

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 ROV dropped to seabed

What happened?

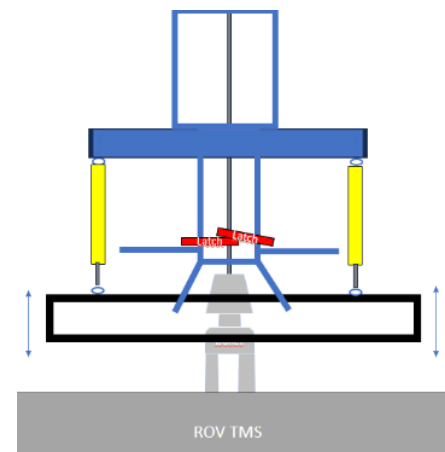
During recovery of an ROV system, the ROV TMS (Tether Management System) experienced a problem latching to the LARS (Launch and Recovery System). The umbilical was damaged directly above the Docking Bullet on the TMS, and was then sheared by the A-Frame docking head latch mechanism. The ROV then dropped into the sea and subsequently landed on the seafloor in a safe zone.



Umbilical Winch End



Umbilical Breaking Point



Sketch of Latches in Abnormal Position

What went right

No-one was in the line of fire and the potential zone of impact during the event.

What went wrong

- An excessive amount of cold and dirty grease was in the latch mechanism which resulted in a slower than expected latching motion;
- The operator of the LARS system could not see the mechanical locked position indicator before releasing the umbilical tension, which resulted in a failed latch attempt. After repeated attempts to dock and lock, the umbilical separated with the result that the ROV fell into the sea and dropped to the seafloor.

What was the cause

- The latch mechanism was not cleaned and lubricated to OEM specifications;
- The LARS procedure specific to the installation was not followed;
- Supervision did not verify the correct maintenance plan nor the LARS procedure before work started.

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Lessons and actions

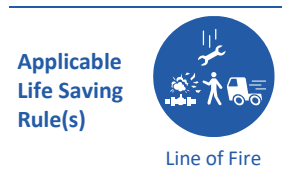
- The latch design can damage an umbilical if it functions improperly and operates incorrectly;
- The company took the following actions
 - Restored latch functionality to normal by cleaning and lubricating, then verifying, the components function per OEM specifications;
 - Reiterated that crew should follow the LARS procedure for the specific ROV system onboard;
 - Ensured that supervisors verify that the correct maintenance plan and LARS procedure is available and is used for the specific ROV system onboard.

Members may wish to refer to:

- [High potential near-miss: Dropped ROV/TMS leading to equipment damage](#)
- [Equipment damage – dropped ROV/tether management system \(TMS\)](#)
- [Loss of ROV: dropped object](#)

2 UK HSE: Service lifts on offshore and onshore wind turbines

The UK Health and Safety Executive (HSE) has published Safety bulletin ED01-2024 on [Service lifts in offshore and onshore wind turbines](#).



What happened

A wind turbine service technician suffered serious injuries when his hand was trapped between fixed and moving parts of a service lift. The worker was able to place his hand into an aperture whilst sending the service lift down using the 'one touch to operate' external controls.

The external controls were positioned on the moving parts, and the design of the landing gates and associated guarding did not prevent him reaching the moving lift car which crushed his hand against the gate.

What was the cause

Design of the base and the upper-level landing gates and associated guarding of a service lift in a wind turbine did not prevent access to the moving lift car. It was possible to reach the moving lift car and become crushed or sheared by it against the rigid portions of the gate.

In addition, failure to follow established standards for reach distances meant that the external controls were not situated in a position of sufficient distance from the danger zone.

The UK HSE noted that:

An absence of defined industry standards for the safe design of service lifts within wind turbines has resulted in discrepancies in the application of required safeguards by designers and manufacturers. This is a potential risk to users. Hazards from the design, guarding, and positioning of controls should be identified and addressed by manufacturers or suppliers. A new standard, 'BS EN 81-44 - Safety rules for the construction and installation of lifts. Special lifts for the transport of persons and goods. Part 44. Lifting appliances in wind turbines' is due to be published. This standard sets the benchmark for the safe design of service lifts and associated safeguards.

The UK HSE noted further that:

- Duty holders who operate wind turbines, and employers of persons who operate or undertake maintenance activities on such wind turbines, should immediately check the design of gates, associated guarding, and the position of the external controls of lifts in use;

- If existing guarding or the position of the external controls is inadequate, you should reposition controls and/or install sufficient guarding. You should either withdraw lifts from use or implement short term suitable control measures to mitigate risks until this work is complete;
- Control measures can allow short-term continued use of the lift until the repositioning of the external controls and/or the installation of additional guarding can be completed.
- Manufacturers and suppliers should help duty holders who operate lifts, or employers of users of lifts, that they have supplied, to eliminate these hazards, and ensure that all lifts supplied satisfy the appropriate regulatory requirements.

Members may wish to refer to:

- [LTI: head injury](#)

3 Dropped halogen lamp caused small fire

What happened

During painting work taking place on a vessel during the hours of darkness, a halogen lamp fell from a scaffolding where the work was taking place, causing a small fire in a scaffold board below. Motormen and deck mechanics promptly responded, adhering to the appropriate emergency protocols, and the fire was extinguished easily. There were no injuries, but the lamp was destroyed and the scaffold board damaged.



Damaged scaffold board



Halogen lamp that fell

What went wrong

- Our member’s root cause analysis discerned that the lamp was blown over by gusts of wind. It was placed in an open environment, exposing it to the weather conditions;
- There was a lack of proper supervision of the halogen lamp during the breaktime absence.

