IMCA Safety Flash 11/18

June 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) 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.

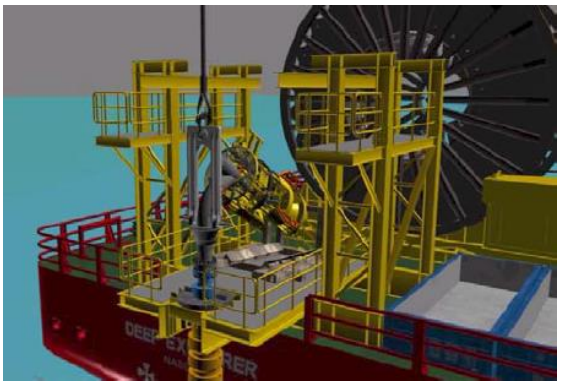
A number of other organisations issue safety flashes and similar documents which may be of interest to IMCA members. Where these are particularly relevant, these may be summarised or highlighted here. Links to known relevant websites are provided at www.imca-int.com/links Additional links should be submitted 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 Uncontrolled Movement of a Riser

What happened?

A riser moved unexpectedly away from the vessel. The incident occurred during the deployment of a production riser from a hang-off frame located starboard aft. All rigging had been connected and the crane had taken the load and slewed inboard to allow the removal of the hang-off plates and beam. A 3-tonne lever hoist was also attached to assist in this activity. The rigging team were about to remove the chain hoist (before slewing the crane outboard) when there was an unexpected sudden movement of the riser to starboard. The chain hoist parted and the riser moved clear of the hang-off platform to approximately 8m off the vessels side.



What went wrong? What were the causes?

The proposed arrangement had been risk assessed and it was noted that the riser was leading away from the vessel (this was in line with the written procedure). A decision was made to install a bellyband (soft sling) around the riser which would be connected to a lever hoist. This would be used to steady the riser to assist the riggers in the removal of the hang-off collars and beam. This rigging was arranged and secured to the riser end fittings and the process of deployment continued. The bellyband was in addition to the existing procedural requirements, but there had been no management of change (MoC) process followed for this addition.

The crane was slewed inboard to allow the removal of the beam (as per procedure). Once the hang-off collars and beam had been removed, the crane operator requested a movement outboard as he was concerned with the 3° side lead on the crane wire. The confirmation was to move the crane outboard 'just a touch'. Two personnel remained in position to remove the additional rigging. The CCTV footage showed the crane slew to the left and come to a stop. Almost immediately, the bellyband lever hoist failed. The riser suddenly moved left, bending a section of handrail on the hang off platform as it moved.

Our members' investigation concluded that the causes of the incident were a lack of risk perception and the failure to follow procedures (engineering and MoC). Key points include:

- The introduction of the bellyband rigging was not identified as a change and therefore was not managed via the MoC process;

- The effects of moving the crane jib on the riser were not considered;
- As the risk was not identified and managed via the MoC process, once the movement of the riser began, the 3-Tonne lever hoist was not sufficient to prevent the incident from occurring;
- There was ineffective communication between the rigging supervisor and the crane operator;
- It was important to ensure supervisor involvement in shift briefings and toolbox talks (TBT) and communicating relevant information which allowed personnel to understand the task (step by step) and hazards associated with each step.

What actions were taken? What lessons were learnt?

- A clear task outline should be provided so that all personnel involved understand all the steps involved;
- Instructions should be precise, accurate and free of ambiguity;
- Any change, no matter how small, should be subject to the MoC process.

Members may wish to refer to the following incidents:

- High potential stored energy incident: inner buoyancy module clamp failure during removal [involving work on a riser where changes to the work process were not subject to a Management of Change process.]
- Lost Time Injury (LTI): rigger struck by rigging under tension [in which the investigation identified the need to identify and mitigate all risks associated with a Management of Change (MoC) process.]

2 High Potential Near Miss: Worker Inadvertently Lifted by Crane (Marine Safety Forum)

What happened?

The Marine Safety Forum (MSF) have released Safety Alert 18-07, which shows that during routine operations using a platform crane to transfer a bulk hose between a platform and a platform supply vessel (PSV) a worker got caught in the rigging and was lifted off of the deck by the crane. As the hose landed on the vessel deck, an AB went to release the hook from the lifting sling. While slightly bending forward and down to clear the hook, the crotch strap of his lifejacket formed a larger than normal bight. As the AB released the hook, it was incorrectly placed inside the bight and as he returned to the upright position the hook was caught. Unfortunately, the AB did not notice this, and signalled to the crane operator to 'hoist'. This resulted in the AB being lifted above the deck and out over the side of the vessel. The AB's immediate reaction was to hold onto the pennant wire to keep tension off the crotch strap. The crane driver and second AB quickly became aware of the situation and were able to land the AB safely back on deck. The AB remained suspended for around 11 seconds and was unharmed.

What went wrong? What were the causes?

- The crotch strap on the lifejacket was not suitably tightened on this occasion. A change in body posture created a larger than normal 'bight' which allowed the hook to become attached;
- The hook and lifting sling landing directly on the deck of the vessel;
- The AB's posture during the disconnection of hook;
- A momentary lack of awareness on the actual location of the hook, i.e. left open, close to the body.

