

# IMCA Safety Flash 16/19

July 2019

These flashes summarise key safety matters and incidents, allowing wider dissemination of lessons learnt from them. The information below has been provided in good faith by members and should be reviewed individually by recipients, who will determine its relevance to their own operations.

The effectiveness of the IMCA safety flash system depends on receiving reports from members in order to pass on information and avoid repeat incidents. Please consider adding the IMCA secretariat ([imca@imca-int.com](mailto:imca@imca-int.com)) to your internal distribution list for safety alerts and/or manually submitting information on specific incidents you consider may be relevant. All information will be anonymised or sanitised, as appropriate.

A number of other organisations issue safety flashes and similar documents which may be of interest to IMCA members. Where these are particularly relevant, these may be summarised or highlighted here. Links to known relevant websites are provided at [www.imca-int.com/links](http://www.imca-int.com/links) Additional links should be submitted to [info@imca-int.com](mailto:info@imca-int.com)

Any actions, lessons learnt, recommendations and suggestions in IMCA safety flashes are generated by the submitting organisation. IMCA safety flashes provide, in good faith, safety information for the benefit of members and do not necessarily constitute IMCA guidance, nor represent the official view of the Association or its members.

## 1 LTI: Foot Injury After Standing on Rotating Winch Drum

### What happened?

An AB was taking part in a task to re-spool a wire onto an aft deck tugger winch, when he climbed onto the side of the tugger winch and, whilst stood there, the rotating winch drum trapped both his feet. His injuries include a fractured foot and severe abrasions.

His boots (proper personal protective equipment (PPE)) prevented a much more serious injury.



### What went wrong?

- ◆ The crewman failed to identify the hazards associated with the tugger winch;
- ◆ None of his colleagues intervened or told him to stop when they might easily have **STOPPED** the job' when he put himself in the line of fire;
- ◆ The risk assessment was inadequate – it did not include this particular hazard associated with the tugger winch.

### What actions were taken? What lessons were learned?

- ◆ "Hazard hunt" focusing on winches and the hazards associated with them;
- ◆ Review of risk assessments related to deck operations to ensure that the hazards associated with winches are captured;
- ◆ Someone was injured because no-one intervened or stopped the job; remind all that it's OK to **STOP** the job if it's unsafe.



Members may wish to refer to:

- ◆ [Hydraulic umbilical winch operation – trapped thumb](#)
- ◆ [LTI: Tugger Winch Incident \(MSF\)](#)
- ◆ [Winching Equipment \(2000\)](#)

## 2 Sprained Ankle Whilst Climbing on Equipment

### What happened?

A crewman slipped and sprained his ankle climbing off equipment on which he had been working. The incident occurred inside a transition piece (the lower part of an offshore wind turbine tower). A crewman was climbing down off a cable rack (on which he had climbed to loosen cable cleats and apply a heat blanket) when he slipped off and twisted his ankle, losing balance and falling onto the floor.

He managed to walk back to the vessel over the walk-to-work (W2W) gangway on his own, and suffered no fractures; however, he sprained his ankle, restricting him from normal duties for three days.

### What were the causes?

- ◆ The cable rack was not designed to be climbed on; the spacing between rungs varies and does not follow the standard for fixed ladders;
- ◆ Access to the work location on top of the cable rack was not addressed in the risk assessment and the related procedure;
- ◆ Inadequate mitigations implemented; the narrow workspace in the transition piece does not allow the use of stepladders and work platforms.

### What lessons were learned?

- ◆ Identify hazards at design stage to ensure that safe access can be achieved;
- ◆ Before starting work, safe access to any site should be established. If this can't be achieved, then **STOP** the job and report the issue to your Supervisor;
- ◆ Ladders and platforms – safe and appropriate to the conditions should be used and working at height processes should be followed.

