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 Unsafe flooring led to man overboard fatality

A fatality occurred in January 2023, on an offshore worksite, whereby a worker fell overboard because of a dislodged section of polymer grating, commonly used in the offshore industry. The incident did not occur on an IMCA members' facility.

What happened

On a jackup rig in transit, a crew member was reported missing, believed to have gone overboard. The missing crew member finished their shift at 18:00 and was last seen just after 19:00. During the investigation it was identified that a section of polymer grating outside an accommodation door, used to provide a means of access and egress, had become dislodged, thereby exposing employees to the hole in the decking area.

It is understood that the lost crew member must have fallen through this hole.

Further inspection by the UK Health and Safety Executive revealed that further multiple polymer grating systems had been installed similar to the one that was dislodged and were found to be unsecure. See also https://www.hse.gov.uk/safetybulletins/floor-grating-systems.htm

Examples of typical polymer grating systems and detail of various fittings

Actions

There is potential for a similar incident to occur on IMCA members' vessels or installations, in work areas such as towers, reels, cranes and access platforms, or ROV systems, and on external walkways.

- Identify areas on the vessel where this kind of grating is found (Glass Reinforced Plastics (GRP) or Fibre Reinforced Plastics (FRP)) and ensure that the fasteners are installed as per the OEM instructions;
- Ensure the possibility of such grating coming loose and falling, is included in existing dropped object checklists;
- Update planned maintenance systems as required.

Members may wish to refer to

- BSEE: Crewman fell to his death through faulty grating
- Near miss – grating dislodged and fell, leading to crewman slipping
- Lost time injury (LTI): loose grating fell from crane, a man fell through and was injured
- Near-miss: Missing grating on platform in fuel tank

2 Rope access technician slipped and dislocated shoulder

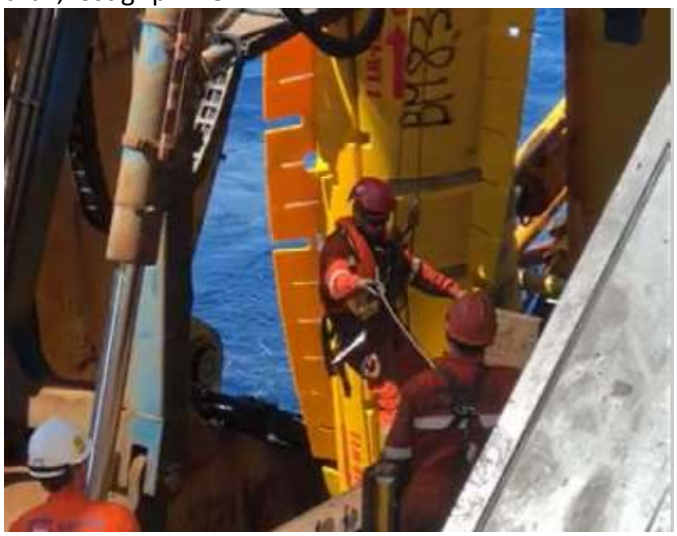
Applicable Life Saving Rule(s)

Bypassing Safety Controls

Working at Height

What happened

A rope access technician sustained an injury to the right shoulder while accessing the vessel transom port-side platform, following buoyancy module pad retrieval from the pipe string. Upon reaching the buoy loader area, the rope access technician climbed on top of the platform handrail, lost grip when reaching for the handrail, and fell approximately 1m.



What went wrong

The rope access technician lost grip after stepping with both feet on the wet and slippery handrail (angled stiffener). Due to the wet, slippery environment and due to one grease-contaminated glove, he was unable to sustain his body weight with his hands and fell simultaneously rotating his body which was still connected to the ropes, leading to a dislocated shoulder.

What was the cause

Our member noted the cause as inadequate risk planning and risk assessment.

Lessons and actions

- For rope access operations in particular, task planning and Job Safety Analysis should be exhaustive and detailed;
- Taking shortcuts, no matter how trivial, have the potential to trigger a chain of events that can lead to an incident.

Our member:

- Held a safety stand-down with the rope access subcontractor;
- Raised awareness on hazards and risks associated with slips, trips and falls;
- Arranged refresher training in Job Safety Analysis and Risk Assessment for rope access teams;

- Amended onboard JSA's to reflect the potential risks;
- Investigated an alternative means for rope access technicians to be able to move safely around the areas in which they need to work.

Members may wish to refer to

- Crew member in small boat slipped and dislocated shoulder
- Lost time injury – person slipped on the stairs and broke his arm

3 LTI – worker fractured arm during mooring line handling

Applicable Life Saving Rule(s)

Line of Fire

What happened?

A mooring rope (weighing 2.9kg per metre) hit a crew person and caused a broken arm. The incident occurred as crew were preparing to unmoor and move a barge. The operation was proceeding as planned when one of the forward mooring station winches in use tripped out. The mooring crew at the forward station informed the Chief Officer about the winch tripping, using UHF. The mooring crew at the aft mooring station, on hearing this information, decided to stop the barge by adding an additional coil on the bollard. Whilst one of the crew was attempting to coil the rope on the bollard, due to a sudden increase of tension on the line, control of the rope was lost, and the rope hit the worker on the left forearm causing the injury. The injured person received first aid treatment promptly and was subsequently evacuated by helicopter.

