

IMCA Safety Flashes summarise key safety matters and incidents, allowing lessons to be more easily learnt for the benefit of all. The effectiveness of the IMCA Safety Flash system depends on Members sharing information and so avoiding repeat incidents. Please consider adding safetyreports@imca-int.com to your internal distribution list for safety alerts or manually submitting information on incidents you consider may be relevant. All information is anonymised or sanitised, as appropriate.

1 Portable electrical equipment – serious fire in the accommodation

What happened?

A member reports a serious fire in the accommodation on a vessel at anchor. There was no injury nor loss of life, but there was significant and costly damage to the vessel, reputational damage and ten days loss of earnings whilst off-hire.

Fire was smelt in a cabin; on investigation a massive fire was discovered in a nearby cabin. The alarm was raised and the crew were mustered. The crew managed to extinguish the fire but it took nearly four hours to contain and it was necessary to use boundary cooling provided by other nearby vessels.

What was the cause?

It was noted that first appearances showed the bedroom of the cabin to be completely damaged. The damage in the day room was much less. This had given the initial impression that the fire had originated from the bedroom. However investigation revealed that the fire had actually started from the day room.

Further investigation showed that the fire was caused by an electric kettle in the day room which had been left on while the occupant was not in the cabin. **There is a very high probability that the kettle cut-off safety switch did not operate.** This led to the overheating and caused smouldering eventual catching fire of the kettle handle and all the subsequent fire.

Lessons learned

- Fire-fighting
 - A nearby cabin was identical in plan: an understanding of this cabin made the task of the fire-fighters easier;
 - The fire-fighters were unable to safely enter the burning bedroom, and the fire was attacked by breaking a port hole and inserting a fire hydrant;
 - It was found that fire-fighters with full beards were less able to fight the fire effectively owing to smoke leakage into their BA sets;
- Portable electrical equipment
 - Consider carefully the origin and quality of permitted portable electrical equipment;
 - What portable electrical equipment should, and should not, be permitted in cabins and elsewhere?
 - To what extent should such equipment be left powered while the cabin is unoccupied?

Applicable
Life Saving
Rule(s)



Energy
Isolation



Burnt out day room of cabin



Identical similar day room

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- How is such equipment connected to the vessel mains (extensions, sockets etc)?

Members may wish to refer to:

- Galley electric shock – uncontrolled portable electrical equipment
- Fires caused by electronic device chargers
- Fire in the accommodation: electronic items in cabins
- Fire in vessel accommodation - Overheating notebook computer

2 Rope under tension parted on deck

What happened

A wire rope parted under tension and struck someone’s helmet. There was no injury. The incident occurred during preparation for a shore-side pull of an export cable; the cable lay vessel recovered an onshore winch wire. The rigging connection failed resulting in the parted rope striking an operator’s helmet.

The winch wire from the onshore site was connected to the cable lay vessel winch via recovery rigging. The supporting workboat hauled the onshore wire to make the connection with the cable lay vessel wire. When the connection was confirmed, the Shift Supervisor on the cable lay vessel gave the order to pay in and recover the connected winch wires. The Shift Supervisor, positioned at the top of the chute platform, noticed a polypropylene rope was attached to the rigging which was not part of the approved rigging arrangement. The polypropylene rope suddenly came under tension, parted, recoiled and struck the Shift Supervisor’s helmet. The helmet shell separated from the inside webbing. No-one was harmed.



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What went wrong?

- Nine persons were on the cable lay vessel deck at the time, all neglecting the ‘Line of Fire’ Life Saving Rule;
- The crew on the workboat did not follow the company approved rigging arrangement;
- There was no supervision on the workboat to ensure the approved procedure was followed;
- There was a language barrier; the workboat crew only had minimal English.

Actions

- Follow the Life-Saving Rules; **do not place yourself in the line of fire;**
- Ensure better close collaboration between third-party vessels:
 - Confirm that procedures have been reviewed by crews
 - Ensure they attend Hazard Identification and Risk Analysis (HIRA) meetings
 - Ensure that they are fully familiar with the task plan on site.
- Ensure adequate levels of supervision for the task in hand;
- Where appropriate, ensure bilingual documentation is available for key documents and that a translator is available who is familiar with the task.

Applicable
Life Saving
Rule(s)



Bypassing
Safety
Controls



Line of Fire

Members may wish to refer to:

- Stored energy near miss: Person nearly hit by equipment caught during light daughtercraft operations
- Dutch Safety Board: fatality when mooring line snapped
- Fall from height during yard visit [Many similar causal factors including language difficulties.]

3 Line of fire near miss – almost a head injury

During cable trans-spooling operations, someone almost suffered a very serious head injury.

Applicable
Life Saving
Rule(s)



Line of Fire

What happened?

Whilst a messenger rope (a mooring line) was being pulled across from a cable vessel to a barge, a crew member was standing near the chute to visually monitor the operation. Due to the height difference between vessel and barge, the messenger rope crept up as the pull tension increased, until it reached the top of the chute wall and exited the chute. Due to the angle between vessel and barge, the rope violently shot sideways, striking the helmet of the crewmember, knocking his helmet off his head. Had the rope been 10 cm lower (or the crewmember have been 10 cm taller), he would have been hit on the head with potentially very serious (if not fatal) consequences.

Our member notes *“that three weeks later, almost exactly the same thing happened on another vessel while offloading a cable to shore. Again, purely down to luck, a serious injury was prevented.”*



Stills from CCTV footage of the actual occurrence, showing the rope striking the crew members' helmet.

