

# IMCA Safety Flash 01/18

January 2018

These flashes summarise key safety matters and incidents, allowing wider dissemination of lessons learnt from them. The information below has been provided in good faith by members and should be reviewed individually by recipients, who will determine its relevance to their own operations.

The effectiveness of the IMCA safety flash system depends on receiving reports from members in order to pass on information and avoid repeat incidents. Please consider adding the IMCA secretariat ([imca@imca-int.com](mailto:imca@imca-int.com)) to your internal distribution list for safety alerts and/or manually submitting information on specific incidents you consider may be relevant. All information will be anonymised or sanitised, as appropriate.

A number of other organisations issue safety flashes and similar documents which may be of interest to IMCA members. Where these are particularly relevant, these may be summarised or highlighted here. Links to known relevant websites are provided at [www.imca-int.com/links](http://www.imca-int.com/links). Additional links should be submitted to [info@imca-int.com](mailto:info@imca-int.com)

Any actions, lessons learnt, recommendations and suggestions in IMCA safety flashes are generated by the submitting organisation. IMCA safety flashes provide, in good faith, safety information for the benefit of members and do not necessarily constitute IMCA guidance, nor represent the official view of the Association or its members.

## 1 Safety Flashes – Summary of 2017

This is a summary of the safety flash incidents reported during 2017, highlighting some trends worthy of note and one or two matters of interest.

148 incidents in 32 safety flashes were published during 2017. It should be noted that all published safety incidents are now available on the IMCA website as individual web pages. Safety flashes, comprising a PDF format collation of a number of incidents (normally 5 incidents), are still circulated to members by email.

102 incidents were reported by IMCA members during 2017. The remainder of the incidents published came from government bodies, regulators and trade associations, including the Marine Safety Forum (MSF). IMCA works closely with other industry bodies and regulators to ensure that appropriate incidents are passed on and lessons learned are circulated to members.

We continue to encourage **all** IMCA members to contribute their incidents to the IMCA safety flash system. This is an important way to influence industry safety awareness by actively taking part. It is worth reminding members that IMCA will work closely with contributors to ensure the strict anonymity and appropriateness of all published safety flash material. Nothing is published without clear permission from the contributing member.

### IMCA members’ reports

Reports categorised by LTI types used in IMCA Safety Statistics	
Dropped objects	13%
Line of Fire/Caught between/Struck Against	9%
Slips and trips	5%
Falls from height	3%

### Fatalities

One fatality was reported which occurred on IMCA members’ operations. A member of an ROV crew was crushed when caught between the tether management system (TMS) and snubber ring whilst working on an on-deck ROV.

### Lost Time Injuries

12 LTIs were reported by IMCA members. These were:

- ◆ **Six** hand/finger LTIs:
  - finger injury during pilot ladder preparation
  - finger injury handling heavy shackle pin

- finger injury during main engine exhaust valve overhaul
- hand injury resulting from clothing catching on door
- hand injury when load dropped from lifting magnet
- wrist Injury when using power tool at height;
- ♦ **Two** falls from height – BOTH incidents occurred when a worker fell through a hatch on a vessel in a shipyard;
- ♦ **Two** during subsea/diving operations:
  - leg injury caused during HP water jetting
  - deadman anchor toppled over and harmed diver;
- ♦ Other:
  - slips and trips: arm broken following slip on the stairs
  - line of fire: injury to leg – unplanned movement of fire flaps.

#### Areas of work in which incidents are reported

Areas of work in which incidents are reported	
Lifting	16%
Diving	12%
Engine room	9%
Small boats/lifeboats/rescue boats	9%
Mooring	2%

#### Other significant causal factors identified:

There is some overlap as incidents can have multiple causal factors attached to them:

- ♦ Failure to follow procedures is a significant cause in around a third of reported incidents;
- ♦ Damaged equipment or failed equipment is a significant cause in around a quarter of reported incidents;
- ♦ Seamanship and/or mooring issues are a causal factor in 13% of reported incidents;
- ♦ Finger and hand injuries remain an area where members should focus their efforts, as these still form 12% of reported incidents;
- ♦ Stored energy/pressure was a causal factor in around 4% of reported incidents.

## 2 The 2017 Safety Flashes

A full list of the safety flash incidents of 2017 – including those from other organisations which IMCA has passed on to members is available at <https://www.imca-int.com/alerts/downloads/safety-flash/17/>.

## 3 A Summary of Safety Flash Incidents Not Otherwise Published in 2017

IMCA is grateful for all submissions of safety incidents for inclusion in safety flashes. During 2017, a number of incidents received by IMCA from members were not been published as safety flashes. A summary of these, as far as is appropriate, is included here.

- ♦ 75% of the incidents were not published as having insufficient lessons learned or impact value to members, through lack of information supplied, lack of photographs or images, or lack of appropriate conclusions.
- ♦ 16% of the incidents not published were because there was no approval response from the submitting IMCA member after several attempts over eight weeks.

- ◆ Two incidents were not published because the submitting IMCA member opted to withhold permission to publish owing to changing local circumstances. These are omitted here.