What actions were taken? What lessons were learned?

- Hook awareness - ensure hook is clear of the body and any snagging hazards;
- Buddy check during the TBT before work starts;
- Raise awareness across the fleet for all lifting operations;

- Discuss amongst the industry and fleet deck crews on a suitable “pause point” before giving signal to crane operator.

The full safety alert can be found on the Marine Safety Forum website.

Members may wish to review the following incidents relating to injuries caused by clothing being caught:

- LTI: hand injury resulting from clothing catching on door
- Near miss: drawstring on storm jacket nearly drawn into rotating equipment

They may also wish to look at the following incidents relating to snagged lifting gear:

- Near miss: snagged lifting bridle
- Lifting bridle snagged – failure to “stop the job”

3 Near Miss: Potential Dropped Objects on Temporary Buoys (TBMs)

What happened?

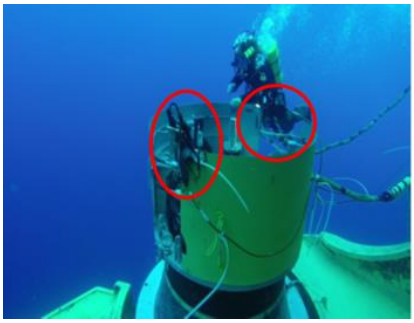
A member has reported two near miss incidents involving potential dropped objects. The objects were left on top of a temporary buoyancy module (TBM) during the installation of a tension leg platform (TLP).

In the first incident, two subsea lamps (each weighing 10kg in the air) were discovered on top of the TBM after it was retrieved back to deck. In the second incident, during an inspection of the top of a TBM, also after it was retrieved back to deck, a rigging crew discovered a wire cable retaining pin (weighing 10kg in the air) lying loose on top of the upper bumper.

Incident 1 – Two temporary subsea lamps found on top of the TBM

What went wrong? What were the causes?

1. Subsea lights fixed to steel support



An investigation discovered that the lamps were temporarily fixed to the TBM by the diving team, and should have been removed after they had finished their task in accordance with their post installation dive tasks. All other subsea lamps used during the task had been removed.

- Not all subsea lamps were recovered as per post-installation dive tasks;
- The missing subsea lamps were not identified immediately;
- The company was unaware of the missing subsea lamps; there was no notification given by the subcontractor;
- There was no awareness of the possibility of loose equipment being left behind, causing a dropped object threat to the company lifting crew.

What actions were taken?

- Ensure that subcontractor personnel are properly reminded of the company procedures for subsea material recovery;
- Further emphasize to crew the importance of stop work authority and of speaking up when they see an unsafe condition – which in this case was found to be very effective.

Incident 2 – A wire cable retaining pin was found lying loose on top of the TBM

What went wrong? What were the causes?

Investigation discovered that the object was an 'ROV friendly' wire cable-retaining pin. The pin was used to retain a wire in a sheave from which a ball grab was suspended. In order to retrieve the ball grab, an ROV was used to remove the retaining pin. After removal of the pin, the ROV was to let go of the pin, which would then stay suspended under water hanging from a rope. As this pin was not lashed properly, it became loose and landed on top of the upper bumper.

- Inadequate lashing using inappropriate rope made it possible for the pin to drop;
- The importance of proper lashing was not acknowledged by the divers or the dive supervisor.

What actions would be taken?

- This incident would be circulated as a lesson learned.

4 Two Potential Dropped Objects (Marine Safety Forum)

The MSF have published two safety alerts relating to potential dropped objects from cargo operations.

Incident 1: Missing protection cover becomes high potential dropped object

Vessel crew found a twist lock pocket cover missing from the aft main deck. The cover had washed out during heavy weather in transit. The vessel was later informed that the cover had been found in the pocket of a five-foot container which had been offloaded ashore. This would have constituted a serious high potential dropped object scenario to the crew, shore side workers and the general public.

What were the causes?

An investigation discovered that the rubber which keeps these deck covers in place was in poor condition. This enabled them to become loose and be washed out. Some additional observations were made and listed as contributing to this incident:

- Inadequate inspection;
- Inadequate maintenance;
- Adverse weather and sea conditions.

What corrective actions were taken?

- A temporary deck cover was made to remove the tripping hazards created by the missing cover. New covers were ordered and delivered on board;
- Regular checks on the condition of the covers were to be made; this was to be added on the planned maintenance system (PMS);

- After heavy weather, visually check the deck to see if anything is missing.

The full safety alert can be found on the MSF website.

Incident 2: Potential dropped object on top of a container

The crew on a platform noticed an object on top of a container onboard the supply vessel. The object was later found to be a large piece of wood weighing 1kg, with a possible fall height of 15–30 meters during lifting operations; there was the potential for a fatality. The origin of the wood was not known. CCTV images were captured of the container arriving at port and before being lifted onto the vessel; the wood was not seen on top of the container at either of these points. Therefore, the wood appeared on top of the container at some point between being loaded onto the boat and arriving at the offshore installation.

The MSF notes:

- The vessel Master was contacted, who arranged for the object to be removed;
- No preventative actions were taken – it was a great spot by the deck crew;
- This potential dropped object demonstrates the importance of pre-lift checks and good observation at all stages in the supply chain.

The full safety alert can be found on the MSF website.