Lessons learned

- The angle and height difference between the vessel and the barge were not identified as hazards;
 - Identify risks for each separate operation, and use the Management of Change process if things change;
- There was a difference between spooling speeds on each cable tank – they were not synchronised. This allowed tension to build up and caused the “climbing up” of the rope in the chute;
 - Ensure communication is clear and that everyone clearly understands what their role is;
 - Consider a practice or a dry run!
- There was poor management of the cable tension between the two chutes. Had there been more slack this would have prevented this occurrence;
 - Follow the procedure and pay attention particularly when moving cable, rope or wire between winches;
- A total of 12 crew members were watching the operation from different positions; **nobody stopped the job!**
 - Speak up! Dare to call an **ALL STOP**;
- There was nothing to stop the rope exiting the chute;
 - Our contractor has modified all their chutes, adding a bar across the top to totally enclose the chutes during similar operations – safety by design.

- Our member notes:
 - Be aware of your surroundings;
 - Stay out of the line of fire of ropes under tension;
 - Do the Last Minute Risk Assessment prior each job.

Members may wish to refer to



- [In the line of fire](#) (IMCA SEL 036, video)
- Short video (“Are you prepared to work safely”) [Line of fire](#)
- [Mooring incident: mooring line slipped off and snapped back](#)
- [Dropped flexible pipe incident](#)

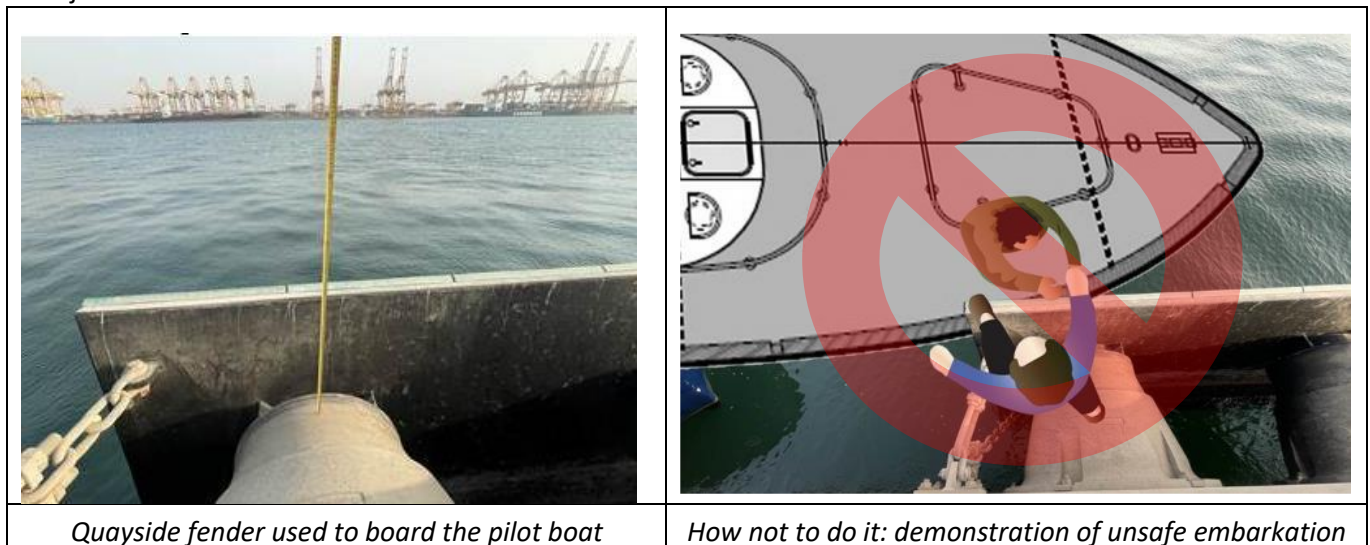
4 Unsafe personnel transfer – man overboard

What happened

After completing a standard diving activity for underwater hull cleaning on a pilot boat, the diver used the quayside fender to embark from the jetty to the pilot boat. In so doing, his right foot slipped, resulting in an uncontrolled movement. The Diving Supervisor, assisting his safe embarkation onboard the forward deck, also lost his balance, resulting in both of them jumping into the water away from the fender and vessel. Their lifejackets inflated immediately, and both swam towards the quay ladder, located a few meters away. No injuries were sustained.

Applicable Life Saving Rule(s)

-  Bypassing Safety Controls
-  Line of Fire



What were the causes?

- There was no suitable means of access/egress to or from the pilot boat;
- Complacency – “task seen as routine”;
- They ought have stopped the job but they didn’t: Stop Work authority was not exercised.

Actions

- Find a safe means of access/egress arrangements at temporary locations;
- Re-emphasise importance of Stop work authority as an obligation and responsibility.

Members may wish to review:

- [High potential near miss: AB slipped over the side during mooring operations](#)
- [Non-fatal man overboard incident](#)

- MAIB: fatality during transfer from a workboat to a barge
- LTI: step into open deck hatch causes fall

5 Shortened lanyard on MOB beacon

What happened?

The practice of shortening the lanyards on MOB beacons was discovered by someone visiting a vessel. This was accordingly communicated to the Chief mate to be fixed.

If the lanyard is shortened, the MOB beacon may fail to activate, or, if it were activated, the person who fell overboard may find themselves in the potentially hazardous situation of being too close to the heavily smoking MOB beacon while handling the life buoy.

What went wrong?

- There was a lack of understanding of how these Life Buoys operate, as well as failure to perceive relevant hazards;
- There was improper/incomplete inspection of Life Saving Appliances onboard.

Lessons learned

- Check length of similar lanyards attached to MOB beacons; the correct length will be prescribed in the manufacturer's manual. It should be long enough to allow the life buoy to gain a good inertia after being thrown, before releasing the MOB beacon from its cradle;
- Include check of MOB beacon in planned maintenance schedule.

Applicable
Life Saving
Rule(s)



Bypassing
Safety
Controls

