

IMCA Safety Flash 02/18

January 2018

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) 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. Additional links should be submitted to 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: Feet Trapped in Motion Compensated Telescopic Gangway

What happened

A crewman got his feet trapped under the sliding step of an Ampelmann motion compensated telescopic gangway. The incident occurred during the hours of darkness when he was using the gangway to walk from a W2W ('walk to work') vessel to a normally unmanned installation. He suffered serious but not life-threatening injuries, resulting in a lost time injury (LTI). The emergency response was activated and he was evacuated to hospital.

What went wrong?

This incident is still in the final stages of investigation.

The following observation has been made:

- ◆ The gap between the sliding step and the fixed part of the gangway on this particular system was sufficiently large to trap the steel toecap of a regularly sized safety shoe/boot.



What were the causes of the incident?

- ◆ There was no specific design criteria for the gap between the sliding step and the fixed part of the gangway, nor was there an absolute norm for the monitoring of the gap;
- ◆ There was insufficient lighting on the gangway which resulted in a lack of awareness of the location and movement of the sliding step;
- ◆ The gangway induction video did not generate sufficient awareness regarding the potential hazard of the movement of the sliding step and its associated pinch points.

Lessons learnt

Ampelmann has learnt that despite its systems being designed and tested to be safe, more rigorous standards, controls and checks are required particularly for dealing with the risks associated with the sliding step.

The sliding step is well marked, but the markings are not clearly visible at night. Better lighting would increase awareness of the location of the moving sliding step and its associated pinch points.

Actions taken?

- ◆ Immediate check of the gap has been conducted on all Ampelmann gangways of this sort, and where required, corrective action taken;
- ◆ Reassessment of engineering specification of the gap in production, and implement maintenance procedure for regular monitoring of gap;
- ◆ Improve the existing safety video by increasing the emphasis on the sliding step and the associated pinch points;
- ◆ Increase the night-time visibility of the sliding step on both existing and future systems:
 - retrofit gangway lighting to the existing fleet
 - include gangway lighting on future gangway designs.

Members may wish to refer to the following incidents:

- ◆ [Lost time injury \(LTI\): Crewman injured foot during offshore renewables mooring operation](#);
- ◆ [Hydraulic umbilical winch operation: Trapped thumb](#) [winch operator trapped his thumb between the safety guard and the drum].

2 Lifeboat Damaged During Deployment Drill

What happened

A lifeboat was damaged because of equipment failure during a routine deployment drill. During a routine boat drill in port, the starboard lifeboat was lowered to water level. The hooks were released by pulling the release wire in the boat. When the crew were hooking the boat back on, the lock lever of the forward hook would not turn. After much difficulty, the lock lever was turned enough to prevent the boat from unhooking.

During this delay in hooking, owing to the wave motion, the boat came in contact with the side of the vessel, causing minor damage where the railing supports were drilled through the lifeboat's fibreglass hull.



Plastic and metal sheathed wire broke. The worn-down condition could not be seen during routine inspections

What went wrong? What were the causes?

- ◆ The release wire was broken inside the sheathing and this was not visible to the crew;
- ◆ The on-load release mechanism hook could not be locked in the shut position and the locking piece for the forward hook froze, delayed the hoisting;
- ◆ A **causal factor** was that the release wire was not inspected or checked by the maker during the 5 yearly tests of lifeboat in the dry dock which had been completed two months prior to this incident;

- ◆ **Root causes** identified included:
 - there were no clear instructions in the maker’s manual regarding renewal intervals of sheathed wires;
 - inadequate compliance/risk seen as tolerable – the service technician certified the condition of the boats and its equipment as good based on the test conducted at a recent drydocking.

What actions were taken? What lessons were learnt?

- ◆ Deeper awareness needed of the risks involved with hidden or difficult to access failure or corrosion;
- ◆ Instructions on renewing the release wires as per maker’s recommendation to be placed on board;
- ◆ Use portable fenders if available when work is being carried out on boats while at water level and the sea state demands it.

Members may wish to refer to the following similar incidents:

- ◆ Open lifeboat – Corroded tie band side plates;
- ◆ Failure of lifeboat release hook mechanism;
- ◆ Near-miss: Corrosion-related failure of bolts used to secure lifeboat winches;
- ◆ Lifeboat damaged whilst being lowered on davit.

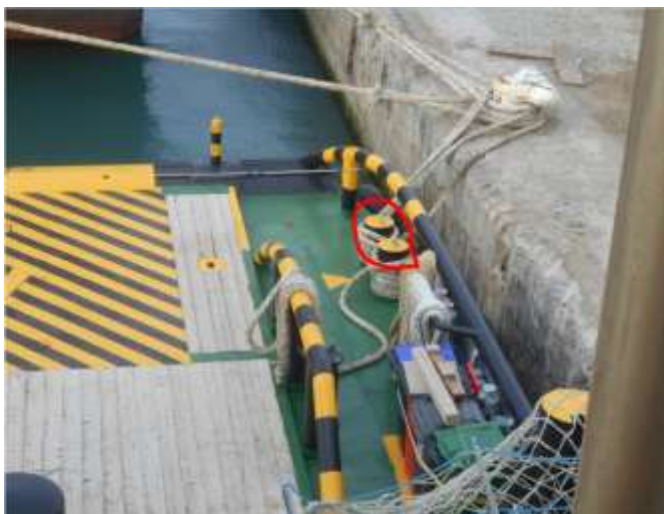
3 High Potential Near Miss: AB Slipped Over the Side During Mooring Operations

What happened

During mooring operations, an Able Seaman (AB) jumped from the vessel to the quayside to receive the mooring ropes. In doing so he slipped over the bulwark and fell over the side into the sea from a height of 1.75m. At that time, the gap between the vessel and the quay was 0.5-0.6 m.

