IMCA Safety Flash 10/03

August 2003

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 Near Miss – Modification of Machinery

Keywords: Near-miss

A member has advised of the following near miss. A mechanic was working on a jet pump when a bracket holding the jet hose failed. The bracket was being used to rack jet hose. When falling, the hose could potentially have struck the mechanic and caused injury. Fortunately it did not.

Investigation showed that the bracket had been welded to the jet pump in the field and appeared to have failed upon the equipment returning from a project.

The company has noted the following:

- Welding or cutting reduces the designed strength of a frame and can causing lifting points and/or the frame to fail during lifting options;
- Any modifications to standard-configuration equipment needed 'in the field' should be considered using the company's management of change procedure prior to them being carried out;
- Any such modifications will only be made after completion and approval of the management of change process, involving rotating stock and safety personnel;
- Any such modifications, if approved, should only be carried out by an appropriately certified welder;
- No modifications should be made which bypass or override any safety device under any circumstance.

2 Fatality – Fall from Height Arising from a Failure to Use Personal Protective Equipment

Keywords: Fall

We have received the following incident report, involving a fall from height from an offshore platform.

A contractor was working on the skimmer level of an offshore platform, approximately 10½ metres above the water, to wrap a light fixture in preparation for sandblasting operations.

He had been told by his supervisor in their safety meeting to use a 'spider' (a lifting device), safety harness and work vest to get to the fixture, as it extended outward from the walkway. However, the contractor chose to lean out from the walkway and through the handrails, instead of using his PPE.

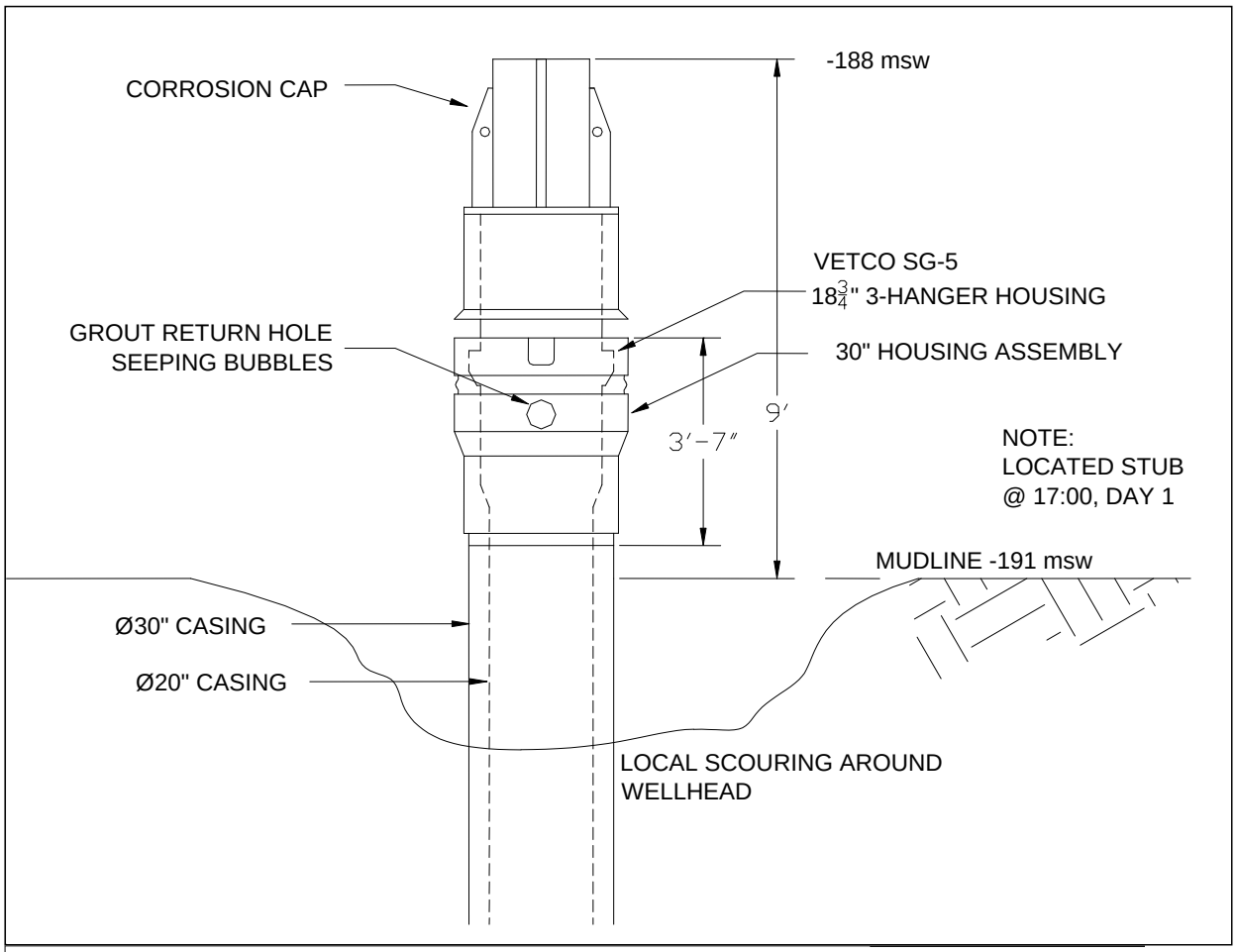
While attempting to wrap plastic around the light, the fixture broke off of its pedestal and the contractor, who had the majority of his weight shifted outward, fell, striking his head on the way down and entering the water unconscious. He was retrieved from the water, but never regained consciousness.

