

IMCA Safety Flash 09/19

May 2019

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) 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 Additional links should be submitted to info@imca-int.com

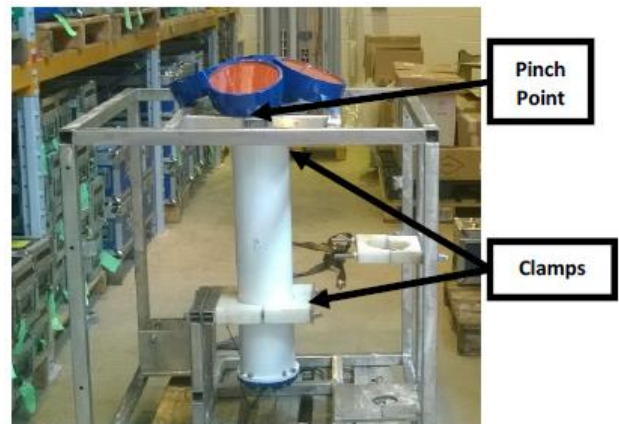
Any actions, lessons learnt, recommendations and suggestions in IMCA safety flashes are generated by the submitting organisation. IMCA safety flashes provide, in good faith, safety information for the benefit of members and do not necessarily constitute IMCA guidance, nor represent the official view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

1 Line of Fire/Pinch Point – Fractured Fingers

What happened?

A crewman suffered a pinch point injury resulting in two fractured fingers and a fingertip amputation. The incident occurred when a piece of equipment weighing 86kg was being installed by warehouse personnel into a seabed frame. The equipment was lowered into the frame using a forklift with a lifting attachment, but before the securing clamps were fully tightened, the lifting strops were removed.

It was then observed that the equipment was not aligned correctly, so it was manually turned in the frame. Whilst turning the equipment it slipped through the hand tightened clamps, crushing the injured person’s fingers between the equipment and the frame.



What went wrong? What were the causes?

Our member’s investigation found:

- ◆ There was no risk assessment or work instruction in place for this task. This was found to be the case for many of the routine tasks carried out in the warehouse/workshop;
- ◆ The warehouse team had not carried out this task before without supervision;
- ◆ There were insufficient engineering controls to prevent the incident from occurring.

What actions were taken? What lessons were learned?

- ◆ A straightforward modification to the seabed frame engineered out the pinch point. When designing equipment, it is vital that safety during installation, maintenance and transportation is considered, as well as operational safety;
- ◆ Review workshop, warehouse and yard activities to ensure that suitable risk assessments are in place and used:
 - seemingly routine activities should be adequately supervised and subject to suitable and sufficient task risk assessment; in this instance, no risk assessment or instruction was in place covering the task
 - previously the task had always been supervised by a senior engineer, but on this occasion, the workshop personnel carried it out unsupervised.

Members may wish to refer to:

- ◆ Finger Injury: Pinch Point
- ◆ Hydraulic Umbilical Winch Operation – Trapped Thumb
- ◆ Lost Time Injury (LTI): Thumb Injury

2 Rigger Sustains Injury to Left Hand

What happened?

A rigger was struck by a lever hoist hook, which led to a restricted work case. The incident occurred during lifting operations and had the potential to have resulted in a more serious outcome. Two vessels were engaged in offshore vessel to vessel lifting operations. A heavy lift crane was being used to lift and land the load – a product reel – from one vessel to another, when the load moved in an unplanned and unexpected way.

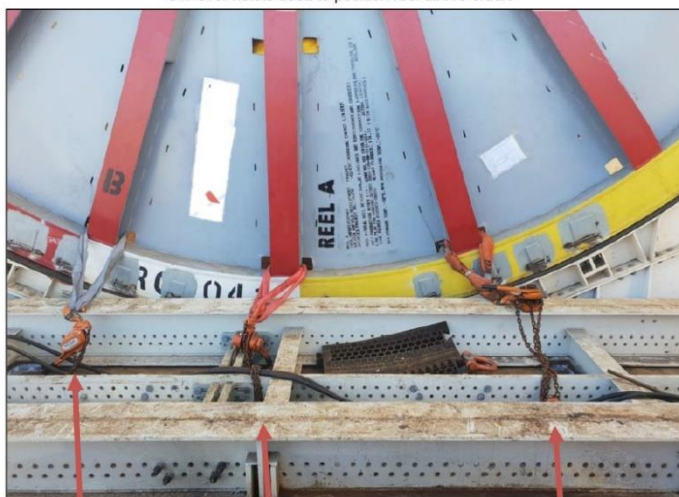
What went wrong?