What went wrong

Confusion, because there was a lack of clear communication with no proper instructions during the operation. The radio communication addressing the tripped winch was misunderstood at the aft mooring station as an "ALL STOP" signal. Instructions were given to secure the mooring rope "in slack" by adding another loop into the bollard. However, the barge was already moving and the mooring line came under tension due to that movement. The injured person was in an unsafe position, with his arm in the line of fire.

Lessons and actions taken

- Over-confidence may lead to poor judgement and making mistakes – if in any doubt, follow the instructions;
- Minimize confusion and ensure there are clear and properly understood communications;
- Our member arranged
  - Further training on Line of Fire risks;
  - Refresher training for marine crew regarding hazards in mooring operation;
  - Awareness sessions customized to the role and responsibility of the Team Leaders and Supervisors, addressing the key elements of their duties.

Members may wish to refer to:

- Dangers when mooring and unmooring
- Person injured by mooring lines
- Serious injury during mooring operations: rope parted

4 Serious hand injury during mooring operations

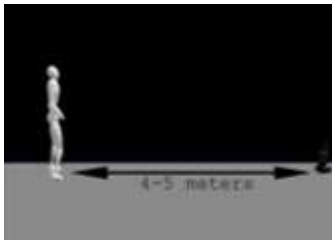
Applicable Life Saving Rule(s)

Bypassing Safety Controls

Line of Fire

What happened

A dock worker suffered a serious hand injury during mooring operations. The incident occurred as the vessel was prepared for departure from the berth. The mooring foreman signalled the team to let go, keeping one line on the bollard. The injured person grabbed the rope at the end of the eye near the area of the splice and began to remove it from the bollard. Halfway through removing it from the bollard, the rope suddenly tightened, causing the eye of the rope to catch onto the side of the bollard while his right hand got stuck in between two ropes. The injured person was able to pull out his hand from the trapped gloves and shout for help, before receiving first aid.



Position of injured person

Signalling to vessel crew to slack while approaching the line

Grabbing the rope at the end of the eye

Hand caught between the two ropes

What went wrong

- There was a lack of planning, a lack of risk assessment, a lack of forethought: the injured party put their hand in the line of fire;
- Insufficient slack was provided in the rope when the dock worker attempted to grab the spring line from the bollard. As the ship's crew attempted to slack the spring line, tension mounted and caused the rope to tighten on the vessel's winch;
- The absence of a messenger or tail line attached to the ship's mooring lines.

Lessons learned

- Stop and think before acting – take the time to think things through;
- Keep your hands and fingers out of the line of fire;
- Be ready to stop the job if someone else is looking as though they are putting themselves or others at risk.

Members may wish to refer to

- LTI: fractured finger during anchor handling
- LTI finger injury during mooring operations

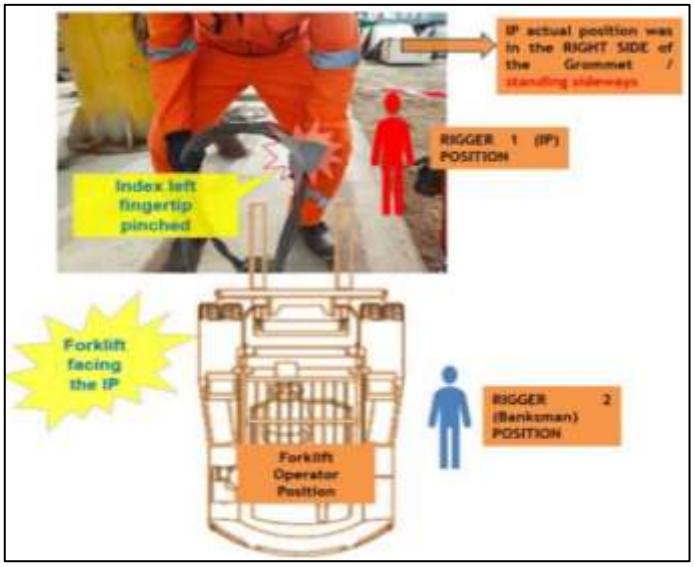
5 LTI – fingertip pinched by wire sling

Applicable Life Saving Rule(s)

Line of Fire

What happened

A rigger suffered a serious injury when his finger got trapped between a sling and one of the forks on a fork-lift truck. The incident occurred when the rigger was installing a steel wire sling on one fork of the fork-lift truck in stand-by, and the fork-lift operator started to lift the fork without instruction or alert from the banksman nearby.



What went wrong

- The experienced fork-lift operator started to lift the fork without any instructions, without any reference to the Banksman who was the person through whom communication ought have been channelled;
- The rigger took no account of the fact that his fingers were IN THE LINE OF FIRE;
- Neither the task nor its risks were suitably assessed by the lifting team.

What were the causes

Our member identified the following as causes:

- Complacency – the fork-lift operator acted without thinking, based on previous experience;
- Lack of communication.

Lessons

- Always wait on clear instructions or signals from the Banksman during lifting operations, particularly if you don't have a clear overview of the work area;
- Think through where you position yourself – keep out of the line of fire;
- Ensure everyone involved in the task takes part in, and is properly briefed at, a toolbox meeting before starting, and that this meeting covers all the hazards involved;
- Our member took steps to arrange for this particular task to be done in a different way in order to prevent recurrence.

Members may wish to refer to:

- Line of fire LTI: Finger injury during lifting operations
- Lack of safety awareness: crush injury during lifting operations
- Crushed finger injury during wire transfer operations