

IMCA Safety Flash 12/12

November 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) 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

I Lifeboat Damaged Whilst Being Lowered on Davit

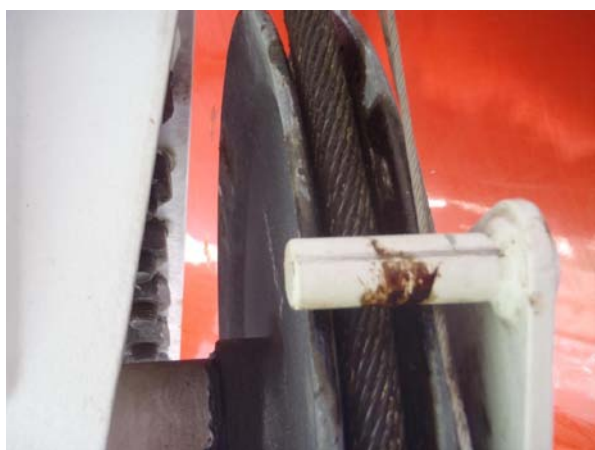
A member has reported an incident in which a lifeboat was damaged. The incident occurred when the davit was boomed out to lower the lifeboat. The lowering was part of a functionality test after adjustment of limit switches by the manufacturer's service engineers.

Whilst booming out, one of the remote control wires for lifting the brake got trapped behind a wire sheave arrangement. When the wire became taut, the remote control wire lifted the static brake and the lifeboat started lowering while it was still above the deck. The lifeboat got stuck on its protection fender, from which the stainless steel turnbuckle parted. The lifeboat then swung out sharply and was damaged in several locations when it swung back in, hitting the side of the vessel. The lifeboat then descended to the water on the centrifugal brake control. It was not possible to stop the process as the remote control wire remained stuck and taut, lifting the static brake.

The lifeboat was moderately damaged, suffering a puncture hole in the starboard side bottom (approx. 5 x 5 cm), crushing damage to the fibre-glass on the starboard forward top (approx. 80 x 15 cm), and loss of some of the water sprinkler tubing, which came off when the lifeboat hit the side of the vessel. No one was in the lifeboat at the time and there were no injuries.



Figures showing damage to lifeboat



Figures showing how remote wire got stuck behind a wire sheave arrangement

During our members' investigation the following points were noted:

- ◆ It was unclear when the remote control wire had slipped in between the sheave and sheave guard. It was difficult to observe the many obstacles which could potentially foul this wire;
- ◆ If the remote wire had been kept under adequate tension this would have prevented the likelihood of it fouling;
- ◆ The fact that the lifeboat could be lowered while not yet fully boomed out could be considered a design error. The manufacturers have been asked to investigate this further;
- ◆ The likelihood that the remote wire could become fouled was not foreseen by the manufacturers, and there were no written procedures or instructions covering this.

The following recommendations were made:

- ◆ Persons involved with lifeboat lowering and recovery should ensure that the remote wires are constantly out of the sheave and not fouled with any other rigging.

2 Near Miss: Dropped Object

A member has reported an incident in which a pipe-wrench weighing 1.2kg fell 15m to the deck. The incident occurred when hand tools were being hoisted up for use by personnel working at height. Two workers at height were preparing to lift three tools at once from the deck to their working platform, using a low pressure air hoist. A tag line was attached to one of the tools to help guide and avoid entanglement. Once the load could no longer be controlled by the tag line a "NO GO ZONE" was put in place and the DROPS zone directly below was cleared of personnel. As the tools came to the level of the working platform one of them got caught on the bottom of the platform, which tore the stitching of the single leg tether (rated at 30lbs breaking strain). The result was that the tool fell 15m back to the deck. There were no injuries. The workplace was made safe and a safety stand-down was held.



Figures: (L) pipe-wrench that fell (R) snapped single leg tether

Our member's investigation noted the following:

- ◆ The crew had held a job safety analysis (JSA) meeting beforehand and identified and assembled the tools required for the job;
- ◆ The immediate cause of the incident was that the tool became caught during the lift, which caused the DROPS tether stitching to tear, allowing the pipe wrench to fall to the deck below.

Our member drew the following key lessons from the incident:

- ◆ DROPS training plans should be continually emphasized;
- ◆ Care should be taken with the safe work load (SWL) of straps and tethers used for hoisting tools;
- ◆ Single leg tethers should not be used as lifting devices;
- ◆ Establish a pre-use inspection and regular inspection cycle for DROPS equipment;
- ◆ Carefully identify entanglement points on the lift route when hoisting tools aloft.

