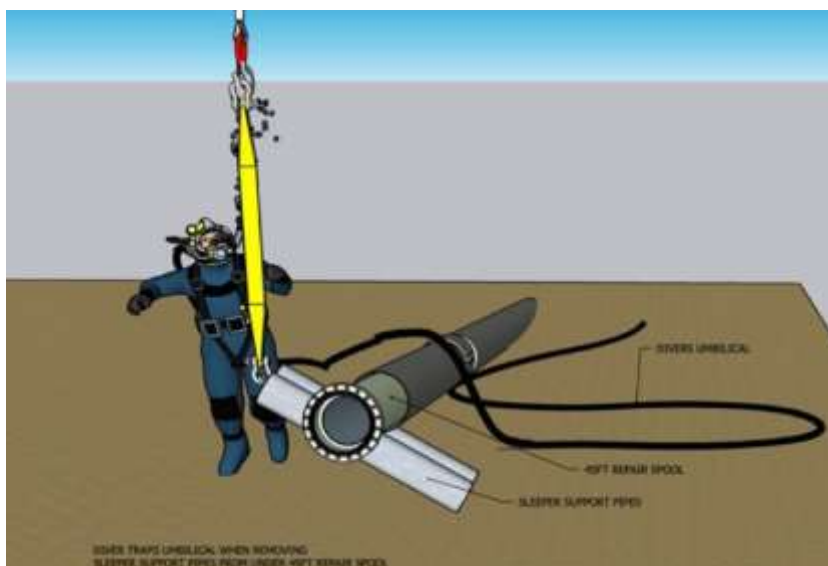


IMCA Safety Flashes summarise key safety matters and incidents, allowing lessons to be more easily learnt for the benefit of all. The effectiveness of the IMCA Safety Flash system depends on members sharing information and so avoiding repeat incidents. Please consider adding safetyreports@imca-int.com 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 Umbilical management – near miss

What happened

A diver was working with the barge crane to remove two sleepers from under a newly installed 16" x 45 ft (40cm x 13.5m) repair spool. The crane was rigged directly onto the sleepers to be moved. Once the sleepers cleared, the pipeline moved and rolled over a section of the divers umbilical. The diver discovered that his umbilical was trapped and was able to free it himself. Visibility was excellent, it was daylight, and the diver was able to move his umbilical over to a suspended section of pipe, and was unharmed.



What went right

- Both diver and supervisor were very experienced and were able to work very quickly on a solution;
- This was a decompression dive that did not exceed the planned bottom time.

What were the causes

- Procedural - no procedure existed for the sleeper removal, due to an oversight during the project planning phase;
- Human Performance - the diver did not recognize the line of fire umbilical management hazard;
- Human Performance - the Dive supervisor did not call an "all stop", due to a lack of full procedural understanding. No MoC (management of change) was created.

Corrective Actions

- Develop a removal procedure to include the removal of the diver's umbilical from the bottom, before starting the operation;
- Review with the entire crew the Umbilical Management process and sleeper removal procedure.

Members may wish to refer to

- [Near miss: divers umbilical drawn beneath a load](#)
- [Unexpected movement of conductor during diver dredging operations](#)
- [Lost time injury \(LTI\): DMA toppled over, injuring a diver](#)

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2 Lost ROV incident

What happened?

An ROV got trapped inside the platform structure due to strong tidal current. Subsequently the tether was damaged, and the ROV lost power and telemetry. Attempts to free the slightly positive ROV and pull it carefully out of the structure, but these were not successful. Ultimately, the vessel was needed elsewhere, and the tether was cut and secured to the jacket. Upon returning to the platform the next day, the damaged tether parted during a new rescue attempt. The ROV drifted away from the platform and after a few hours the signal from the ROV's beacon was lost. A new vessel was summoned to search for the lost ROV with its WROV, but the ROV was not found. The incident occurred during a routine platform jacket inspection.

What went wrong

- Emergency procedures were not detailed enough to cover the scenario that actually occurred; the workboat was not launched in time to secure the ROV in the short interval it was at surface during rescue attempt from the platform;
- The ROV crew was understaffed: There were two operators, but the complexity of the operation warranted a three person team;
- The ROV transponder interrogation rate was set too high – too frequent – resulting in premature exhaustion of the beacon battery.



The ROV at the surface just before the tether parted and the ROV drifted away from the platform.

What was the cause

- Direct cause: The tether parted due to abrasion against the jacket structure, and the ROV was lost with no communication to it;
- Root causes
 - Insufficiently detailed instructions, risk assessment of hazards, and emergency recovery procedures;
 - Understaffed team.

Corrective action/lessons learned

- Procedures revised to include more details; environmental limitations and more details for a recovery scenario;
- Added a current reading on ROV pilot user interface (GUI).

Members should be aware of and make full use of IMCA R 004 *Guidance for the safe and efficient operation of remotely operated vehicles*

3 Incorrect gangway rigging

What happened

A member reports several cases of gangways being rigged incorrectly.

Incident 1

What went wrong

- The bottom of the gangway was placed on the deck less than 1m from an un-barriered drop on the quay, which could potentially have led personnel descending the gangway to fall;
- A safety net was not mounted correctly.