While falling, he managed to grab the vessel fender with his hands, keeping the upper part of the body out of the water. The vessel Master had a direct line of sight to the incident; he immediately stopped the engines and manoeuvred the stern away from the quayside using the bow thruster. This prevented the AB from being crushed between the vessel and quayside as well as from being drawn into the propeller.

He was helped back onto deck by a colleague and after a check-up it was confirmed that he appeared to be unharmed. Nevertheless, he was sent to a medical facility on the same day for proper examination which verified his fitness for work.



What went wrong? What were the causes?

- ◆ **Procedures not followed:** By jumping from the vessel to the quay, the crewman violated existing written procedures. All other persons present were aware that this practice was forbidden, and were aware of the possible consequences, but no-one stopped him;
- ◆ **Shortcuts:** The vessel Master did not ask the Port Authority for assistance due to alleged issues experienced in past, where this assistance was either not provided or was provided with a significant time delays. As a result, a shortcut was taken by the vessel crew, which resulted in the incident;
- ◆ **Routine acceptance of risk/complacency:** It was concluded by the investigation team that the unsafe practice of jumping from the vessel to the quayside had developed over time without being confronted or stopped by management.

Lessons learnt

This was a high potential near miss incident which could have been avoided if assistance was requested by the vessel Master from onshore. This incident could easily have resulted in a fatality, and serves as another reminder that shortcuts and deviations from established procedures and safe working practices are not acceptable.

Members may wish to refer to the following incidents:

- ◆ [Non-fatal man overboard incident;](#)
- ◆ [Man overboard fatality: Tragic consequences of failing to follow safety procedures](#)

4 LTI: Finger Injury While Using 'Safe Hands' Tool

What happened?

Step Change in Safety (<https://www.stepchangeinsafety.net>) reports an incident in which a crewman sustained a finger injury while using a 'safe hands' tool to manoeuvre a container into place. Crew were working to move load handling containers onto the skid deck using a 'safe hands' tool (blind lift).

A container was landed onto the skid deck. As it was being manoeuvred into position against the back skid rail, the container moved to the right. The crewman moved towards the side of the container and during this process his hand (which was placed at the back end of the 'safe hands' tool) came into contact with a scaffold rack. His finger was nipped between the scaffolding rack and the butt of the 'safe hands' tool, resulting in the loss of the tip of one of his fingers.

Operations were stopped and the load made safe. A time out for safety was held with the deck crew to review practices and the risk assessment.

What went wrong? What were the causes?

- ◆ Although all personnel on the job were competent and experienced in conducting the task, the focus and attention of the injured person was on moving the container and not on his immediate surrounding;
- ◆ The gap between the container and the scaffolding rack was not identified as a hazard before starting the job;
- ◆ The load handler's hand was at the back of the 'safe hands' tool and out of his view and focus.

See [here](#) for the Step Change Safety Moment.

Members may wish to refer to the following incident:

- ◆ [Line of fire LTI: Finger injury during lifting operations](#)



IMCA publishes a wide range of safety promotional material including the following:

- ◆ [Pocket card and short video – In the line of fire;](#)
- ◆ [Longer video – In the line of fire.](#)

5 Near Miss: Potential Dropped Object Due to Unsecured Door

What happened?

[Step Change in Safety](#) reports an incident in which there was a potential dropped object due to an unsecured door on a load. The incident occurred when a flat pack spooler unit was being lifted from a vessel onto a platform.

What went wrong? What were the causes?

During the lift, the storage door had opened which revealed a small tool box inside which was not secured.

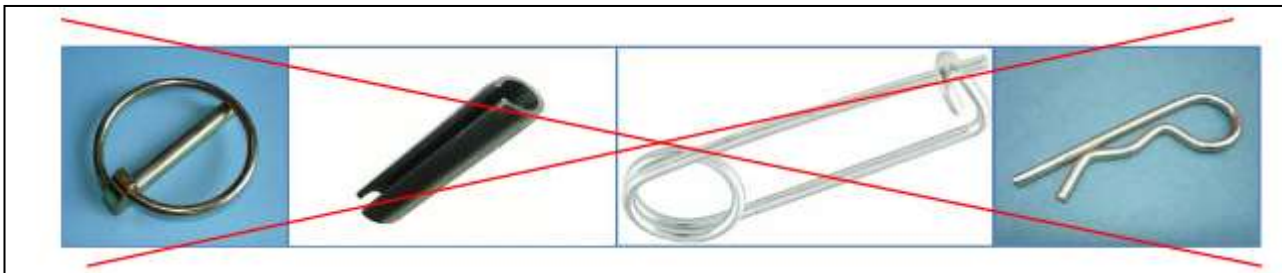


Actions taken?

- ◆ Secondary retention solution put in place:



Unsuitable secondary retention methods include linchpins, R-clips, spring/roll/nappy pins or any other type of pin device. All these means of secondary retention for lifting equipment or securing at height can spring open or be knocked out.



See [here](#) for the Step Change safety moment.

Members may wish to refer to the following incident:

- ◆ [High potential near miss: Dropped object.](#)