

## IMCA Safety Flash 01/12

January 2012

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 [webmaster@imca-int.com](mailto:webmaster@imca-int.com)

### I Near Miss: Crane Hook Block Dropped to Deck

A member has reported an incident in which a crane winch wire parted and the hook block was dropped to deck. The incident occurred when the crane operator began to extend the jib of the crane without letting out the winch wire at the same time. The extending jib caught the hook block and caused the crane winch wire to part. The hook block, which weighed 30kg, dropped 10 metres (m) to the deck. There were no injuries.



*Crane following incident*

An investigation revealed the following:

- ◆ The crane operator was not paying proper attention to the extending jib;
- ◆ The crane operator had not informed his supervisor that this work was taking place;
- ◆ The crane operator was effectively working alone: there was no-one else watching the crane whilst it was being operated;
- ◆ There was no locking or warning mechanism fitted to the crane to prevent this from happening.

The following measures were taken to prevent recurrence:

- ◆ Review training of persons operating cranes and winches;
- ◆ Review of risk assessment for this job;
- ◆ Investigate installation of lock protection sensors for this kind of crane.

## 2 Lost Time Incident (LTI) – Laceration to Finger

A member has reported an incident in which a crewman on a dive support vessel suffered a serious laceration to one of the fingers of his left hand. The incident occurred when deck crew were engaged in opening the aft bell moon pool door prior to diving operations.

During this operation, it was normal practice for a member of the deck crew to use his foot to hold open the spring-loaded retaining hook for the aft bell moon pool door. However, after three failed attempts to hold the retaining hook with his foot, a crewman decided to use his hand instead. Whilst doing this, the hook slipped and the injured person's hand was caught between the hook and the edge of the moon pool door. One of the fingers on the injured person's hand was badly cut as a result. The location and depth of the laceration was such that it had to be treated ashore to minimise risk of infection. The injury was X-rayed and redressed and the injured person was away from work for a week.



*Spring-loaded latch operated by foot*

*Fingers were trapped here*



*Showing rope tail in use (making manual handling unnecessary)*

An investigation revealed the following:

- ◆ The immediate cause of the incident was that the securing hook was too stiff to be held open by foot;
- ◆ The root cause was that the old spring had recently been changed out and a new one fitted to the securing hook, which made it too stiff to operate. The potential problems this change introduced were not noticed, highlighted or addressed before operations restarted.

The following action was taken:

- ◆ The hook was modified to remove the need for hands to be in close proximity of the locking clamp. A hole was drilled in the clamp and rope attached to facilitate safe operation. Future operators will pull to release the hatch to open, thereby encouraging a hands free approach.

### 3 Near Miss: ROV Broke Free of Cargo Strops during Heavy Seas

A member has reported an incident during bad weather in which an ROV which had been tied down broke free when the vessel was rolling heavily. The ROV started swinging on its supporting crane winch wire and narrowly missed personnel working nearby. No-one was injured; the ROV suffered slight damage.

The incident occurred whilst the vessel was waiting on weather in approximately 4m seas and 36 knot winds. The vessel was manoeuvring close to a floating production storage and offloading unit (FPSO) at the time and made a sudden turn, which caused an extreme roll. The stands upon which the ROV was stood slipped and the ROV itself moved, which caused its cargo strops to loosen. As a result the ROV began to swing on the crane winch wire, which was supporting the weight of the vehicle.

The ROV hit the bulkhead a number of times and narrowly missed two crewmen nearby. The crew managed to get the swinging ROV under control; the crane was started and the ROV lowered onto the deck, where it was properly sea-fastened and an assessment of possible damage then took place.

It was found that there had been some slight damage to the hydraulic hoses on the torque tool, which was attached to the ROV.

An investigation revealed the following:

- ◆ The immediate cause of the incident was that the existing fastenings were not adequate to hold the ROV against an extreme sudden movement of the vessel;
- ◆ Contributory factors were poor communication between bridge and back deck, poor judgement of sea conditions, and loss of concentration.

Members may also refer to [IMCA M 205](#) – *Guidance on operational communications*.

### 4 H<sub>2</sub>S Leak during Umbilical Laying

A member has reported an incident in which there was a H<sub>2</sub>S (Hydrogen Sulphide) leak during umbilical laying operations. A deck-hand and others on deck noticed a smell of rotten eggs. Vessel management were informed, activities were halted and the area isolated. A specialist contractor was brought in to test the air for H<sub>2</sub>S, and when the area was tested clear, operations were resumed. No-one was contaminated and no-one reported feeling sick or ill.

The following was noted:

- ◆ Owing to lack of awareness that there might be H<sub>2</sub>S in the umbilical, there were no control measures in place;
- ◆ Appropriate tests and measurement of potential H<sub>2</sub>S should be made before and during such umbilical deployment operations;
- ◆ If leaks are found, umbilical operations should be halted until a specialist contractor can be brought in to assist in dealing with the gas.

### 5 Dropped Object: Injury Resulting from Failure Caused by Corrosion

The United States (US) Department of the Interior Bureau of Safety and Environmental Enforcement Gulf of Mexico OCS Region (US BSEE) has published a safety flash regarding a dropped object injury resulting from the corrosion-based failure of the eline (electric line) used in well abandonment operations. A crewman who was guiding equipment into a well-bore, was struck on the foot and injured by a falling object. It was found after the incident that the eline was corroded and brittle with some strands broken.

Members can find further information at [www.bsee.gov/Regulations-and-Guidance/Safety-Alerts/SA\\_298-pdf.aspx](http://www.bsee.gov/Regulations-and-Guidance/Safety-Alerts/SA_298-pdf.aspx)