

## IMCA Safety Flash 17/09

December 2009

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](mailto: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](http://www.imca-int.com/links). Additional links should be submitted to [webmaster@imca-int.com](mailto:webmaster@imca-int.com).

### I Injury During Personnel Transfer Capsule Operation

A member has reported an incident in which a person was injured during a personnel transfer capsule operation. Three persons involved in pipeline commissioning activities on a recently installed jacket were preparing for a personnel transfer back to the vessel from which they had initially been transferred. The method of transfer was to be by the transfer capsule.

Prior to the actual lift, a swing developed on the crane's headache ball. The swing gathered momentum, despite the efforts of the crane operator to stop it, until it eventually hit one of the platform's legs and ricocheted into the capsule frame. A section of the crane rigging and headache ball hit the frame of the transfer capsule before sliding into the interior of the frame and impacting one of the three occupants.

The injured person was medevaced to hospital for attention. After a thorough medical examination and precautionary tests, the worker was released that same evening and deemed fit to return to work for light duties.



*Jacket showing personnel transfer capsule and crane wire*

Following investigation, the following findings were made:

- ◆ Alternative arrangements for accessing the platform had been identified but not considered;
- ◆ For this work, the personnel transfer capsule should have been identified as the primary means in the event of an emergency only;
- ◆ The crane operator had received no training for transfer capsule operations even though this omission had been identified during risk assessment;
- ◆ The transfer capsule operation had taken place safely on two previous occasions and thorough risk management controls had been followed and implemented;
- ◆ On this occasion the risk assessment for the operation had not taken into account a number of important factors and necessary risk control measures were not implemented;

- ◆ Procedures specific for vessel to platform (jacket) transfer were not followed;
- ◆ The personnel transfer capsule was not lowered on to the jacket in the area originally specified during risk assessment;
- ◆ The size of the area to which the capsule was lowered was not in compliance with the manufacturer's recommendations;
- ◆ On this occasion the crane operator did not lay the headache ball down on the jacket during the boarding of the capsule because of worsening swell conditions and restrictions on landing area (see picture);
- ◆ The personnel being transferred took longer than normally required to secure themselves within the capsule;
- ◆ The sea state in this region is known to produce a 'larger swell' at irregular intervals. This was the case in this event as a 'rogue swell' was also involved in causing the initial swing on the headache ball;
- ◆ A shift change had taken place between the initial lift on to the jacket and the recovery from the jacket back to the vessel. The crane operator was the same throughout but the deck foreman and his crew were all new to the operation and not been involved in the task risk assessment (TRA) or toolbox talks.

The following actions were recommended:

- ◆ Risk management processes should be followed thoroughly for all high potential operations and repeated every time an operation is carried out. This is even more important when operations are carried out by different personnel;
- ◆ Actions identified during risk assessments should be fully closed out before operations begin. In this instance crane operator training had not been carried out;
- ◆ Management of change processes should always be followed whenever circumstances change during an operation. If necessary the operation should be stopped whilst this is carried out;
- ◆ All personnel involved in an operation should be fully briefed beforehand during the toolbox talk;
- ◆ Manufacturers' instructions and recommendations on the use of equipment should be followed;
- ◆ All personnel have a responsibility to intervene and stop an operation which is clearly unsafe.

## 2 Loading and Securing of Containers

A member has reported several occurrences over recent months of containers being inappropriately loaded and transported with contents in an unsecured and consequently unsafe manner and seeks to highlight this as a safety issue. It had come to the attention of the company that unsafe packing of containers is something that is still evident, in spite of this issue being addressed in recent years. The potential exists for injury, environmental impact or equipment damage caused by unsecured cargo moving in the container or spilling out when the doors are opened. The company highlighted some recent examples of poor practice:



*The grab handle of this blue steel case has not been secured and the case is resting on top of other equipment*



*The contents of a freight container are left unsecured. Some are labelled as fragile*



*This item is secured in an inadequate manner (nylon strapping) for its weight and value*



*This heavy item was loaded in closed container making it very difficult to unload offshore*



*Orange clump weights (500kg) unsecured and stored on top of lighter materials*



*Heavy and valuable motor left unsecured for transit*

Consideration should be given to the safety of the people at the receiving end and also their material handling capabilities. The loading of containers should be planned to facilitate the ease of unloading on arrival at the destination.

The following actions were suggested:

- ◆ Place contents in suitable containers, giving consideration to material handling capabilities of those receiving the load (i.e. forklift availability, access, container type);
- ◆ Distribute the contents evenly over the floor to maintain balance;
- ◆ Place heavier items at the bottom with lighter goods on top – do not place heavy cargo on top of fragile cargo;
- ◆ Use packing materials to prevent damage between items of cargo;
- ◆ Always lash down (and wedge if necessary) cargo to prevent movement in transit;
- ◆ Do not pack sharp items next to soft skinned drums;
- ◆ Certain chemicals and materials, when combined (possibly through transit damage), can become toxic, highly flammable or explosive – such materials should be kept separate;
- ◆ Ensure the doors and locking mechanisms are secure with locking device attached (including secondary securing device) and where applicable, use door safety nets;
- ◆ Ensure no loose items have been left on the roof of containers.

There is sufficient industry guidance available regarding the safe packing and handling of cargo to and from offshore locations and the International Maritime Dangerous Goods (IMDG) Code should also be followed. Additionally, following the guidance in IMCA SEL 019 – *Guidelines for lifting operations* – should help prevent such occurrences.