

IMCA Safety Flash 17/13

November 2013

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 webmaster@imca-int.com

I High Potential Dropped Object

A member has reported an incident in which a heavy steel bar fell 10m onto the deck. The incident occurred during ROV deployment, when a round steel bar weighing approximately 20 kg became detached from above the cursor frame umbilical drum mechanism and fell approximately 10m onto the deck (moonpool doors). The object fell and struck the deck and then rolled under the ROV transfer plinth. There were no injuries or damaged caused, though at the time one member of the ROV deployment crew was standing in the moonpool area approximately 2-3m away from the point of impact and the ROV was approximately 1.5m off the deck.

The ROV launch operation was immediately stopped, the ROV was lowered back to deck, the item recovered, operations were suspended and investigations began.



Figure: Showing ROV umbilical winch drum from which steel bar fell



Figure: Looking to the top of the ROV hangar at the cursor and cursor winch

Our members' investigation revealed the following:

- ◆ The steel bar was identified as having come from above the cursor frame umbilical drum. It was used to stop the umbilical jumping on the drum;
- ◆ During a maintenance period (5 months prior to this incident), to upgrade parts of the existing ROV launch & recovery system, the manufacturer had fitted a guide above the drum as an improvement to the incumbent system. The function of this steel bar was to stop the umbilical jumping and fouling;
- ◆ The cause of the incident was found to be: three separate steel bars were fitted to a holding guide frame and held in place with bolts at each end. The ROV umbilical on the drum was rubbing against the guide causing the bolts to loosen over a 5 month period. This was due to there being insufficient clearance between the round steel bar and the umbilical when on the cursor drum.

Our member made the following recommendations:

- ◆ Weekly inspection checks on the steel bar guides, inspection interval to be reviewed, confirmed and included in planned maintenance system;
- ◆ Inspection to include confirming a minimum of 5mm clearance between the guide bar and umbilical;
- ◆ Ensure that the securing bolts are tight and torqued on all guide bars;
- ◆ A secondary securing device to be fitted to the round bars and this to be inspected during the planned inspection. Remedial hold back on all three guide bars as a temporary measure put in place;
- ◆ All future alterations in plant and equipment plant to be suitably communicated, risk assessed and a management of change exercise conducted with all the interested parties;
- ◆ Onboard inspection of work areas to identify potential dropped objects with particular reference to the following areas:
 - Below lifting operations;
 - Cranes;
 - Elevated work areas or platforms;
 - Work spaces where equipment is mounted overhead.

Members may wish to make use of additional IMCA resources as follows:

- ◆ [IMCA SPC 12 - Avoiding Dropped Objects.](#)

2 Small Workboats Used on Offshore Wind Farms: Combined Report on Windcat 9 & Island Panther Incidents

The UK Marine Accident Investigation Branch (MAIB) has published a combined report on two incidents involving small workboats in the offshore renewables sector. The first incident is a contact with a floating target by the wind farm passenger transfer catamaran *Windcat 9*; the second, the contact of *Island Panther* with a wind turbine tower.

It is worth quoting the UK Chief Inspector of Marine Accidents from the foreword of the document: *“The two accidents featured in this report occurred on the same day but in different circumstances. However, they share many common safety issues especially with respect to the standard of watch-keeping observed by the crews of both vessels. In particular, the MAIB’s investigations have highlighted a need for robust crew recruitment, training and assessment procedures to ensure the supply of mariners with the right skills. Flexible but rigorous watch-keeping practices are necessary together with recognition by the industry and regulator that the reliance on paper charts to navigate high-speed passenger transfer vessels is impractical and does not reflect the current custom of the trade.*

Perhaps the most noteworthy outcomes of the two investigations is the conclusion that there is a compelling need for the burgeoning offshore renewable energy industry to produce a comprehensive best practice guide for operators of workboats and to develop an effective means for promulgating safety lessons across the industry. Recommendations have been made to industry stakeholders to progress these two aims in a collaborative way.

There is an opportunity for the offshore renewable energy industry to establish, at an early stage of its development, a shared safety culture which, if the opportunity is taken, will undoubtedly prevent accidents and save lives in the future.”

The report can be downloaded from:

www.maib.gov.uk/publications/investigation_reports/2013/windcat_9_and_island_panther_combined_report.cfm

3 Pilot Ladder Safety

The Oil Companies International Marine Forum (OCIMF) has circulated the following safety flash, regarding pilot ladder safety:

Incident 1 – Pilot Ladders

An inspector was boarding a 1.5 year old ship via a pilot ladder, used in combination with the accommodation ladder. As the inspector was half way up the ladder, one of the side ropes parted leaving the inspector on the ladder with only one rope. Fortunately, the other side rope held and the inspector went back down to the launch and boarded the ship after a new ladder was deployed.

Upon boarding the ship, the inspector checked the damaged ladder and reported that, while the ladder generally appeared to be in good condition, the rope had parted at the upper end where an eye was formed around a thimble to allow for securing the ladder.

The rope around the thimble was covered with (heat shrunk) plastic, which did not allow that part of the rope to be inspected before use.

As it turned out, the rope under the plastic covering was completely rotten.

Incident 2 – A near miss with Embarkation Ladders

A near miss report on a ship outlined that, as part of the safety routines on board, the master inspected the ship's lifeboat embarkation ladders, and noted that the thimble eye by which the ladder secured to the deck had been covered in heat shrunk plastic.

The Master did not approve of this, and asked for these coverings to be removed and the rope inspected.

The covering was removed and, upon inspection, it was noted that the rope was rotten underneath.

Considering that the rope was only about two years old, this deterioration would not have been noted, nor expected, and could have resulted in a serious accident or fatality with worse consequences if the ladder were to be used in an emergency.

These incidents highlight the importance of regularly inspecting every part of all ropes that are deployed on board, whether for safety equipment or for mooring operations.



Figure: showing plastic covering under which the rope was rotten

4 LTI - Pilot Ladder Failure

The Marine Safety Forum has published the following safety flash, regarding an incident in which both ropes on a ladder parted simultaneously, causing the pilot to fall approximately two metres to the deck of the launch. The pilot sustained a lost time injury to his ankle.

The safety flash can be downloaded from www.marinesafetyforum.org/upload-files//safetyalerts/msf-safety-flash-13.34.pdf

5 Near Miss: Fast Rescue Craft Unplanned Descent

The Australian National Offshore Petroleum Safety and Environmental Management Authority (NOPSEMA) has published the following safety flash, regarding an unplanned descent (from 23m) of a fast rescue craft from its davit, whilst crew were onboard. There were no injuries or damage to equipment.

The safety flash can be downloaded from www.nopsema.gov.au/assets/alert/Safety-Alert-57-Fast-Rescue-Craft-unplanned-descent-Aug-2013.pdf