

DEPARTMENT OF THE NAVY  
MILITARY SEA TRANSPORTATION SERVICE, PACIFIC  
N.S.C., OAKLAND, CALIFORNIA 94625

P-25  
5 July 1968

From: Acting Chairman, Military Sea Transportation Service, Pacific  
Safety Council

To: Commander, Military Sea Transportation Service, Pacific

Subj: Command Safety Council Meeting; report of

Ref: (a) COMSTSPAC Staff Inst. 5100.1B

Encl: (1) Brief description of disabling work injuries

1. Pursuant to reference (a), the Command Safety Council met at 0930 on 21 June 1968. Members present were:

CAPT F. L. Lee, USN  
CAPT F. L. Elefante, USN  
CDR H. K. Welge, SC, USN  
LCDR L. P. Gorley, USN  
CAPT R. L. Peterson  
Mr. Gold  
Mr. C. W. Lockard

Mr. C. Caulfield

ACOS Operations, Acting Chairman  
Asst. Chief of Staff, Operations  
Supply Officer  
ACOS Administration  
Assistant Chief Inspector, Alternate  
Industrial Relations Officer  
Director, Safety Division, Advisor  
and Coordinator  
Medical Administrator, Alternate

Members absent:

CAPT T. F. Saunders, USN  
CAPT J. S. Bailey, USN  
CAPT L. B. Melson, USN  
CAPT R. B. Greenman, MC, USN

Chief of Staff  
Chief Inspector  
M&R Officer  
Medical Officer

Associate members present:

CAPT H. C. von Weien  
Mr. R. E. Corliss  
Mr. A. Shaddy

Mr. S. H. Henson

Port Captain  
Assistant to Deputy M&R Officer  
Director, Ship Liaison Division  
and Port Steward  
Marine Investigator Examiner

2. The Chairman noted that the purpose of the meeting was to consider the effectiveness of the Command Safety Program and recommend measures appropriate for improvement.

3. Mr. Lockard briefed the council on COMSTS and COMSTSPAC Safety policies and reviewed delegated responsibilities for carrying out the Command's Safety Program. Responsibility for safety rests with the Command, all levels of supervision, and the individual employee. Safety means efficient controlled operations with no

Subj: Command Safety Council Meeting; report of

accidents. All work or operations are planned and supervised. Thus, for an accident to occur, in most instances, something must have gone wrong. Responsibility for safe operations and thus for accidents which occur is primarily that of the supervisor. Each supervisor is responsible for evaluating the performance of subordinates on a continuing basis. One of the most important factors in that evaluation must be the individual's safety record since safety is an integral and essential part of every operation. Outstanding performance ratings, quality salary increases and promotions all depend, to a large degree, upon safety performance and supervisors must guard against nomination of subordinates for unwarranted meritorious awards.

#### 4. Old Business:

(a) The Sight Conservation, Hearing Conservation, and Motor Vehicle Safety Programs were reviewed and discussed. All were considered adequate. Seven minor eye injuries were reported during the quarter. All resulted from failure to use proper eye protection. Two motor vehicle accidents were reported. One, due to following too closely, was preventable. The resulting damage was \$244.00. The second accident involved a parked car and a dock crane. It was determined by the 12th Naval District Accident Review Board to be non preventable on the part of the operator. Damages amounted to \$117.75.

(b) Relocation of ammonia cylinders from the blue print room to an outside location on the loading platform on the north side of building 310 is scheduled for accomplishment in mid July by NSC Public Works. Installation of additional ventilation in the blue print room is to be taken up with the Western Division Naval Facilities Engineer Corps, San Bruno for accomplishment under Military Construction Funds in accordance with recent advice from COMSTS.

#### 5. New Business:

(a) Twenty-four disabling work injuries and ninety-two first aid injuries were reported during the quarter. Thirty-four percent of the accidents resulting in the injuries involved an unsafe condition and ninety-three percent involved an unsafe act. Thirty-six percent occurred in connection with working surfaces. Twelve of those resulted in disabling injuries. Five were due to falls and four to slips resulting in strains. Taking an unsafe position or posture accounted for fifty percent of the disabling injuries and thirty-four percent of all injuries. Thirty-seven percent of the disabling injuries and sixteen percent of all injuries were muscular strains resulting from slips, trips, and falls. Enclosure (1), a brief description of disabling injuries reported, is attached for information.

(b) Nine passengers were injured, one seriously when he fell while climbing out of a lifeboat which he entered to retrieve a volley ball.

(c) The following ships and shops had no disabling work injuries during the first quarter:

\*UPSHUR  
\*ALATNA  
\*ASTERION

\*BRETON  
\*MERRELL  
\*PETRARCA

\*MYER  
RICHFIELD  
SUNNYVALE

MICHELSON  
\*WATERTOWN  
RANGE TRACKER

Subj: Command Safety Council Meeting; report of

SHOPS: \*17, 26, \*31, \*38, \*51, \*64, \*67, and \*71.