Members may wish to refer to:

- ◆ [Near miss: Improper use of fall-arrest equipment leads to fall](#)
- ◆ [Fatality in ballast water tank – working at height in a confined space](#)
- ◆ [Lost Time Injury \(LTI\): Fall From Height](#) [similar issue in 2013 – crewman fell off while climbing on equipment]

## 3 Line of Fire: Cutting Injury to Index Finger

Whilst using a safety knife to remove the outer sheaving from a core conductor, a crew member managed to cut his finger. The safety knife slipped through the sheaving and resulted in a wound to the soft tissue of the fingerprint area of the left index finger, and a superficial laceration near the mid-point of his ring finger nail.

### What went wrong?

The immediate cause identified was that the injured person had failed to recognise that he had placed himself in the line of fire. He held the cable with his left hand and drew the knife (held in his right hand) towards himself. It was at this point that the knife slipped through the sheaving and made contact with his left index finger and left ring finger.





*Re-construction of the cutting activity*



*The injury received to index finger*

### **What was the cause?**

Additional underlying/root causes also identified by our member are listed below:

- ◆ The risk assessment did not detail suitable control measures to ensure that people were not in the line of fire, nor did it specify the specific tools or PPE to carry out this task;
- ◆ There had been no task risk assessment (TRA) directly before starting the job.

### **What actions were taken? What lessons were learned?**

- ◆ 'Engineer out' potential line of fire injuries; in this instance, alternative tooling and technique to be utilised for the removal of outer sheaving from a core conductor;
- ◆ Continue embedding the International Association of Oil & Gas Producers (IOGP) Life Saving Rules within the company processes and culture;
- ◆ Risk assessment should be suitable and sufficient for the task to be performed, specifying the correct tool(s) and PPE; the correct PPE should be readily available and used.

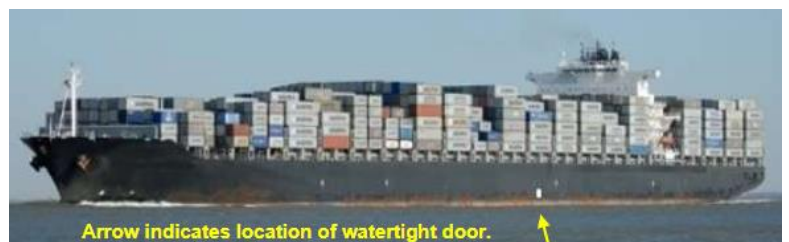
Members may wish to refer to:

- ◆ [Lost Time Injury \(LTI\) – finger laceration due to use of knife](#)
- ◆ [Lost Time Injury \(LTI\): severed tendon](#)
- ◆ [Finger And Hand Injuries](#)
- ◆ [Watch your hands](#) (short video)

## **4 Man Overboard Fatality**

### **What happened?**

The US Coast Guard (USCG) has published [Safety Alert 05-19](#) relating to a man overboard fatality. The incident occurred when a very large (330m) container ship arrived in port in heavy weather (40 knot winds and 4m swell.) The vessel was on a WNW course with seas on the vessel's starboard quarter, manoeuvring at about 10 knots to make a lee in preparation to embark a ship's pilot at a port side hatch. Two crewmen were preparing for the pilot's arrival, behind the hydraulically operated bi-fold hatch door. This was located forward of the bridge and approximately 4m above the waterline – see photographs. As the vessel manoeuvred, it was hit by heavy seas that forced the hatch door open, resulting in flooding of the embarkation space, sweeping one crewman out to sea and injuring another.



The crewman who was washed overboard and subsequently swept out to sea was lost and presumed dead after 28 hours of searching by the local Coast Guard. The injured crewman suffered a broken leg when the pilot ladder fell on him. The hatch door itself was damaged.

#### **What went wrong? What were the causes?**

- ♦ The two crewmen were unable to see the sea from their position behind the hatch door. As they opened the door, seas unexpectedly struck and violently forced it open, flooding the space;
- ♦ One of them was not wearing a harness or safety line, nor a personal flotation device and was washed overboard and subsequently swept out to sea.

