

## IMCA Safety Flash 24/18

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 Electrician Received Electric Shock from a Bare Cable

#### What happened?

An electrician received an electric shock whilst running a new cable through an existing cable tray. While retrieving the cable, his hand touched the bare end of live cable which was in the cable tray. As a precautionary measure, he had a medical evaluation at an onshore medical facility and received a full clearance to return to work.



*Showing inappropriately labelled live cable*



*Properly tagged cable*

#### What went wrong?

- ◆ The cable had apparently been installed and secured at the time of vessel construction and was found coiled and secured in the cable tray with plastic cable ties;
- ◆ The wire end of the cable was not covered; it was cut flush with cable jacket and was labelled 'spare'.

#### What were the causes?

- ◆ A live or energised wire installed during the build phase was hidden from view in a cable tray;
- ◆ The wire was incorrectly labelled;
- ◆ The energised wire was installed and labelled as a heater in the electrical panel with the breaker engaged in the on or closed position, but the end of the wire marked as a 'spare'.

### What actions were taken? What lessons were learned?

- ◆ Our member conducted an onsite 'Cable Verification Campaign' – all accessible cable trays were checked. All spare cables and wires were tagged and identified;
- ◆ Ensure relevant checks are performed during the new build phase;
- ◆ Have a thorough pre-inspection of a work area where cables are present, and notify relevant personnel of any anomalies;
- ◆ Ensure relevant permit to work (PTW)/isolations are in place.

Members may wish to refer to:

- ◆ [Near miss: exposed live electrical cable](#) [the same cause – unlabelled cables left live];
- ◆ [Near miss: live electrical cable](#);
- ◆ [Crewman Received 415V Electric Shock](#).

## 2 OCIMF: Pilot Ladder Side Rope Failure: Unsafe Pilot Transfer

### What happened?

During the disembarkation of two pilots from a condensate tanker, the right anterior side rope of a pilot ladder failed. The structural durability of the ladder was visually assessed by the first pilot and determined to be satisfactory; the second pilot managed to disembark without incident. Further inspection of the ladder revealed a parted side rope, which affected the overall stability of the ladder.

Whilst an incident did not occur this time, the failure of the side rope did in fact create an unsafe condition for pilot transfer, therefore creating a high potential hazard.

### What went wrong?

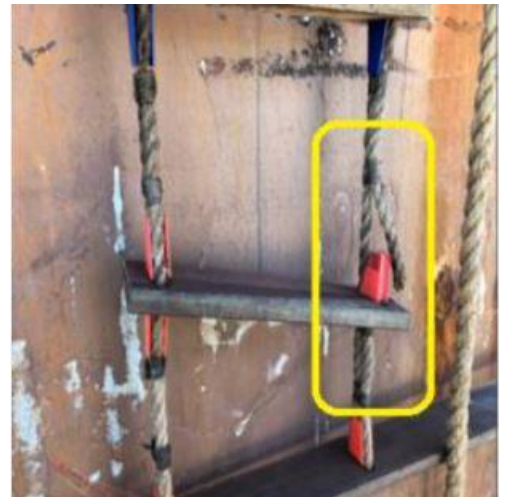
- ◆ The pilot ladder side rope had been weakened due to mould;
- ◆ Inspections that were in place were ineffective.

### What actions were taken? What lessons were learned?

- ◆ A close visual inspection by trained personnel could have noticed the damage;
- ◆ Improvement needs to be made to the ladder inspection processes;
- ◆ Update knowledge on finding faults with pilot ladders and rope damage;
- ◆ Change the pilot transfer procedure and review alternative methods.

