

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](mailto: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 Man overboard during motion compensated gangway transfer

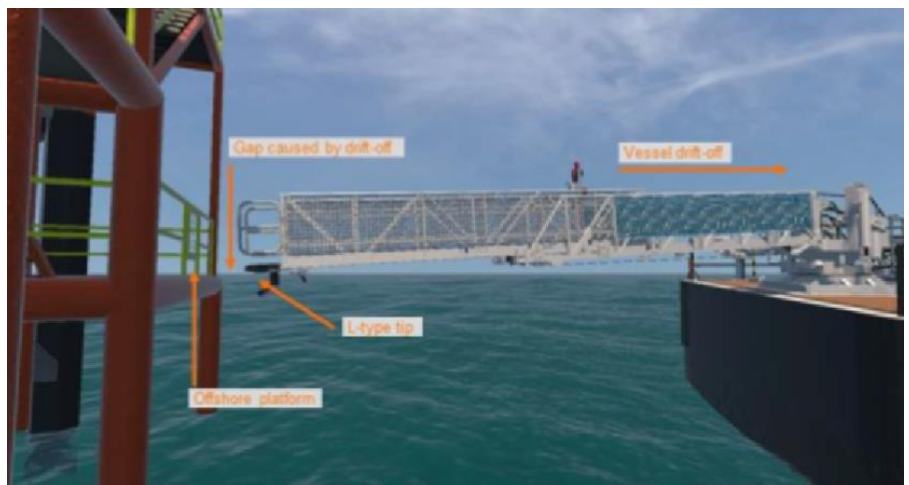
### What happened?

An offshore worker fell overboard from a height of one metre while transferring from a platform to a vessel (non-DP) via a motion compensated gangway. The incident occurred as the vessel drifted off from the platform, resulting in the gangway disconnecting from the platform and creating a gap between the gangway and the platform, through which the worker fell overboard. The worker was able to hold onto the platform's boat landing and was safely recovered back to the platform. After a medical examination, the worker was declared fit to return to work.

Applicable  
Life Saving  
Rule(s)



Line of Fire



### What went right

- The gangway was working correctly and was being operated according to the manufacturer's operational procedures;
- The worker was recovered from the water within 22 seconds with the assistance of the platform's boat landing officer, using a swing rope that was in place.

### What went wrong

- After stepping on to the gangway tip and holding the handrails, the worker heard a warning sound and simultaneously heard the voice from the platform's boat landing officer, which caused him to take a step backward. By the time the worker had stepped back, the vessel had drifted off, resulting in the disconnection of the gangway from the platform. He lost balance and fell overboard through the gap.
- The worker's life-jacket (personal flotation device) did not inflate when he fell into the water. However, he was able to hold on to the platform's boat landing.

### What was the cause

- The vessel (not a DP vessel) operating on manual station keeping, as per normal mode of operation, could not keep station and fully drifted off from the platform;
- After the vessel drifted off, the worker stepped back from the tip instead of stopping and holding onto the railing.

### Lessons and actions

- Ensure you have a clear understanding of the emergency procedures for the gangway before crossing;

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- Other workers transferring should not interfere with the ongoing operation;
- Vessel crew and gangway operator should be well prepared on how to prevent/manage drift off situations through familiarisation of procedures and assessments;
- Ensure that life-jackets and Personal Flotation Devices are checked regularly as fit for purpose;
- Safety induction video should cover all relevant emergency scenarios – the safety induction video was updated.

## 2 UK HSE: fall from height injury at container port

### What happened

The UK Health and Safety Executive (HSE) has prosecuted a logistics company after a worker fell over 10 metres and sustained serious injuries. The worker fell through an open hole in the driver's cab of a straddle carrier, landing on the concrete floor below. The hole had been created by contractors who were replacing a glass floor. See [press release](#).

### What went wrong

- The worker, who was undertaking routine maintenance work, was unaware of the open hole before falling onto the floor;
- The worker's employer had failed to ensure there was a safe system of work at its site – there should have been a system in place that ensured the replacement of the glass floor and routine maintenance work could be carried out safely *at the same time*;
- The company also failed to ensure there was a risk assessment in place;
- The company failed to implement its own policy for the use of permits to work whilst working at height.

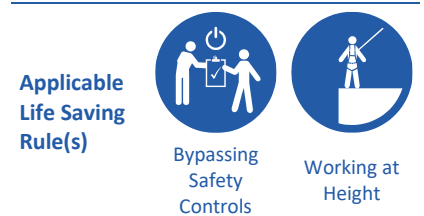
### Lessons to learn

Before performing a similar task, persons involved should be asking the following questions:

- Are you aware of what is going on around you? Take nothing for granted, particularly when working at height;
- How are you dealing with simultaneous operations?
- How are you dealing with the complexities of ensuring safe operations if multiple contractors are working at the same worksite at the same time?
- Is your risk assessment suitable and sufficient? Some recent Safety Flash incidents highlight cases where risk assessment was *not specific enough*;
- Are you following your OWN company rules?