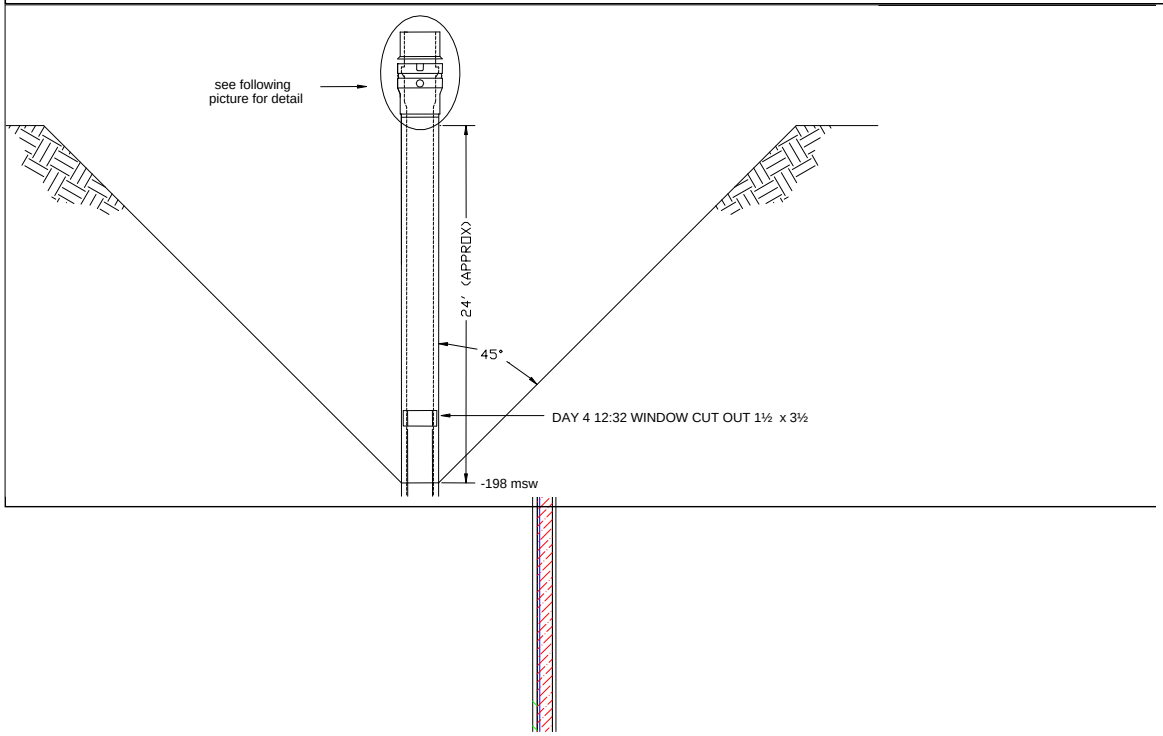
The company involved has reiterated the importance of never taking shortcuts and the need for job safety analyses and understanding of all of the potential hazards. It has circulated information on this incident to be included in all of its safety meetings and site orientations, to underline the consequences of taking shortcuts. It is also reviewing the fall protection section of its relevant handbook.

3 Diver Fatality – Underwater Explosion

Keywords: Explosion

A member has advised of a recent fatality, involving an experienced diver, which occurred during underwater cutting operations as part of a well stub removal project. The site conditions and sequence of events are summarised in the diagrams below.





The company's subsequent investigation has noted the following findings:

- Site conditions had proved to be different from those represented in the end-customer's drawing, in terms of the wellhead connector assembly, bubbling gas and lack of grout between annuli;
- Generic procedures had been produced for what had been considered a 'standard' or 'routine' well stub removal;
- The job safety analysis (JSA) had focused on excavation as the primary risk;
- A 'can do/will do' attitude can be prevalent among dive teams and in the wider industry, which may have caused some resistance to halt operations;
- The project manager only had limited involvement in this operation;
- The on-site procedure, developed by a widely experienced team of diving superintendent, supervisor and diver, proved to be not adequate to avoid the fatality.

The company has noted the following actions:

- It has instigated a 'formal request for information' procedure for retrieval of additional information from customers;
- It has reiterated that salvage and burning jobs are never routine and are potentially hazardous. It has noted the need for detailed procedures and project risk assessments to be prepared, as per its project management procedures;
- It has noted the need for project management procedures to include formal job handover procedures and project risk assessments;
- It has pointed out the need for formal project risk assessments and work site job safety analyses (JSAs) to identify all potential risks before commencement of operations;
- It is aiming for a better implementation of its 'safety stand-down' system through reinforcement training, in accordance with its management-of-change procedures, to bring about a 'can do/will do safely' culture embraced by all employees;
- Again in relation to a better implementation of its management-of-change procedures, the company has noted that, whenever appropriate, project managers, senior and/or onshore management and the customer are to be involved in and to approve all significant changes to procedures.

4 Incident Involving a Crane Boom

Keywords: Crane

We have received a report of an incident whereby a crane boom fell from an angle of 45° onto its rest. There was no one in the crane at the time of the incident, but one person on the main deck was slightly hurt by the debris as the crane boom fell. The crane suffered significant damage to the boom, luffing winch, brake and hydraulic motor and the potential for serious injury is obvious.

No root cause has so far been identified and an investigation is still ongoing. Initial investigations suggest that, although the crane was left parked in a properly parked mode, both winch drum brakes and the safety pawl all stayed off or partially off when the crane was de-energised, when they should all have engaged. Three co-incidental failures seem extremely unusual and investigations are currently centred on whether the hydraulic system could have somehow locked pressure in to keep all the brakes off.