

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 Job stopped safely: safe working load limits exceeded

What happened

Work was stopped during the practical evaluation portion of rigger training in an onshore industry. It was discovered that the application of eye-nuts were not consistent with their intended use. The task was to install rigging and lift something using a 4-leg bridle chain with adjustable length legs. The attachment points, for the 4-leg bridle chain to the load were four machined eye-nuts (see illustration). A student questioned the safe working load limit of the 1/2" eye-nut, which was assumed to be installed by the manufacturer of the item being lifted. After researching the eye-nut, a note was found accompanied with the load chart stating that the eye-nut installed was "for in-line picks only." At that point, work was stopped. The rigging plan to be used involved rigging on the eye-nuts at a 60° angle. Not only were the eye-nuts not being used as intended, but additionally when picking with sling-angles, load capacities are reduced, which would have put the eye-nuts above their safe working load limit.

An alternate load was lifted in this case for training purposes.

This incident, though it is not from within the membership, was passed onto IMCA by a member.

What went right

- The instructor of the class had encouraged a "questioning attitude";
- The student did not assume the manufacturer-supplied eye-nuts were suitable for the task and questioned the rigging plan;
- Work was stopped;
- This was a real-time example of the importance of inspecting and verifying every link in a rigging plan.

Lessons

- Encourage a questioning attitude and a culture where "there are no stupid questions".

Members may wish to refer to

- [Crew member stopped unsafe cargo operations](#)



2 Unprotected openings in floor grating – work stopped

What happened?

Two workers removed grating panels at height on a horizontal lay system, in order to gain access to lift points for further removal of a lateral walkway section. The removed grating created an open hole with the likelihood that someone could have fallen through it.

None of the team involved were wearing the required PPE for working at height and no tool lanyards were used. The area around the horizontal lay system had not been barricaded. The activity was immediately stopped. No-one was injured; no dropped object resulted.

Applicable
Life Saving
Rule(s)



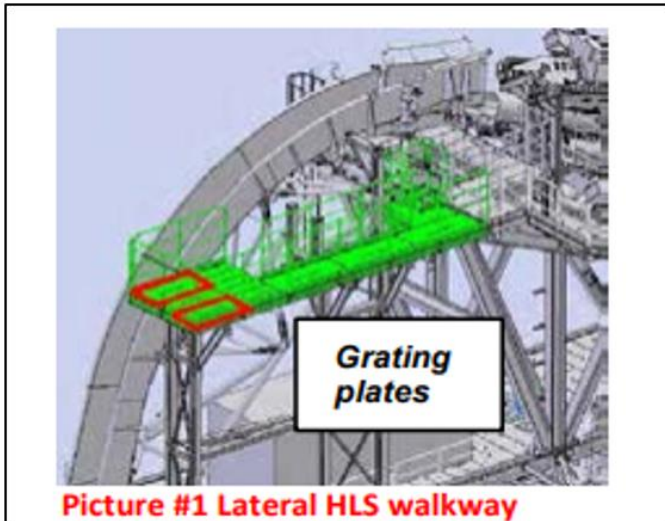
Bypassing
Safety
Controls



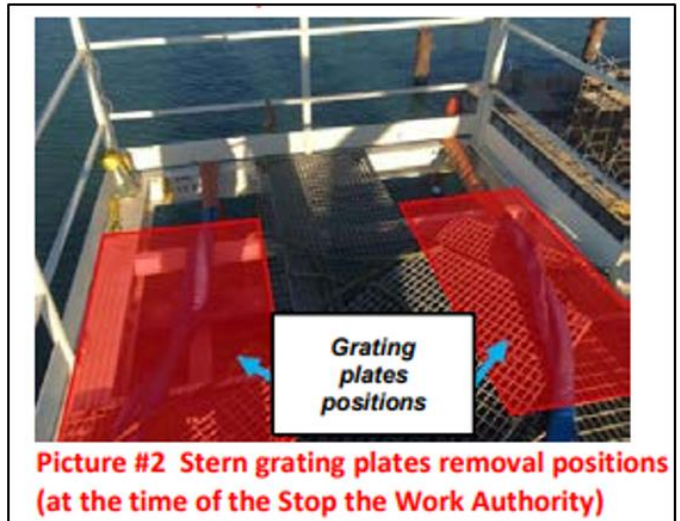
Work
Authorisation



Working at
Height



Picture #1 Lateral HLS walkway



Picture #2 Stern grating plates removal positions
(at the time of the Stop the Work Authority)

What went right - someone stopped the job!

What went wrong

- No-one involved in the activities perceived that the grating removal created a Work at Height hazard; the risks were underestimated.

What was the cause

- Inadequate or improper design of controls / barriers - several grating plates had to be removed in order to reach the structural beams needed to access the lift points;
- There was no Permit to Work in place;
- There were unclear or conflicting reporting relationships – information passed to the workers by a “Vessel Field Engineer” was accepted as actual instruction to do the job.

Lessons and actions

- Remember the importance of the **Stop Work Authority** – this should be used whenever an activity is deemed unsafe;
- Task seen as “routine” – routine activity sometimes leads us to disregarding or underestimating the risks associated with that activity;
- Ensure proper supervision, coordination, and a single point of control for work activities which are carried by two or more different work groups;
- Safety by design: safety aspects should be considered at design phase to ensure any potential hazards are considered, eliminated and/or relevant measures are taken against them.