Those marked with an asterisk (\*) had no disabling work injuries in 1968 including the USNS SWORD KNOT since 1 April 1968.

(d) Change #1 to COMSTSINST 5100.17 requires that all accidents resulting in damage to material or equipment be reported on accident report form NAVEXOS 108. Previously only those resulting in \$100.00 or more in damage were required to be reported. The purpose of the new directive is to account for all accident costs. In this connection, delays, diversions, repairs, material replacement or loss, recalibration of equipment, etc. resulting from fire, collision, breakdown, malfunctions or misuse of equipment are accident costs chargeable to the unscheduled interruption of operations. Change #1 also makes the Medical Department responsible for administering a complete sight conservation program.

(e) Numerous fires in MSTs ships undergoing repair in private ship yards recently indicate that ship's crews must be constantly alert for violation of fire prevention principles by yard workers to assure the safety of the ship, crew and other persons on board. All fires start small but if not brought under control quickly soon get out of hand. With few of the crew on hand to fight fires and reluctance on the part of shipyard operators to call the fire department immediately, prudence demands that fire prevention receive top priority. In the event of a ship fire at San Francisco Bay Area docks, the local fire department should be alerted immediately by phone call, call box alarm, or by sounding fire prolonged blasts on the ships whistle, or any combination of these methods.

#### 6. Recommendations:

That masters and heads of staff officers ashore:

(a) stress supervisory safety responsibilities and assure that subordinate supervisors are familiar with and enforce the requirement of reference (a) in matters under their cognizance.

(b) assure that subordinates with a discreditable safety record are not intentionally or inadvertently recommended for promotion or other official recognition for proficient performance.

## BRIEF DESCRIPTION OF DISABLING WORK INJURIES

1. An engine utilityman was lifting an office desk out of it's sockets. He claimed he twisted his back in the wrong position and suffered a back injury.

COMMENT: Always get assistance when lifting heavy objects. Never lift with back bent or twisted.

2. A chief cook was returning food from the galley to the reefers. While going down an inclined ladder, using both hands to carry the food, he slipped and fell to the deck below injuring his back.

COMMENT: The old saying, "One hand for the ship and one for self" applies here, especially on ladders.

3. An ordinary seaman was taking turns of line around a capstan and in doing so, twisted his back and suffered a back strain.

COMMENT: Exerting one's self while in an unnatural posture is the cause of numerous back injuries.

4. A room steward assisted by another room steward was carrying a deck polisher from one deck to another. Due to poor coordination between them, one had his right middle finger lacerated when they tried to set the machine down. He caught his finger between the machine and edge of casing on the deck. After treatment the man returned to work.

COMMENT: Minor injuries that are not properly cared for often become infected and develop into disabling injuries. This is a good example.

5. A steward utilityman claimed he "hurt" his back while carrying two cases of milk up a ladder from reefers to the crew's messroom.

COMMENT: Virtually all the safety rules were broken here.

(1) Failure to get assistance or failure to make two trips.

(2) Failure to observe a seaman's basic safety rule: one hand for the ship and one for self.

(3) Carrying a load that obstructs vision.

6. A pipefitter was standing on a pump motor that had been covered with an asbestos pad while installing a section of pipe in the overhead. The asbestos pad slipped, causing the man to fall and strike his back on the motor.

COMMENT: Using makeshift platforms or failure to obtain or erect suitable staging, is the cause of many serious injuries.

7. A wiper starting up gangway, slipped on the first step and struck his shin causing a nasty gash. Poor lighting was listed as the cause.

COMMENT: Failure to provide adequate lighting at gangways is a nautical sin and reflects unfavorably on ship's deck officers.

8. A mechanist was attempting to lift a 3/16" X 30" X 60" deck plate, approximately 90 lbs. He claims he felt a sharp pain in his back. The employee has previous history of back trouble.

COMMENT: Employees with previous history of back ailments should not be permitted to lift heavy objects. They should be instructed to get assistance or use a mechanical lifting device.

9. A messman lost his balance in moderately heavy seas and struck his back against a vertical pipe, fell to the deck striking the back of his head. The employee has previous history of back trouble.

COMMENT: Personnel on small ships should be mindful of sudden and sometimes violent motion. Try to anticipate the rolls using handrails whenever possible.

10. An AB maintenance man was carrying stores. He claims he felt a pain in his groin, but did not report the incident to his supervisor at the time. A medical officer later diagnosed the ailment as acute lumbosacral strain.

COMMENT: Lifting with back straight, using leg muscles to do the work and carrying supplies with the back in an untwisted manner will prevent lumbosacral strain.

11. A welder working on a stage, turned around, lost his balance, slipped off the edge of the stage and fell backwards to the deck spraining his back.

COMMENT: The use of a rope rail between suspension cables or a lifeline and safety belt would have prevented this accident.

12. A wiper was removing air filters in a fan room and while doing so a second filter was dislodged and struck the employee causing laceration of the face.