Applicable
Life Saving
Rule(s)



Bypassing
Safety
Controls



Red box shows un-barriered drop

What was put right

- The gangway was relocated closer to a substructure away from the recessed deck and with adequate fencing;
- A safety net was correctly mounted to cover the gap between the ships.

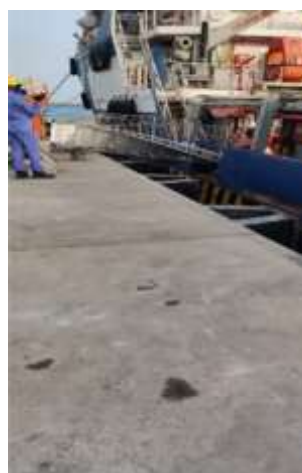
Lessons learned

- Gangways should not be used at an angle of inclination greater than 30° from the horizontal;
- A safety net should be used where it is possible that a person may fall from the gangway;
- Gangways should never be secured to a ship's guardrails unless they have been designed for that purpose. If positioned through an open section of bulwark or railings, any remaining gaps should be adequately fenced;
- As far as practicable, the means of embarkation and disembarkation should be sited clear of the working area and should not be placed where cargo or other suspended loads may pass overhead.

Incident 2

What went wrong

A Platform Supply Vessel (PSV) was alongside loading deck cargo. The PSV suddenly started moving alongside the jetty due to propeller wash from another vessel passing nearby. A passing workman on the quayside observed that the gangway had got stuck over a quayside bollard and was getting deformed by the vessel movement. He released the gangway rope and informed the gangway watch. The gangway was recovered to the vessel. It was found that it was significantly damaged; it was quarantined and sent away for repairs.



Gangway bent round quayside bollard



Deformed gangway

What was the cause

- Crew failed to assess the risks related to potential vessel movement due to weather conditions and other vessel movements nearby – in this case, propellor wash;
- The gangway watch was not thorough enough – a passing worker noticed what was happening.

Lessons learned

- Ensure risk assessments related to gangway management cover risks of vessel movements due to weather conditions and impacts of waves from other vessels passing nearby;
- Ensure gangway watch and management is suitable and sufficient.

Members may wish to refer to

- Vessel gangway rolled off platform tower and fell to the quayside in high wind
- Equipment on quay damaged when vessel started listing
- Unsafe boarding of vessels
- Vessel hull damage due to quayside contact

4 Blocked emergency exit hatch

What happened

An engine room emergency exit hatch could not be opened. The emergency exit hatch providing egress from the engine room to the vessel's main deck on the starboard side at the stern, was found blocked during the Master's routine inspection/walkaround. The hatch could not be opened from the engine room compartment.



Emergency Exit hatch blocked by wire ropes

What went wrong

It was discovered that the hatch was blocked by wire ropes left on top of it during recent spooling works on the main deck area. These activities had been observed on deck, as part of anchor handling preparation process conducted by a contractor party. The used wires left on top of emergency hatch was not noticed by the deck crew.

What went right

This serious issue was swiftly discovered and corrected following a regular "safety walkaround".

Lessons learned

- Keep emergency escape routes free of obstructions and in a safe condition at all times;
- Better control of third-party activities onboard;
- Hold regular "cold eyes" or cross-departmental reviews and safety walkarounds. You may be surprised at what the cook will discover on a walk round the back deck, or what the third engineer will spot on a visit to the bridge wing;
- Imagine yourself in the position of the person who might be trapped by that stuck hatch. What can YOU do to make sure that never happens?

Members may wish to refer to

- Only a centimetre – an emergency exit hatch blocked by mooring ropes
- Stuck emergency hatch freed
- Get it fixed!! Deteriorated seals on emergency hatch

- Inadequate maintenance and securing arrangements of emergency exit hatches

5 MSF: LTI - hand injury

What happened

The MSF reports in [Safety Alert 22-12](#) an incident involving an inadvertent self-inflicted finger injury. This serious injury was sustained while someone was replacing a knife into its sheath. The crew member had been splicing 12mm polypropylene rope for use as guide ropes on the gangway. He had removed his gloves to splice the ropes, and once finished, attempted to put his knife back into its sheath at his belt, still without gloves.



What went wrong

He missed the sheath with the knife and pushed the knife into and down his left Index finger, causing a large deep incision, requiring surgery to correct possible tendon damage, and close the wound.

What can we do right?

Our hands are our most used tool. Protecting your fingers and hands is important. Damage to the nerves in your fingers and hands, loss of a finger, skin burns or allergic reaction, can negatively impact the quality of your work, your productivity – or worse – end your career and seriously detract from your quality of life.

- Only use knives for their intended purpose;
- Never use “homemade” tools;
- Cut away from yourself, away from your body, keeping all fingers out of your cutting line;
- Use all personal protective equipment required including gloves;
- Cut on a stable surface;
- Stay focused;
- Don't rush, take plenty of time, care and pay attention to what you and your knife are doing.



Please see the IMCA safety video [Watch your hands](#)

Members may wish to refer to

- [Lost time injury \(LTI\): Severed tendon](#)
- [Lost time injury \(LTI\) – finger laceration due to use of knife](#)
- [Line of fire: cutting injury to index finger](#)