Our member took the following actions

- Assessed the feasibility of installing accessible lifting points removing the need to remove grating plates;

- Looked at other project mobile equipment to assess how accessible lifting points are;
- Re-evaluated the need for a Permit to Work when certain activities are carried out in a changed work environment (such as grating removal that could create a WAH hazard);
- Ensured mobilization / demobilization plans include designation of single Responsible Person.

Members may wish to refer to

- Crewman falls down open hatchway during simultaneous operations
- LTI: step into open deck hatch causes fall
- Near miss: engine room hatch left open without barriers
- LTI: person fell down hatch inside crane pedestal


3 Uncertified bosun’s chairs

What happened

A member conducting management visits to vessels discovered three separate cases where “Bosun’s Chairs” or similar support structures or working at height activities related to painting and repair works, had been fabricated by crew from wooden boards and ropes.

Our member notes that using uncertified fall arrest equipment, including a “Bosun’s Chair”, can pose significant hazards and risks to the user. Fall protection equipment, such as harnesses, lanyards, and anchors, should always be sourced from a reputable manufacturer, appropriately certified, and in accordance with local regulatory requirements.

**Applicable
Life Saving
Rule(s)**



Bypassing
Safety
Controls



What went wrong

- Lack of hazard recognition and appreciation: Uncertified fall arrest equipment used on some vessels, despite clear SMS requirements to the contrary;
- Lack of awareness of existing company standards and procedures;
- Inadequate audit & inspection process: should have picked up on this earlier – the use of uncertified “Bosun’s Chairs” was not identified nor challenged by shore personnel.
- The lessons were not learned: this has been identified before as an issue on some vessels but still not put right.

Actions

- The unsafe “home-made” equipment was removed and destroyed;
- Arrangements were put in place for only suitably designed and certified fall arrest and man-riding equipment to be used for Working at Height activities.

Members may wish to refer to

- [Uncertified lifting gear found in use](#)

- [Near-miss: Anchoring of rigging to uncertified points](#)

4 Fire in the laundry room

What happened?

A smoke detector was activated. A deck officer checked the origin of the alarm which was coming from an area close to the laundry room. A general fire alarm was sounded; all personnel started to muster, and a firefighting team assembled.

The fire team found the source of the fire which was coming from an industrial tumble dryer in the laundry room. The fire was safely extinguished before the personnel muster was complete.

What went right

- Everyone started to muster quickly and professionally;
- The fire fighting team responded to the action area and put out the fire.

What went wrong

Our member noted that in this case:

- The air flow of the tumble dryer heating system may have allowed flammable material (particulate) to be conveyed through the electrical heating elements and pushed into the drum containing the clothes. The electrical elements are not protected (isolated) and are positioned very close to the actual rotating drum;
- The dryer had undergone recent maintenance (troubleshooting) and the control panel and set-up parameters had been changed during this process, and were different from the original;
- There was no smoke detection in the laundry – only heat detectors – and the alarm was by the smoke detector adjacent the door of the laundry in the corridor because the door was partially open;
- The type of tumble dryer conformed to no known industrial standard.

What were the causes

- Use of equipment that was not certified to have met regulatory safety, health or environmental requirements;
- Changes to the dryer in the troubleshooting/maintenance process;
- Lack of smoke detection in the laundry.

Lessons and actions

- Use equipment complying with a recognized industrial design standard;
- Use spare parts that are either original and/or fully compatible with the equipment;
- Review fire/smoke detection system to identify potential improvements particularly in laundry area.

Members may wish to refer to

- [Near miss: oily rag activated smoke sensor in vessel laundry area](#)
- [Subcontractor ROV control room damaged by fire](#)
- [Fire in incinerator exhaust gas manifold](#)



5 BSEE: Heat-related Illnesses occurring offshore

What happened

The United States Bureau of Safety and Environmental Enforcement (BSEE) has published [Safety Alert 467](#) relating to heat related illnesses occurring offshore.

BSEE notes that there have been multiple recent instances of personnel experiencing symptoms of heat-related illnesses while working offshore. Some examples include:

- An operator noticed a contractor working on a platform experiencing dehydration symptoms. The affected individual was given fluids and told to rest. Out of caution, he was later transported to shore for further evaluation;
- An onsite medic observed signs of severe heat exhaustion in an employee. The employee was treated with IV fluids on board. After consulting with the onshore doctors, the employee was transported in a medevac helicopter to a local emergency room for further medical attention.

Heat exhaustion can be defined as “the body’s response to an excessive loss of water and salt, usually through excessive sweating.” Heat exhaustion is most likely to affect people with high blood pressure and those working in a hot environment.

IMCA members in their operations can experience high temperatures on their worksites and these temperatures and humidity can cause a person to have a higher potential of heat stress. Heat stress can result in heat stroke, heat exhaustion, heat cramps, or heat rashes. Heat can also increase the risk of injuries in workers as it may result in sweaty palms, fogged-up safety glasses, and dizziness.



IMCA has published an Information Note on working in hot weather conditions, which can be found [here](#).