

IMCA Safety Flash 05/19

March 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) 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 High Potential Near Miss: Passenger on a CTV Narrowly Avoided Being Crushed Between Vessels

What happened?

A passenger on a crew transfer vessel (CTV) climbed over the bulwark during a vessel-to-vessel manoeuvre, but narrowly avoided being crushed.

Whilst conducting routine crew transfer duties, a vessel was requested to return to a workboat it had just visited, as a passenger had forgotten his mobile telephone. When the vessel got near the workboat, the passenger who had made the mistake rushed outside and climbed over the bulwark with one leg. He thus put himself in a position where his leg could have been crushed as the two vessels came together. The deckhand pulled the passenger to safety over the bulwark and onto the deck before the two vessels made contact, and thus the possibility of injury was averted.

What were the causes of the incident?

The passenger was feeling embarrassed by the need to alter the sailing schedule of the CTV due to his mistake in forgetting his mobile phone. His haste and anxiety overrode his situational awareness. Though the passenger was a trained seafarer, he acted outside of his normal behaviour and put himself in considerable danger.

What was the outcome?

A change in schedule or abnormal circumstances can cause those who are trained and experienced in a task to act unrecognisably or without consideration for risk.

The crew reinforced the correct procedure for transfer onboard and made it clear that passengers are requested to remain seated or within the recognised safe areas of the vessel until instructed to embark/disembark.

Members may wish to refer to:

- ◆ [Unsafe Attempt Of Personnel Transfer Between Vessels](#)
- ◆ [High Potential Near Miss: AB Slipped Over The Side During Mooring Operations](#)

2 Near Miss: Potential Fall Through CTV Hatch

What happened?

A passenger on a crew transfer vessel (CTV) came very close to falling down an open hatch. The incident occurred after a vessel crew change had been abandoned due to poor weather conditions for the transfer. The CTV returned to port. Poor weather conditions resulted in many passengers becoming seasick.

On arrival in port, the passengers disembarked the CTV via the personnel transfer pontoon. One passenger was lagging behind the others and then made his way back on to the vessel (to retrieve a personal bag) without alerting the vessel crew. At this point, the CTV crewman had already opened a deck hatch to retrieve equipment from below decks and was stood below deck with his head protruding through the hatch opening at deck/foot level.

After speaking to the crewman in relation to the bag he had left on the CTV, the passenger attempted to gain access to the vessel cabin via the walkway in which the hatch was open. This action had the potential to injure both the CTV crewman and the passenger. The passenger was prevented from doing so by the site representative, who thus prevented injury to two people.



What went wrong? What were the causes?

- ◆ The passenger re-boarded the vessel without alerting, or seeking the permission of the vessel crew;
- ◆ The passenger was suffering the effects of seasickness and was possibly less aware of potential hazards;
- ◆ The chain on the pontoon between the vessel and the pontoon was not replaced following disembarkation of passengers and site representative boarding;
- ◆ There was no physical barrier for the open hatch - site personnel providing barrier/lookout;
- ◆ Due to short notice and early hour of the day for the crew change, the passengers had not received a site induction but were provided with a site 'chaperone' and should have received a vessel induction.

What lessons were learned?

- ◆ Barriers should be in place around open hatches;
- ◆ Where possible, hatches should be opened when only vessel crew are onboard;
- ◆ All persons onboard should be informed when hatches are opened;
- ◆ Development of procedure for management of opening hatches to add to vessel SMS;
- ◆ There should be clear site and CTV induction stating that permission is to be sought before boarding a CTV;
- ◆ Physical barrier (gate) to be closed and bolted once all passengers have disembarked the CTV.

Members may wish to refer to:

- ◆ [Crewman falls down open hatchway during simultaneous operations](#)
- ◆ [Fall through open hatch in walkway](#)

3 Near Miss: Diver Reports Tight Gas

What happened?

Shortly before the start of diving operations, a diver reported that his gas was becoming tight, resulting in him having to switch to his bailout and return to the submersible diving chamber (SDC).

SDC checks were completed by a diver who was new to the system; he was assisted by a diver who was familiar with the system. The full SDC checklist was used, covering:

- ◆ Internal valve status and function;
- ◆ Electrical checks;
- ◆ Equipment checks.