COMMENT: Investigation failed to reveal how or why the second filter was dislodged. Exercise more caution or request assistance.

13. A chief electrician slipped and fell when he stepped into some liquid on deck. As he fell, he extended his arm to absorb the fall which caused a fracture of his right wrist.

COMMENT: Wipe up liquids, spills or leaks whenever they occur. In addition, the source of leaks should be detected and corrected.

14. An AB seaman was removing a pin from a tank top cover. He struck the drift pin a glancing blow with a maul which struck his left index finger causing a fracture.

COMMENT: Exercise extreme care when performing jobs that are infrequently done.

15. An assistant cook was transporting trash and garbage from the galley to the fantail in an uncovered cardboard box during adverse weather. The wind blew a tin can with lid attached, which was protruding outward from the box. The sharp-edged lid struck the employee's hand causing a wide laceration.

COMMENT: Completely remove lids from cans. Carry trash in covered containers never in open receptacles on open decks.

16. An AB seaman was painting a pipe bracket. As he dipped his brush and turned to continue painting, he struck his head against an N.B.C. sprinkler tip causing laceration on forehead.

COMMENT: Exercise extreme caution when working in close quarters. This is particularly important during adverse weather conditions.

17. An engine utilityman, assisted by another employee, was lowering a shelf that had been removed from the bulkhead. Due to sweaty hands the employee dropped his end of the shelf and it fell on his foot causing laceration and bruise of the big toe, right foot.

COMMENT: Never handle heavy objects with sweaty hands. Safety shoes would surely have reduced the severity of the injury, if not prevented the injury all together.

18. An assistant cook was opening a valve to put water in a steam jacketed kettle. As he did this, steam exhausting from the boiling soup scalded his right hand.

COMMENT: Steam exhaust pipes should exhaust in a remote area not likely to burn or scald personnel working on or around the kettle.

19. An engine utilityman was using a mechanical device to lower stores down a ladder trunk from one deck to another. In doing so, one heavy item became jammed between the ladder handrail support and the bulkhead. While trying to free the item by pulling up on the rope, he felt a twitch in the lower part of his back.

COMMENT: Get assistance to guide stores down narrow ladder trunks or raise heavy items with the mechanical device. Back injuries are seldom sustained while pulling downward. They are often caused by lifting or pulling upward while in an unnatural posture.

20. A waiter bent down to pick up a bowl and felt a sharp pain in his back. He went to the sick bay and got a "pain killer" without notifying his supervisor. Next morning, while preparing for work, he fainted from the pain and fell injuring his nose and eye.

COMMENT: Never twist body in an unnatural position while bending.

21. An AB maintenanceman tripped over a deck valve on the after, port, sponson and fell spraining his left knee.

COMMENT: There is no substitute for alertness and awareness while working around necessary hazards. Extreme caution should be used while working in little used areas.

22. An engine utilityman was standing on four 3" manifold valves tightening nuts on the bilge pump steam cylinder valve. He lost his balance and fell backwards striking lower portion of his body on an 8" valve and fell to the deck.

COMMENT: Never use valve wheels as a working surface. Provide and use a firm, secure platform.

23. An engine utilityman was using a jack to replace an end piston in an auxiliary feed pump. The jack slipped. The man attempted to prevent the piston from falling. In doing so, his hand was crushed when the piston fell on it.

COMMENT: In cramped quarters where only one man can work, block heavy objects

up in proper alignment before attempting to jack them into place. Means to prevent the jack from falling should also be taken.

24. A plumber/machinist was applying test pressure of approximately 50 P.S.I. to a Griscom-Russell "Soloshell" evaporator when a leak developed around one of the glass observation ports. He positioned himself in front of the port and proceeded to tighten the threaded securing ring. The glass port ruptured and blew out into the employee's face and chest.

COMMENT: Always release pressure before attempting repairs of this nature. Stand clear while test pressure is being applied. Never exceed recommended test pressures. Recommended test pressure in this case is 30 P.S.I.

25. A boatswain was climbing a vertical ladder on the after masthouse with greasy hands. His hands slipped and he fell impaling his lower left side on a cleat.

COMMENT: Never climb ladders with greasy hands or feet.

26. An engine utilityman jumped down from a stock of pallets of about 10-12 feet high, landing on his heels, and suffered a contusion of the heel of his right foot.

COMMENT: Investigation did not reveal how the man managed to get on the pallets. Never climb on unstable platforms or jump from high places.

27. A steward utilityman was cutting carrots when the knife slipped and cut his right forefinger.

COMMENT: Keep hands and handles dry when cutting meat or vegetables. Keep wounds clean and dry to prevent infection which often causes minor injuries to become disabling.

28. A reefer engineer was checking an ice flaker machine. He inserted his left hand to feel the freezer assembly to determine if it was running hot. The worm shaft caught and amputated the tip of his ring finger, left hand.

COMMENT: Always stop equipment before inspecting or attempting any work on it. Throw switch or pull the plug and tag to insure no one else energizes it.