IMCA Safety Flash 04/06

March 2006

These flashes summarise key safety matters and incidents, allowing wider dissemination of lessons learned 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.

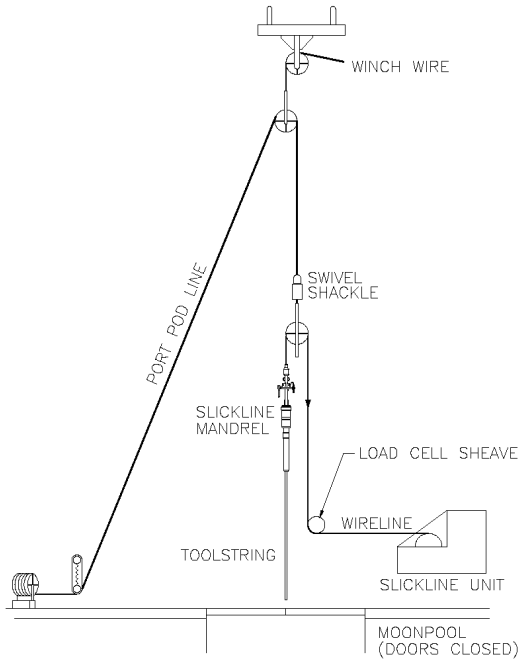
The effectiveness of the IMCA safety flash system depends on receiving reports from members in order to pass on information and avoid repeat incidents. Please consider adding the IMCA secretariat (imca@imca-int.com) to your internal distribution list for safety alerts and/or manually submitting information 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 webmaster@imca-int.com

1 Fatality – Falling Object

A member has advised of a fatality, the initial details of which follow.

During wireline toolstring recovery, accidental contact with the wireline sheave was made, causing the assembly to fall to deck, fatally injuring a crew member. This occurred when the port pod line was raised to allow visual inspection of the bottom of toolstring and to break tool down without wireline being paid out first.



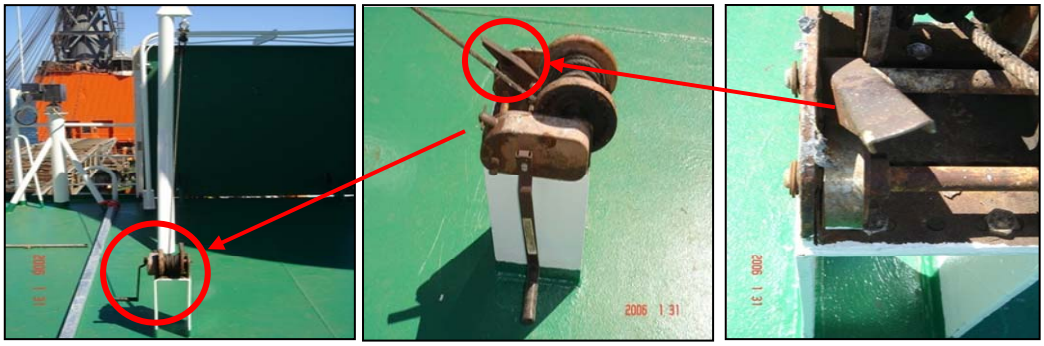
GENERIC SLICKLINE RIGGING SET UP

The company has noted the following lessons to be learnt:

- The common industry practice of working in close vicinity to suspended wireline tools presents a dropped object hazard that should be recognised and eliminated;
- Communications between all team members involved with lifting operations needs to be improved;
- In lifting operations, all necessary steps should be taken to ensure that tools/devices are not drawn into any sheave;
- Risk assessments of wireline lifting operations must identify such hazards;
- Written work procedures must clearly state how risks will be managed;
- Common work practices and contingency activities must be subject to risk assessment and documented as a written procedure.

2 Wrist Injury Sustained During Vessel Maintenance

IMCA has received a report on an incident wherein a member of a vessel crew sustained wrist injuries during maintenance activities. Two crewmen were raising a small landing platform from one deck to another using a small hand driven winch. One was operating the hand-driven winch, turning the handle in a clockwise direction. As the handle approached the 2 o'clock position, the crewman's hand slipped off the handle. There being no ratchet mechanism fitted to the winch, the handle spun around in an anti-clockwise direction, striking the crewman hard on the left hand at the top of the forefinger and thumb. He suffered some bruising to the left wrist and was taken to hospital. Subsequent x-ray examination of the wrist revealed that no bones had been broken.



The company's investigation of the accident revealed the following causes:

- the winch handle was too small;
- the manual brake system was not fit for the purpose;
- the existing winch was primitive and overdue for replacement;
- the winch had been relocated due to accommodation installation and its proper use had not been tested;
- the other crewman, who had been operating the manual brake, had been unable to apply it immediately.

The company implemented the following corrective actions:

- order and fit a newer and better winch, more fit for purpose;
- appropriate pre-testing of equipment after relocation;
- perform job safety analysis before the specific operation;
- review configuration of winch wire set-up;
- as an interim measure, until the existing winch is replaced, lengthen winch handle on existing winch.