that during a SAR recovery, the SAR swimmer should not have any other responsibilities in the boat aside from providing aid to the recovered individual. NTTP 3-50.1, Figure 2.2 identifies the boat officer as the bow hook while conducting a man overboard recovery.

The rated capacity of an RIB is based off of normal weather in sheltered waters. According to NSTM 583, Paragraph 4.1.6, always reduce capacity in extreme weather or open seas. Small boats are able to operate safely in Pierson-Moskowitz sea spectrum state of three and survive in a state of four.

Below are some operating precautions and guidelines according to OPNAVINST 5100.19:

- a. Never engage a crank when the hoisting motor is engaged.
- b. Inspect all equipment before use.
- c. Conduct a safety brief prior to all evolutions. Ensure boat riders wear inherently buoyant life preservers with hard hats and chin straps.
- d. Conduct a pre-mission boat inspection.
- e. Keep all nonessential personnel clear of the area.
- f. Post a Davit Winch Watcher equipped with a whistle.
- g. Always check the sea painter during the morning boat report and prior to launching the RIB.

Recommendations

- Shipboard personnel familiarize themselves with all references and requirements regarding small boat operations and conduct training to the same.
- Contact the afloat safety directorate of the Naval Safety Command at NAVSAFECEN_CODE30_AFLOAT@navy.mil for assistance or any questions related to small boat operations.

References:

- a. NSTM 583 Vol I & II
- b. OPNAVINST 3120.32
- c. NTTP 3-50.1
- d. OPNAVINST 5100.19



Fall Protection during availabilities

By Lt. Cmdr. Gary Ullrich

Availabilities present unique challenges for fall hazard protection. With scaffolding staged at various locations around the ship, open deck hatches used for access or temporary services and various entities outside of ship's force personnel conducting work on board, the scope of the fall protection program grows significantly.

Using the Department of the Navy Fall Protection Guide, OPNAVINST 5100.19F and recently collected data from Naval Safety Command local area assessments, we will discuss keys to fall protection success during your next availability and some recent data on common issues seen in the fleet.

If you are a fall protection program manager or a competent person (CP) for your ship, you can better prepare for an upcoming availability by communicating with your ship's maintenance management officer (SMMO) and becoming aware of any items in the work package requiring scaffolding, platforms or aerial lifts during the availability, including requirements for open accesses for extended periods of time.

Remember, per OPNAVINST 5100.19F (B13-4), with the exception of shipyard personnel during an availability, the commanding officer is responsible for providing fall protection to embarked Navy civilians and military personnel exposed to fall hazards on any elevated walking working surface with unprotected sides, edges or floor openings, from which there is a possibility of falling 5 feet or more to a lower level; or where there is a possibility of a fall from any height onto dangerous equipment, into a hazardous environment or onto an impalement hazard.

Before the availability, identify the CP at the Regional

Maintenance Activity (RMA) or shipyard that will be conducting the availability. The CP is key for you as the ship's fall protection representative to identify and solve issues as they arise. The RMA CP must conduct daily fall protection walkthroughs before the day's work begins, verifying and signing daily inspection tags on rigged scaffolding structures, ensuring open accesses and hatches have proper safety devices in place to prevent falling and that no unguarded edges exist. As the ship's CP, you must conduct these walkthroughs as well, so coordinate early with your RMA counterpart and bring any discrepancies to the daily safety meeting or directly to the ship or RMA safety representative.

Finally, find opportunities to discuss availability-specific fall protection safety with the crew. Availabilities are an unusual and fluid environment and Sailors must be aware of the hazards they may encounter and how to get them corrected. Do not assume that everyone onboard is knowledgeable about the myriad fall protection hazards that may present themselves.

The fall protection program is vital to shipboard safety and even more so in an industrial environment.

- Engage with your SMMO early to identify job tasks that will require fall protection, such as scaffolding, open hatches and unguarded edges.
- Get to know the RMA CP and engage with them often, conduct daily walkthroughs and ensure ship personnel and contractors comply with fall protection requirements.
- Provide training to the crew on the specific hazards that may be encountered while in the availability and who and how to report them.

PPE non-use cited in 114 mishaps

By Senior Chief Operations Specialist Luke McKenzie

There is an ongoing trend of personal protective equipment (PPE) noncompliance throughout the naval enterprise. Naval Safety Command has assessed 84 afloat units during seven local area assessments and found more than 70 PPE-related discrepancies. In fiscal 2022, there were 114 reported mishaps where PPE noncompliance was cited as a causal factor.

The best way to protect personnel from exposure to workplace hazards is to eliminate the hazard. When elimination or engineering controls are not feasible or are unable to reduce the hazard to acceptable levels, PPE must be used. PPE does not eliminate the hazard itself; rather, it establishes a "last line of defense" against exposure to hazards. In some cases, PPE may be the only means of protection.

Navy policy requires activities provide, use and maintain PPE when deemed necessary and that such use will lessen the likelihood of injuries or illnesses. Whether caused by misuse or improper maintenance, PPE can become ineffective without the wearer realizing it, thereby creating potentially serious consequences. For this reason, an accurate hazard assessment, proper equipment selection, storage, maintenance, training – including equipment

limitations and mandatory enforcement of equipment use are key elements of an effective safety program.


Commanding officers should ensure sufficient PPE is aboard to meet the crew's needs and adequate funding is provided to obtain or replace missing or worn-out PPE.

Additionally, safety officers and supervisors should ensure PPE use is monitored for required work or in required spaces as well as being worn properly and effectively with selection based on workplace evaluation and recommendations contained in the industrial hygiene survey, NSTM, HMUG and MRCs.

All hands should ensure they wear or use the required PPE to perform assigned work in a proper manner. If the required PPE is not available for the assigned work or if instruction is needed on how to wear or use the equipment, the affected person must notify their supervisor immediately.

References:

- a. OPNAV-M 5100.23 CH-1, Chapter 20, Navy Safety and Occupational Health Manual
- b. OPNAVINST 5100.19F, Section B, Chapter 12, Navy Safety and Occupational Health Manual for Forces Afloat



Aviation Boatswain's Mate (Handling) Airman Titus Lathan performs preservation work in the hangar bay aboard USS Ronald Reagan (CVN 76), while in port at Commander, Fleet Activities Yokosuka, Jan. 9, 2023. (Photo by Mass Communication Specialist 3rd Class Daniel G. Providakes)



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Check out our resources and publications: *Approach* and *MECH* magazines; surface and aviation safety newsletters; Safety Awareness Division (formerly Lessons Learned) products and more!

The Naval Safety Command, located on Naval Station Norfolk, Virginia, provides resources and guidance to develop a Navy safety culture in which everyone is trained and motivated to manage risk, and to ensure the combat readiness of our forces and the Navy's global warfighting abilities.

We provide policy, doctrine and guidance; safety surveys and assessment visits, training and education, multimedia products, marketing and outreach campaigns, and recognition and awards programs.

Our magazines, current and archived, can be found at <https://issuu.com/navalsafetycommand/stacks>

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