The safety issues covered in the unpublished incidents are summarised here, in rough order of frequency of topic:

#### **Damaged equipment (4 incidents)**

- ◆ Towing pennant for a rig parted: equipment failure owing to wear and tear;
- ◆ Hydrostatic release unit malfunctioned on newly received life rafts following servicing;
- ◆ Split pin of gog eye shackle sheared off during rig positioning;
- ◆ Alternator bearing damaged during operations, causing some smoke.

#### **Small boats, rescue boats, lifeboats and davits (4 incidents)**

- ◆ Crewman in small boat injured during single point mooring operations in heavy seas;
- ◆ Near miss: crack discovered on buoyancy of small boat during operations;
- ◆ Emergency release mechanism on lifeboat found to be inoperative;
- ◆ During lowering of rescue boat, it tilted outward resulting in the canopy falling into the sea; it was found that the canopy was fixed to the main structure with adhesive only.

#### **Mooring or anchor handling (3 incidents)**

- ◆ Anchor lost: inspection revealed that the locking part of the swivel at the anchor end had given way;
- ◆ Use of heavily weighted “monkeys fists” prohibited as too heavy and likely to injure crew;
- ◆ During anchor handling, the chaser ring parted and the anchor dropped from the stern roller to the sea bed.

#### **Lifting operations**

- ◆ Generator frame and canopy door damaged whilst loading – poor lift plan, improper rigging, unplanned lift;
- ◆ Container snagged by installation crane.

#### **Falls from height**

- ◆ A shipyard worker stood on railings to get the job done, lost his balance and fell 5m, suffering a broken rib and hip fracture;
- ◆ Near miss/safety observation: Engineer discovered using a wooden box instead of step ladder to work at height;

#### **Slips and trips**

- ◆ Crewman injured when he slipped whilst descending stairs – sprained ankle;
- ◆ Near miss/safety observation: tripping hazard on deck due to buckled deck timber.

#### **Engine room issues**

- ◆ Lube oil leakage seen from main engine lube oil supply line. Inspection revealed that a gasket on lube oil flange had given way;
- ◆ Fine fuel spray was seen from main engine fuel oil return line. Copper gasket of the end plug had a cut on the sealing surface.

#### **Falling/dropped objects**

- ◆ A 5kg lamp tripod stand at the top of the main mast got uprooted and damaged an adjacent wind sensor before falling 10m. Cause: welds failed due to corrosion and vibration; improper inspection regime;
- ◆ Near miss: a visual inspection of containers containing radioactive substances revealed a loose bolt for the door latch mechanism. The bolt could have fallen; radioactive sources could have potentially been ejected.

### **Hot work**

- ◆ Near miss/safety observation: While vessel was inside the 500m zone (safety zone), deck crew were observed performing chipping activities on main deck's metal structures. Job stopped;
- ◆ Near miss/safety observation: metal brush grinder being used for deck cleaning with no permit to work. Crew did not realise that any task leading to sparks is categorised as Hot Work. Job stopped.

### **Electrical issues**

- ◆ Hydraulic power pack circuit breaker tripped and power shut down occurred during subsea cold cutting operations. Cable replaced;
- ◆ A semi-submersible pump caught fire after its cooling water supply was inadvertently switched off.

### **Hoses and bunkering**

- ◆ Bulk hose was drawn into the propeller and subsequently parted;

### **500m zone**

- ◆ 500m zone found to have many fishing boats in it when supply vessel was asked to approach the rig for unloading. Fishing gear caught in propeller of supply vessel.

### **Worker collapsed**

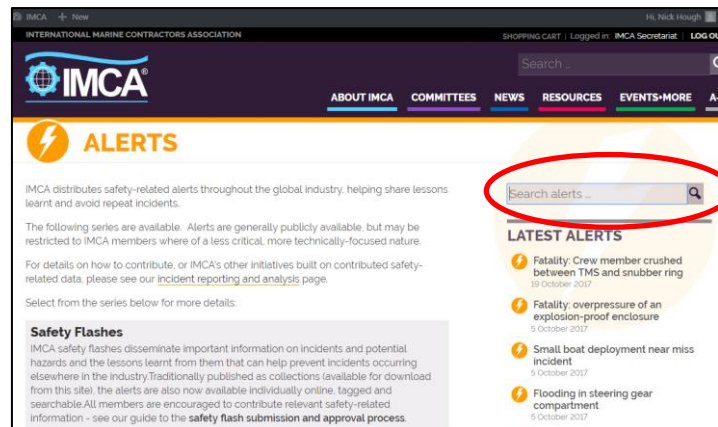
- ◆ A worker in a refinery collapsed due to high blood pressure, low blood sugar and hypertension.

### **Personal Protective Equipment (PPE)**

- ◆ Near miss/safety observation: Crewman found chipping paintwork whilst working over water without wearing a lifejacket and safety harness.

## 4 Full Search Capability

The **full text** of all IMCA safety flashes can be searched – not just the titles. Enter your text in the box at <https://www.imca-int.com/alerts/safety-flash/>



## 5 Safety Flash Rating System

IMCA is gaining feedback from readers on what is and isn't considered important, using a simple star-based feedback system – see below. Please feel free to use this functionality.