Members may wish to refer to the following incidents:

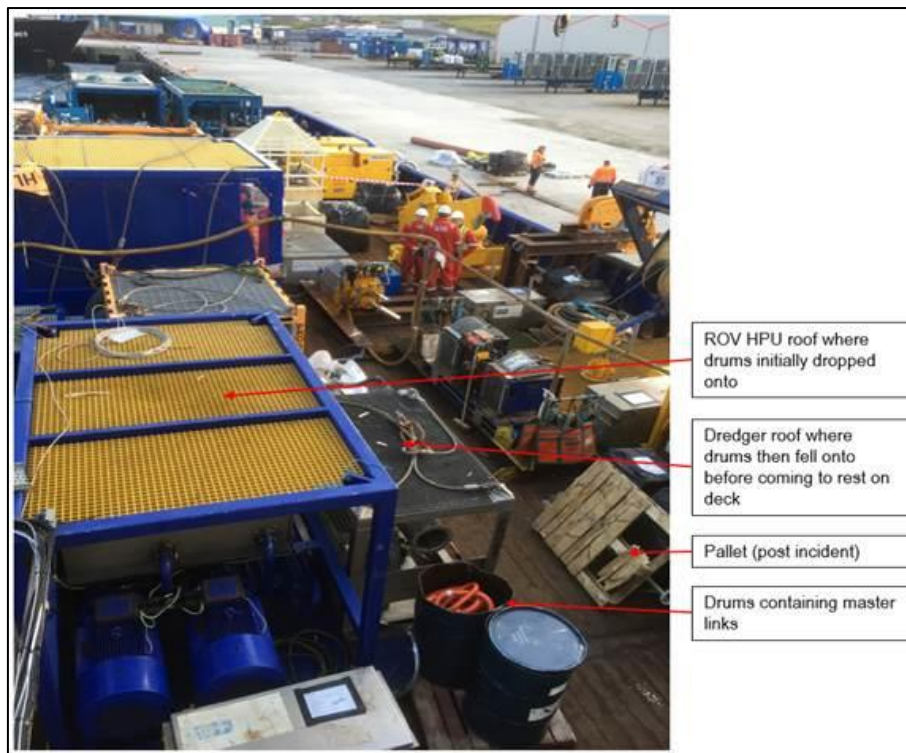
- ◆ [Pilot ladder safety](#);
- ◆ [Near-miss: Pilot ladder failure](#);
- ◆ [Pilot ladder requirements](#);
- ◆ [LTI: Finger injury during pilot ladder preparation](#).



### 3 Pallet Failure: High Potential Dropped Object During Lifting Operations

#### What happened?

A wooden pallet broke whilst it was being lifted during mobilisation, causing its load to fall to deck. There was no injury to personnel nor was there any damage to equipment. The pallet load consisted of two drums containing lifting master links and was lifted onboard from the quay using basket slung arrangements. When the load was approaching its final laydown area, part of the pallet broke, causing the load to invert and the drums to drop onto the ROV hydraulic power unit (HPU) equipment on deck and then onto the deck itself. Part of the contents of one of the drums was also released.



#### What went wrong? What were the causes

- ◆ The practice to basket sling a pallet had become the 'norm' following the pallet lifter being sent away for repair 5 weeks earlier; a replacement was not sourced;
- ◆ Personnel failed to comply with lifting guidelines, best practice, lift plans and task risk assessments;
- ◆ Personnel involved in the lifting operations did not intervene or challenge this unsafe lifting practice;
- ◆ There was ineffective and inadequate supervision and control of lifting operations;
- ◆ The drums containing the master links were not decanted into dedicated lift baskets prior to arrival at quayside.

#### What actions were taken? What lessons were learned?

- ◆ Further discussion of 'stop work authority' and the importance of feeling able to intervene or challenge when faced with unsafe practices;
- ◆ Ensure that there is a pallet lifter onboard, fit for purpose and certified for use;
- ◆ Consider decanting lifting equipment and accessories into dedicated lift baskets prior to transportation to the quayside/vessel (this is also relevant to all other equipment too);
- ◆ Ensure and verify all personnel involved in, supporting and controlling lifting operations fully understand lifting operations processes, procedures and good practice compliance requirements;

- ◆ Ensure and verify all personnel involved in supporting and controlling lifting operations review and sign off on existing vessel and site-specific lift plans and lifting operations task risk assessments, to verify their compliance and understanding of risk control measures and mitigations.