- ◆ Throughout the operation, banksmen on one vessel and project riggers on the other were not communicating with each other as they were operating on different radio channels;
- ◆ To aid the landing of the reel onto the cradle, changes were made to the ballasting of the crane vessel, which altered the position of the crane boom and thus caused the load to move in an unexpected way. This ballasting operation was not communicated to the project riggers on the other vessel;
- ◆ The movement of the load happened just as the project riggers connected three 6.3Te lever hoists to the load to aid its final positioning onto a cradle;
- ◆ The reel swung approximately 1.5 metres towards the riggers. This movement caused the 3 lever hoists to lose tension and disconnect. The reel then moved back towards the port side, allowing two of the lever hoist hooks to snag and come under tension;
- ◆ The riggers realised what was happening and rushed in to disconnect the lever hoists. One lever hoist was disconnected however, tension on the second lever hoist became too great, resulting in the hook disengaging from its snagging point in an uncontrolled manner and striking the rigger on the hand.



Before unexpected movement

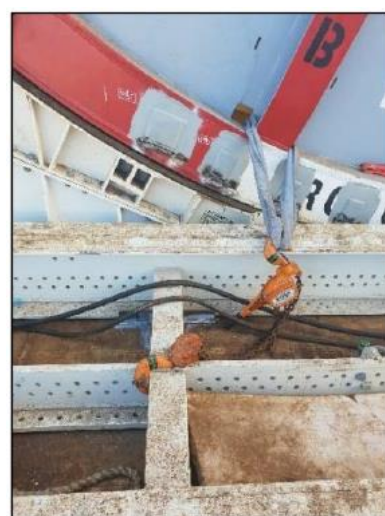
3 x lever hoists used to position reel above cradle



Snagged then released under tension causing injury to IP

Snagged but was successfully cleared by a rigger

Did not snag when reel moved back towards Port



After unexpected movement

What were the causes?

Our member notes that this incident could have resulted in a far more serious injury or a fatality. Our member considered that the decision to use lever hoists for this type of operation was flawed and dangerous.

- ◆ The introduction of the lever hoists was not identified as a change and therefore was not managed via the management of change (MoC) process;
- ◆ There was ineffective communication between the banksman on the one vessel and the rigging supervisor and riggers on the other;
- ◆ The centre of gravity of the load was offset and was not corrected;
- ◆ Procedures and lift plan were not followed;
- ◆ There was insufficient 'line of fire' toolbox talk (TBT) and risk assessment;
- ◆ Personnel may have put themselves at further risk by reacting without understanding the danger.

What lessons were learned?

- ◆ Personnel should keep clear of suspended loads until safely landed;
- ◆ Any change or deviation from procedures or lift plans, even minor, needs to be subject to a MoC process;
- ◆ Communications between all members of the lifting party is crucial and should be established before work starts;
- ◆ Load centre of gravity should be confirmed and lift rigging adjusted accordingly before lifting starts;
- ◆ Lever hoists may not be appropriate in a dynamic application during ship to ship operations and, in this case, were not used in compliance with manufacturers guidance.

Members may wish to refer to:

- ◆ [Uncontrolled movement of a riser](#)
- ◆ [Lack of safety awareness: crush injury during lifting operations](#)
- ◆ [Hand Injury](#)
- ◆ [Guidelines for lifting operations \(IMCA SEL 019\)](#)
- ◆ [Guidelines for management of change \(IMCA SEL 001\)](#)

3 Slip on Wet Surface (Marine Safety Forum)

The Marine Safety Forum (MSF) has published [Safety Alert 19-02](#), in which a crew member on bridge duty slipped on a wet area of the deck, landing on his back.

What Happened?

The vessel was standing by outside the 500-metre zone, waiting on weather, and was pitching and rolling, when the crew member slipped and fell onto his back. The crew member felt no pain immediately after the incident, travelling home as part of the rotation. Only later did he visit the local doctor, where it was confirmed symptoms corresponded with damaged ribs, which would heal naturally over time.

What were the causes?

- ◆ The spilled water came from an unsecured kettle in the utility area of the bridge;
- ◆ The water from the kettle had spilled onto the deck and was not clearly visible to the crew member as it was dark.

What actions were taken?

- ◆ The kettle was fitted with a proper securing bracket for adverse weather;

- ◆ The crewmember visited their doctor at home to be checked out;
- ◆ The incident was discussed by both shifts during safety meetings.



Unsecure Kettle



Secured Kettle

The full safety alert can be found on the [MSF website](#).

4 Unsafe Actions and Conditions – Inhibited Alarm Buttons

What happened?

On a vessel safety walk-round, an unsafe condition was found whereby alarm push buttons for acknowledgement/mute were kept pressed using toothpicks and scotch tape.

While these were not fire alarms, the principle is the same and for this reason, this incident has been included in a safety flash covering fire-related incidents.

Visual alarms, buzzers and sirens are installed and available for a reason. Timely attendance to alarms is vital to protect personnel, equipment and the vessel against major failures and incidents.

Members may wish to refer to:

- ◆ [Be Alarmed By All Alarms](#) (USCG)