Members' attention is drawn to the following IMCA material which may be of assistance:

- ◆ [IMCA SEL 019 Guidelines for lifting operations](#)
- ◆ [IMCA SPP 04 Avoiding dropped objects](#)
- ◆ [IMCA SPC 05 Lifting equipment](#)
- ◆ [IMCA SPC 06 Working at height](#)
- ◆ [IMCA SPC 12 Avoiding dropped objects](#)

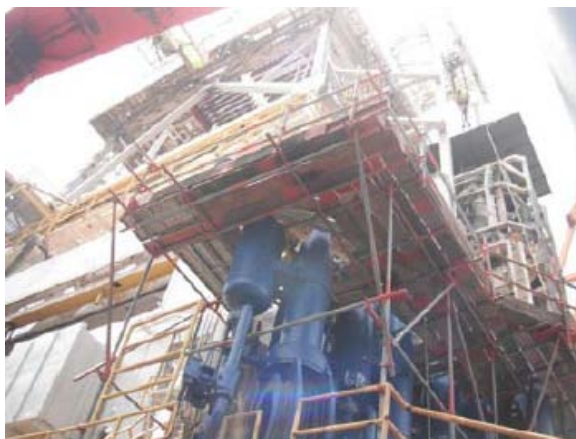
3 High Potential Near Miss: Dropped Object

A member has reported an incident in which a piece of angle bar fell 11m to the deck. The incident occurred when shipyard workers and third party contractors were in the process of removing a tensioner platform. It was mistakenly assumed that contractors had completed the cutting of the tensioner platform, as all barricade tape directly under the cut tensioner platform had been removed.

Workers were rigging the tensioner platform to be lifted out when they noticed a piece of angle bar that had not been cut, hence, preventing the platform from being lifted. A worker was deployed to cut the angle bar. He cut the top side of the angle bar before he passed the cutting torch to another person to cut the bottom part of the angle bar because it was beyond his reach. This second person then cut off the angle bar and placed it on the scaffold before returning to his original task. As he did so, he unwittingly kicked the angle bar off the scaffolding, and it fell to the deck below.

Four members of the crew were on the deck when the piece of angle bar fell from scaffold platform above and landed next to them, approximately 1.5m away. Had the piece of angle bar struck one or more persons in that group, it could have caused severe or fatal injuries.

An immediate safety stand down was held for all personnel involved.



Figures: (L) Tensioner platform (R) showing where angle bar landed and bounced



Figure showing piece of angle bar where it finally landed

Our member found that the root causes of the incident were as follows:

- ◆ One of the workers doing the cutting was not qualified to do this task;
- ◆ The unqualified worker doing the cutting did not remove or secure the angle bar from the scaffold;
- ◆ There was no barricading tape found below the scaffold platform.

Our member took the following corrective actions:

- ◆ All loose materials should be removed from all high level working platforms. If this is not possible, all materials must be relocated away from the edge of platform and should be properly secured;
- ◆ All areas underneath where work is taking place at height should be barriered off with hazard tape when overhead work is in progress, and should remain until after the overhead work is completed;
- ◆ A guard worker may be posted outside the danger zone to prevent access to the hazardous dropped object zone;
- ◆ Only properly trained and competent workers should be allowed to carry out the work;
- ◆ Before work at height starts when the vessel is in the shipyard, appropriate inspection of the worksite should take place by qualified shipyard personnel.

Members' attention is drawn to the following IMCA material which may be of assistance:

- ◆ [IMCA SEL 019](#) *Guidelines for lifting operations*
- ◆ [IMCA SPP 04](#) *Avoiding dropped objects*
- ◆ [IMCA SPC 05](#) *Lifting equipment*
- ◆ [IMCA SPC 06](#) *Working at height*
- ◆ [IMCA SPC 12](#) *Avoiding dropped objects*

4 US Coast Guard Alert: Problem with Certain Kinds of Personal Flotation Device

The United States Coast Guard (USCG) has published the following Marine Safety Alert regarding certain Mustang Survival Inflatable PFDs with Hammar MA hydrostatic (HIT) inflation systems which may not inflate and require a new re-arm kit to properly inflate by manual or automatic activation. This safety alert identifies which products are affected. Certain inflatable personal flotation devices may be subject to delayed or non-inflations. Further information can be downloaded from www.fish.state.pa.us/newsreleases/2012press/uscg_alert_3-12.pdf