

## IMCA Safety Flash 25/17

October 2017

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 Fatality: Crew Member Crushed Between TMS and Snubber Ring

#### What happened

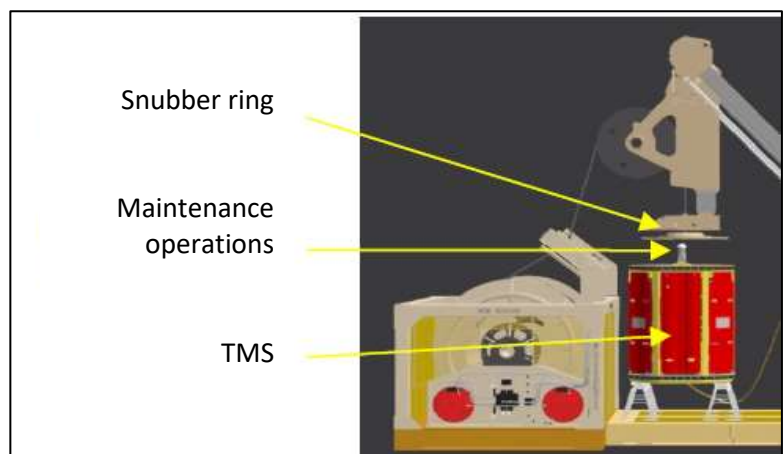
During a maintenance operation, a member of an ROV crew sustained fatal injuries when he was trapped between the top of the tether management system (TMS) and the snubber ring.

#### What went wrong/causes

It should be noted that this incident remains under investigation. Additional information will be provided in due course.

#### Lessons learnt/actions taken

- ◆ Maintenance activities should be properly risk assessed and undertaken in accordance with company procedures;
- ◆ Maintenance activities often introduce additional hazards into the workplace; these should be fully understood, assessed and managed;
- ◆ There should be a documented safe system of work, for example, a maintenance manual and/or work instruction;
- ◆ If activation of the equipment is necessary to complete the maintenance activity, for example for testing purposes, extreme care needs to be taken which includes removing all personnel from any danger zone;
- ◆ Avoid undertaking a maintenance activity under a load or between a load and fixed point;
- ◆ Equipment must be turned off and isolated when being worked on.



The incident highlights the need for strict compliance with the 'golden' or 'life-saving' rules used by all contractors and clients.

Members may wish to refer to the following incident:

- ◆ [Fatal accident in connection with the operation of an A-frame based launch and recovery system \(LARS\) used for ROV operations](#) [*"The combination of technical and human error had resulted in an unfortunate breach of barriers causing the fatality"*].