



LOSS OF LIFE WHILE CHANGING PISTON

Vessel at anchorage and engineers were planning to decarb a unit by removing the piston. Job kick started in the morning as planned and without any issues the Piston and stuffing box was removed. By noon, the job of reinstallation was underway. Onboard team was using Piston lifting tool. The lifting tool has two stationary claws and one adjustable claw. The claws sit in the piston lifting grooves on top of the piston. An engineer, stationed at upper platform, was in charge of lowering the piston using the Engine room crane. Two oilers were assisting the Engineer. Another Engineer, inside the crankcase along with the technician and another oiler, was responsible for placing the stuffing box into position. Both Engineers, belong to one nationality, holding the radio and interacting in their native language. Chief Engineer was standing out and was supervising the entire operation without the VHF radio. Once the stuffing box was stowed at the position, chief engineer instructed all other Engineers to come out from the crankcase. All other personnel came out, except an oiler. Chief Engineer without noticing one person inside the crankcase, instructed to turn the Engine using turning gear. Engineer handling the piston lifting tool, dropped the piston inside the crankcase. A loud noise was heard. Oiler inside the crankcase found unconscious and was given medical aid. Unfortunately, on the way to hospital the oiler declared deceased.

Probing the Incident:

On probing, it was found that no proper planning or meeting held to discuss the overhaul procedures.

Also, the Engine maker instructions was not followed as per maker's manual.



Furthermore, mode of communication between the Engineers was not the common official Language. Chief engineer, who was leading the operations was not using a VHF radio.

Key takeaway:

1. Before a major operation to be carried out a proper discussion to held in the tool box meeting. Also, the procedure as per maker manual to be adopted.
2. A risk assessment, to identify the hazards, of all the operation to be done before carrying out the operation. Comprehensive checklist to be followed to avoid any flaws.
3. Mode of communication followed should be the official language already established onboard. All the crew members should be furnished with appropriate communication device onboard.

To understand in brief reg the above case study please write to newsbite@tribocare.com / info@tribocare.com.

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