Lessons

- Was this lamp fit for the job? Consider the use of LED lamps;
- Shut down all equipment before taking a break, or ensure a watch is kept over running equipment;
- Ensure installed equipment is stable and safe before starting work, and also after returning from a break;
- Remain aware of weather conditions and what is going on around you when working.

Members may wish to refer to:

- Day Signal mast broke off and fell to deck

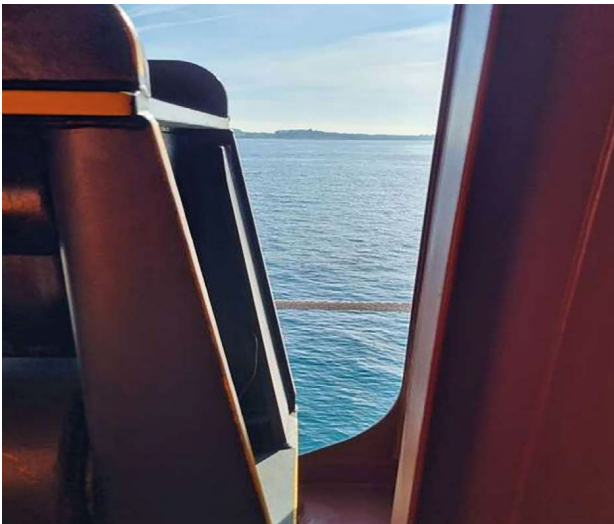
4 MAIB: Man overboard – unguarded opening

The UK Marine Accident Investigation Branch has published [Safety Digest 1/2024](#), consisting of lessons from recent Marine Accident Reports. IMCA has reviewed the report and passes on to members some of the incidents which we consider to be of interest. This is one of them.

What happened

A crew member fell overboard from a vessel approaching port in the early hours of morning. The deck crew were preparing the ship's mooring lines for berthing when, during an attempt to pass a heaving line around a structural pillar next to a fairlead, the crew member lost balance and fell overboard through an unguarded opening.

The bridge was notified; the ship's engine was immediately stopped. The crew member in the water was unable to reach the lifebuoys that were thrown by the ship's crew. A line was thrown from the ship's deck and the crew member, who was floating aft, grabbed hold of it and secured it. The ship's crew used the line to haul the crew member back on board. Following medical assessments on the ship and ashore the crew member was declared to be uninjured and in good health, showing no signs of hypothermia.



The unguarded opening at the time of the incident



The guarded opening following remedial action

What went wrong

- The opening was unguarded – there was nothing to stop anyone falling through it. Whilst with hindsight, after someone fell through it, it was obvious, the unguarded opening was not spotted when the vessel was designed nor during daily operations or previous surveys and audits;
- The action of swinging a heaving line to pass it around the structural pillar had been performed many times without incident, but on this occasion the momentum of swinging the line caused the crew member to overbalance and fall.

Lessons learned

- Work conducted near a vessel's side should include an assessment of the hazard of falling overboard before starting;
- "Dynamic risk assessment" – a valuable tool to quickly identify, analyse and control workplace hazards as they arise. Are you safe, right here, right now?? 'On-the-spot' assessments can be useful to prevent a developing hazardous situation becoming more serious during real-time activities. **Stop the job** if you are uncomfortable with it or feel unsafe;

Actions

- The company required each vessel to undertake an immediate mooring area hazard assessment to prevent similar incidents in the future;
- The company took immediate action to guard the opening – there was swift remedial action to fabricate and install a railing and support to mitigate the risk.

Members may wish to refer to:

- [Positive: vessel improvements made following a man overboard incident](#)
- [Man overboard incident \(not fatal\)](#)
- [Man overboard from stinger](#)

5 MAIB: A slip into the hold

What happened

A crew person was working on a bulkhead locking bolt at the forward end of a hold on a cargo vessel and slipped and fell to the bottom of the hold, resulting in an open fracture to the upper arm. The incident occurred after dark in rainy conditions. Wearing a safety harness with a lanyard and safety hook, the crew person used the recessed footholds in the side of the cargo hold to climb about 2.5m to access one of the bulkhead locking bolts, and attached the safety hook. The crew person was unable to reach the locking bolt and, using one hand to hold on, disconnected the safety hook and attempted to move it to another position. But instead, they slipped from the foothold and their hand slipped from the single handhold before the safety hook could be attached to a securing point, causing the fall.

Owing to difficulties in lifting a casualty out of the hold bottom, medical attention was administered at the scene for over an hour before the crew person could be transferred to hospital for further treatment.

What went wrong

- The safety harness worn in this case was equipped with only one lanyard and hook, limiting the ability of the wearer to move around safely at height;
- There was insufficient illumination: the crew person was working at height in the dark and in the rain;
- The vessel’s Working at Height risk assessments were not sufficiently comprehensive;
- The vessel had neither the procedures nor the equipment to recover an injured person from the cargo hold. Without suitable crew training and recovery equipment, it is possible for a survivable injury to become a fatality.

Lessons

- Think about what could go wrong and then plan and be prepared to respond in the event that it does; it could be you lying at the bottom of the hold in serious pain.

Members may wish to refer to:

- [High potential near miss: Dropped Paraguard stretcher during drill](#)
- [LTI – Person fractured pelvis in a fall from a ladder](#)

Applicable Life Saving Rule(s)

Bypassing Safety Controls





recessed foothold



Injured person