The USCG reiterates the need to take the greatest care with personnel transfer at sea, especially in heavy weather conditions. Even though the side hatch door was located on the port side and was being brought onto the vessel's lee, the crew's inability to observe and assess the sea conditions combined with the ship's roll and sea state presented significant risks.



The US Coast Guard strongly recommends the following actions:

- ♦ A thorough review and update of vessel Safety Management Systems (SMS), procedural manuals and guidance that relates to pilot transfers;
- ♦ Reinforce the importance of wearing personal protection devices and safety lines when working over the side of a vessel, when exposed to the elements or when there is an absence of barrier that could prevent an accidental water entry;
- ♦ Ensure officers and crew identify potential hazards and conduct a risk assessment, to include a consideration of weather conditions, prior to opening hatch doors of this sort;
- ♦ Ensure crew communications between navigation watch officers and crew, in situations such as this, are clear and provide suitable supervision of activities, considering sea state and other changing conditions.

Members may wish to refer to:

- ♦ [Engine Room Emergency Hatch Damage](#) [during heavy seas]
- ♦ [Near Miss: Cargo Shifted in heavy seas whilst alongside platform](#)
- ♦ [Near Miss: Cargo Shifted on deck in heavy weather](#)

Members may also wish to search at [www.imca-int.com/safetyflashes/search](http://www.imca-int.com/safetyflashes/search) for terms such as pilot or man overboard.

## **5 Two Incidents Relating to Life-Rafts/Life Boats**

### **Incident 1: Life-Raft Inadvertently Deployed**

During monthly inspection of the life-raft, the port side life-raft was accidentally released into the water and activated. The incident was reported to the bridge, vessel made a MOB manoeuvre and crew were mustered. FRC was lowered to retrieve the life-raft, which was recovered without incident.

#### **What went wrong?**

The second mate was doing the monthly inspection of the life-raft. He inspected how to release the life-raft and checked if it was lashed properly. In doing so he accidentally opened up the clip that launched the life-raft into the water, and because the painter line was still connected, the life-raft was activated.

The second mate was inexperienced with this type of release system and on his first job on this kind of vessel, made his first contract on this type vessel.

### **What actions were taken? What lessons were learnt?**

- ◆ Place an extra seal on the locking clip to prevent accidental opening when walking past or during inspection and make clear that this part must not be opened unless in an emergency. NB: such a seal must still be easy to break during emergencies;
- ◆ Improve familiarising and training of crew;
- ◆ Encourage crew to ask for advice from someone who is more familiar with vessel systems.

### **Incident 2: Lifeboat Davit Failed During Test Deployment**

A vessel was at anchor in a quiet bay and the suggestion was made to take out both lifeboats for tests. Whilst the port side boat was being lowered, with crew inside, a hydraulic part failed, and the forward davit arm fell down to the horizontal. The chief mate (operating the levers) continued to deploy the lifeboat to water, calling down not to release the hooks yet. Crew inside the lifeboat noticed something was wrong because during lowering, the lifeboat tipped bow down by approx. 0.5m. There were no injuries.

The lifeboat was recovered using the forward crane and stored on deck as a quick repair was not possible.

### **What went wrong?**

Investigation revealed that there was a damaged/worn thread and broken bearing in the davit hydraulic equipment.

### **What actions were taken?**

- ◆ Cleaned articulated bearing, found thread inside worn and rusted, bearing cracked and a piece broke off. All other similar articulated bearings checked to see if they also needed to be replaced.;
- ◆ Temporary fix arranged to ensure that the davit arm cannot move further than normal lowering position.

Members may wish to refer to:

- ◆ [Lifeboat Drill – Near Casualty](#)
- ◆ [Lifeboat Damaged Whilst Being Lowered On Davit](#)
- ◆ [Failure Of Life Rafts During Servicing](#)
- ◆ [Life Raft Self-Activates And Falls To The Quayside](#)