On completion of checks, the Bellman was instructed by the Dive Supervisor to secure the gases before returning to the chamber system, as there was a two-hour delay.

Our member notes that securing internal valves when an SDC launch is delayed is a legacy practice to prevent gas usage via leaks through the panels or the diver's hats. The checklist does not cover this practice, thereby introducing reliance on the bellman to remember to put the gas on line prior to the diver locking out.

On returning to the SDC, the internal valves were not returned to their operational position as per the diving checklist.

Diver 1 locked out of the SDC and started to prepare diver 3's umbilical when his gas became tight. He informed the diving supervisors he was going onto bailout. The diving supervisor informed the divers in the SDC that diver 1 was returning and asked them to check his surface gas supply.

Diver 1 came into the bell mouth and raised his head up out of the water line, by which time the bellman had opened the divers supply and onboard gas hull valves to give him surface gas again.

On confirmation of the diver's primary and secondary gases being online, diver 1 locked out again, followed by diver 2.

Our member's summary

The practice of securing the SDC internal gas when there are known delays to locking off was adopted in the past due to system leaks and improper equipment stowage and securing; it is no longer considered good practice.

The purpose of the checklist is defeated if the valve status is changed after the checklist is considered completed. Safety critical checklists can only be effective in reducing human error if used at the correct stage of the process.

Deviation from processes and procedures should be managed and communicated. In this case, the deviation should have been captured in the diving supervisors log or handovers and the checklist should have been repeated.

What lessons were learned?

- ◆ Checklists and procedures are critical for safe operations and should be followed;
- ◆ Any deviations from procedures and processes should be managed;
- ◆ If deviation becomes common practice, then the procedures or checklists should be formally reviewed and updated;
- ◆ If gas supplies are secured whilst the SDC is onboard, a complete SDC internal valve check should be performed to ensure status of all valves is correct before diving operations recommence;
- ◆ SDC internal checklists were updated to consider the scenario noted here.

Members are encouraged to continue to educate both new and experienced personnel on:

- ◆ The importance of following procedures and checklists;
- ◆ The value in providing feedback on procedures and checklists;
- ◆ Use of the management of change (MOC) process for any deviations, regardless of how minor.

Members may wish to refer to:

- ◆ [Near Miss: Diver Loss Of Gas](#)

4 Near Miss: Winch Wire Snagged and Released Suddenly

What happened?

During drilling operations on a land-based drilling rig, the thimble within the hard eye of the winch wire momentarily caught (snagged) on the edge of the drill rig chassis. It then released in an uncontrolled manner very close to the driller. The incident occurred when the driller found it necessary to raise the drill mast, resulting in the winch wire being pulled upwards. As the winch wire was pulled up, the thimble caught on the edge of the drill rig chassis. The driller failed to notice that the winch wire had become snagged and continued to raise the mast, thus continuing to increase the tension in the wire until the steel thimble bent, causing the wire and attached hoist plug to release in an uncontrolled manner.



Hoist plug



Damage sustained to chassis and steel winch wire thimble



The sudden and uncontrolled release of the winch wire and the attached hoist plug had the potential to cause significant personal injuries had it struck a member of the drill crew.

What were the causes?

- ◆ Failure to identify and recognise snagging hazard;
- ◆ Incipient complacency in what was seen as a 'routine' task.

What lessons were learned?

- ◆ Investigate engineering/practical solution: retract the winch wire to a safe position when not in use; where this is not possible, lower the winch wire to a safe location away from all structures and other potential snagging hazards. Keep contained within a trip tray or bucket to prevent a tripping hazard;
- ◆ Highlight the importance of managing all lifting operations, including winch operations and awareness of complacency creeping into routine tasks;
- ◆ Review procedures and task risk assessments to ensure that the potential for lifting equipment (winch wires) becoming snagged is appropriately considered and mitigated. All control measures should be included;
- ◆ Careful check of potential snagging hazards before operation of the winch or the lowering/raising of the drill mast.

Members may wish to refer to:

- ◆ [Near Miss: Snagged Lifting Bridle](#)
- ◆ [High Potential Stored Energy Incident: Inner Buoyancy Module Clamp Failure During Removal](#)
- ◆ [Stored Energy Near Miss: person nearly hit by equipment caught during light daughtercraft operations](#)
- ◆ [Guidelines for Lifting Operations \(IMCA SEL 019\)](#)