Members may wish to review:

- ◆ [Dropped pallet during loading of stores](#);
- ◆ [Failure of pallet lifters](#);
- ◆ [Pallet Lifter Failure](#);
- ◆ [Guidelines for lifting operations \(IMCA SEL 019\)](#).

#### 4 Incorrectly Weighted Monkey's Fist

The Marine Safety Forum (MSF) have published Safety Alert 18-22 in which a 'monkey's fist' had been thrown ashore during a mooring process. A quayside boatman reported his concerns on this.

The images show the condition of the 'monkey's fist' when it was thrown ashore, showing an area of protruding concrete. Upon inspection of the monkey's fist, it was noted that it was heavier than normal. The object was cut open and the inside was found to be concrete, together with two layers of rope making up the outer layer. Should the 'monkey's fist' have struck anyone upon thrown overboard, it had the potential to cause serious injury.



#### What actions were taken?

- ◆ The dangers and potential for injury was discussed with the vessel;
- ◆ A safety memo was created in order to share the learnings from this incident.

The safety alert can be viewed on the MSF's [website](#).



## 5 Release of Stored Energy from Coiled Superloops

### What happened?

A release of stored energy from a coiled superloop resulted in an injury to the person uncoiling the superloop. The member reporting this notes that this is the second such incident that they have encountered in the last year.



*Incident 1*



*Incident 2*

### What went wrong? What were the causes?

In both cases, the injured person was standing in the centre of the coiled superloop releasing fastenings when the sling sprang upwards, striking the person in the face. After the first incident, certain company personnel attended a training course specifically addressing the risk of stored energy in coiled superloops and how to control these risks when uncoiling. It was then the intention that these persons would be present at third-party yards to provide advice when company coiled superloops were being uncoiled.

However, whilst there was a trained person at the yard at the time of the second incident, uncoiling by untrained yard labour took place without taking his advice.

### What was the outcome for the company?

Company work instructions have been updated to include safety instruction on the uncoiling of superloops. The intention of the safety instruction is to raise the awareness of the risks involved in uncoiling superloops and how to control these risks to third parties receiving coiled superloops.

Members may wish to refer to:

- ◆ [Stored Energy – injury sustained whilst removing metal straps](#);
- ◆ [Guidelines for lifting operations](#) (IMCA SEL 019);
- ◆ [Line of fire](#) ('Be prepared to work safely' video);
- ◆ [In the line of fire](#) (IMCA SEL 036, classic safety video).

## 6 Potential Interference of VHF-FM Radio and AIS Reception

The United States Coast Guard (USCG) have published [Safety Alert 13-18](#), regarding numerous reports on poor reception of VHF frequencies used for radiotelephone, digital selective calling (DSC) and automatic identification frequencies (AIS).

### What happened?

- ◆ Poor reception was noticed when around LED lighting on-board vessels (navigation lights, searchlights and floodlights); interior and exterior lights and adornment lighting are just some of the few lighting systems containing LED lighting;

- ◆ The radio frequency (RF) interference caused was found to create potential safety hazards;
- ◆ A maritime rescue coordination centre was unable to contact a ship involved in a traffic separation scheme incident by VHF radio. The ship had also experienced very poor AIS reception;
- ◆ Other ships in various ports experienced degradation of VHF receivers, including AIS, caused by their LED navigation light. LED lighting installed near VHF antennas has shown to interfere with the reception.



### What lessons were learned?

- ◆ RF interference may not be immediately obvious to maritime radio users. However, it may be possible to test for interference caused by LEDs;
  - turn off LED light(s)
  - tune the VHF radio to a quiet channel
  - adjust the VHF radio's squelch control (until the radio outputs audio noise)
  - re-adjust the VHF radio's squelch control until the audio noise is quiet (slightly above the noise threshold)
  - turn on the LED light(s) – if the radio outputs audio noise, then the LED lights have raised the noise floor
  - if the radio does not output audio noise, then the LED lights have not raised the noise floor;
- ◆ If the noise floor is found to have been raised, then it is likely that both shipboard VHF marine radio and AIS reception are being degraded by LED lighting.

The USCG has requested that anyone experiencing this kind of problem, to send reports to [Coast Guard Navigation Center](#).

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