Members may wish to refer to:

- [MSF: LTI – Fall from Height \(control of work during SIMOPS\)](#)
- [LTI: Injury to right wrist](#)
- [IMCA M 023 Guidance on simultaneous operations \(SIMOPS\)](#)
- [IMCA HSS 032 Guidance on safety in shipyards](#)



### 3 Tampering with approved safety devices

#### What happened?

During a client inspection, the sight glass on a vessel main engine lubricating oil storage tank was found to have been fitted with an unauthorised and homemade 'clamp'. An unauthorised 'clamp' was installed on the storage tank without any consideration for the potential consequences. This clamp kept the self-closing valve open at all times, contravening mandatory regulations, company standards and exposing the crew, the vessel and the environment to a significant fire, safety and environmental risk.

Applicable  
Life Saving  
Rule(s)



Bypassing  
Safety  
Controls

#### Why did it happen?

- The modification was made to save time during a routine task, without due consideration to the potential consequences and hazards;
- No onboard routine inspections, safety walk-rounds, observations or interventions had raised a concern regarding the modification.

#### Actions taken

- Thorough search to ensure no such other or similar devices are installed;
- Reminded people of their responsibility to maintain a safe workplace and to raise concerns where any safety devices may have been modified;
- Ensured all personnel are aware that tampering with any valves, alarms, safety devices or other approved measures intended to maintain the safety of the crew, vessel or the environment are unacceptable and will lead to disciplinary measures;
- Daily routines and planned maintenance tasks ought be carried out as per instructions or procedures – there ought be no deviations from the instructions or modifications are made to equipment without the proper approvals or a Management of Change process;
- Ensure that all onboard routines, inspections and walk-rounds consider the integrity of safety devices and highlight any concerns.



*Showing a home-made clamp which ought not have been there*

Members may wish to refer to:

- [Oil tank sight glass push buttons wired open](#)
- [Unsafe actions and conditions – inhibited alarm buttons](#)
- [Deliberate failure to follow instructions: unsafe/quarantined tools brought back into use](#)
- [Plastic cover on smoke detector](#)

### 4 Injury to little finger - LTI

#### What happened

A worker suffered an injury whilst painting an auxiliary winch drum following maintenance. While performing this work a wooden beam was used to prevent the drum from turning freely. Two painters, along with their supervisor, inspected their work area and conducted a toolbox talk before beginning to clean the winch drum base. While cleaning the auxiliary winch drum base, the painters needed to rotate the drum for better access. The two painters manually rotated the drum, one person holding it secured in position, while the other person repositioned the wooden beam to secure the drum. The two workers repeated this process twice without incident. However, the third time, one painter attempted to rotate the drum alone, as the other painter was not present. While positioning

Applicable  
Life Saving  
Rule(s)



Energy  
Isolation



Line of Fire

the wooden beam to secure the winch drum, the drum rotated back, trapping the his little finger between the beam and the winch base. This resulted in a broken finger.

### What went wrong

- One person was trying to do a job that had already been established needed more than one person to do it safely;
- An improvised securing device was used (wooden beam), and this was seen as the most suitable and easy solution to secure the drum;
- Due to the general painting permit that was used for this job, there was no additional risk assessment covering the specifics of painting a winch that might potentially rotate;
- No further assessment was performed on how to properly secure the winch when the drum was in free rotation.



Wooden beam

### Lessons learned

- Stop the job when it cannot be performed safely;
- Don't attempt to perform a two-person job alone; wait for assistance, even when this takes extra time;
- Ensure that a safe and designed-for-purpose securing methods are used, even when this takes more time to prepare;
- Do not use "general" permits and always assess the risks associated with changes introduced to an existing piece of equipment.



Position of hand at the time of the injury (re-enactment)

Members may wish to refer to:

- [Serious Injury from Rotating Winch](#)
- [LTI: foot injury after standing on rotating winch drum](#)
- [IOGP: Squeezed hand due to unintentional activation of winch](#)

## 5 Laceration to right index finger

The Energeo Alliance (formerly IAGC) have published a safety alert relating to a crew person who suffered a laceration to the right index finger whilst going through a door on a vessel.

### What happened

The worker was entering a workshop container located on deck. They opened the door with their right hand and stepped inside holding the door with their right hand to close it behind him. As the door closed, the wind and the movement of the vessel combined to cause the door to close more quickly than anticipated. The injured person's right index finger got caught between the door edge and the door frame, causing a laceration to the right index finger.

### Lessons Learned

- Safety by design: work areas should be designed safely to avoid injuries. Doors inside and outside the accommodation are potential pinch points and this should be addressed in planning;



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Rule(s)



Line of Fire

- Avoid complacency and maintain awareness of the surrounding conditions – take extra care when the vessel is moving during rough weather.

**Corrective Actions**

- Ordered and installed heavy duty door shock absorbers (automatic closers) to eliminate the possibility of being caught in the door and getting injured.



Members may wish to refer to:

- LTI: Hand injury resulting from clothing catching on door
- Line of fire: pinched finger between door and frame
- Crushed finger