

# IMCA Safety Flash 30/19

December 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](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 [info@imca-int.com](mailto:info@imca-int.com)

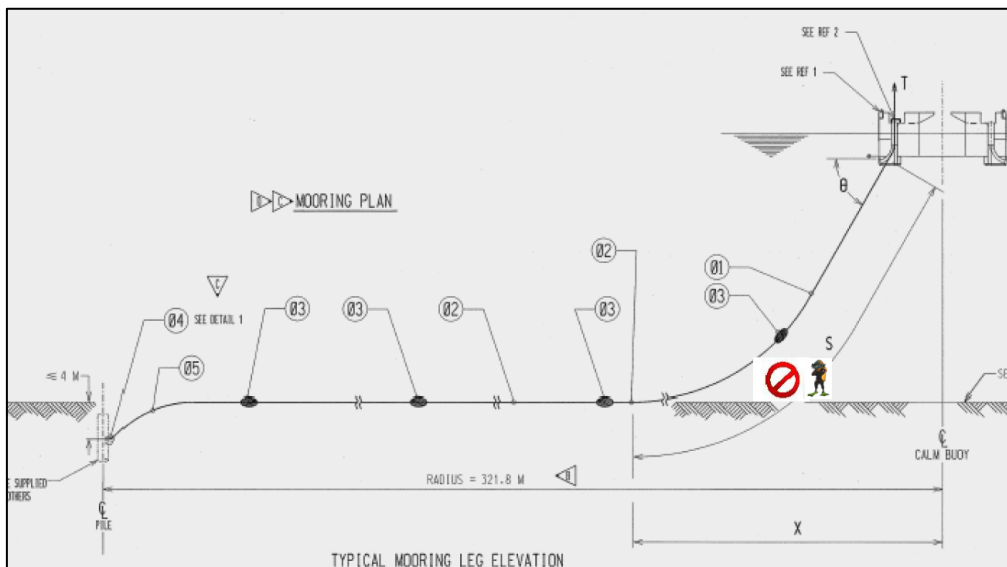
Any actions, lessons learnt, recommendations and suggestions in IMCA safety flashes are generated by the submitting organisation. IMCA safety flashes provide, in good faith, safety information for the benefit of members and do not necessarily constitute IMCA guidance, nor represent the official view of the Association or its members.

## 1 Diver Trapped by Anchor Chain

### What happened?

During diving operations to locate a pipeline end manifold (PLEM) near a single point mooring (SPM), a diver was trapped by an anchor chain. The incident occurred when Diver 1, searching for the PLEM, went underneath the anchor chain without realising it. His umbilical got caught and he turned back to find that it was trapped between the chain and the seabed. He tried without success to free it, and then tried to pass back under the chain, which moved at that moment, trapping the diver at the chest and left shoulder. Diver 2 was deployed to rescue Diver 1; he cut the umbilical and assisted Diver 1 back to the basket and safely back to the surface. Decompression was not necessary owing to the shallow water depth (10-16m) and bottom time.

Diver 1 was diagnosed in the shipboard hospital as having suffered a minor thorax trauma and was discharged for rest.



### What went wrong?

Investigation noted the following contributing factors:

- ◆ Risk assessment and procedures:
  - hazard identification was neither suitable nor sufficient for the project
  - company manuals and procedures were not followed;

- ◆ The client provided necessary information only at a late stage;
- ◆ There were “*adverse environmental parameters*” – heavy seas were causing significant movements of buoy and chains;
- ◆ The vessel was in the wrong place, and the vessel’s movements were inappropriate for the ongoing operation; i.e. the dive basket moved during dive while diver was on the bottom.

### What actions were taken?

Our member took a number of detailed actions and recommendations which may be summarised thus:

- ◆ More effective hazard identification (HAZID);
- ◆ Ensure all necessary information for safe operations is available in a timely way;
- ◆ Reiterate the full authority and responsibility of the Dive Supervisor in diving operations.

Members may wish to refer to:

- ◆ [Near miss: Fouled Diver Umbilical](#)
- ◆ [Trapped Diver Umbilical Incident Resulting In Diver Fatality](#)
- ◆ [Near Miss: Diver’s Umbilical Trapped](#)

## 2 Failed Shackle on Vessel Life Raft

### What happened?

There was a failure of two stainless steel “D” shackles forming part of a life raft hydrostatic release assembly on a vessel. This was discovered whilst the vessel was in the 500m safety zone of an installation. A crew member noticed one of the vessel’s starboard life raft containers was in the water. The life raft was still attached to the vessel via the painter (rope). The crew member immediately notified the bridge team who stopped all non-essential operations and informed the installation. The vessel deck crew attempted to recover the life raft intact by using the painter; however, the life raft inflated. The inflated life raft was secured to the side of the vessel which then departed the 500m safety zone and safely recovered the life raft to deck.



### What went wrong?

The failed/parted shackles released the strap securing the life raft container to its stand. As a result, the life raft container fell into the water but remained connected to the vessel via the painter. The life raft inflated (as expected) when tension was applied to the painter. The shackles potentially failed due to crevice corrosion over time.

### What actions were taken?

- ◆ Appropriate authorities were informed, and arrangements were made to replace the inflated life raft;
- ◆ All remaining life raft stainless steel shackles were replaced;
- ◆ Inspections were carried out to identify vessel equipment with potential for crevice corrosion and galvanic corrosion;
- ◆ Weekly checks to be carried out on the condition of shackles during weekly life raft inspection;

- ◆ The preventive maintenance schedule was improved to ensure the timely replacement of such stainless steel shackles before they fail.

Members may wish to refer to:

- ◆ [Failure Of A Shackle](#)
- ◆ [Welding Of Shackles](#)
- ◆ [Near Miss: Shackle Configuration](#)
- ◆ [Near Miss: Corrosion-Related Failure Of Bolts Used To Secure Lifeboat Winches](#)

### 3 Uncontrolled Movement of Retractable Gangway

#### What happened?

During lifting up and securing of a vessel's retractable gangway, the spring latch of the lifting device disconnected causing an uncontrolled release of the holding wire, and the gangway fell. The hand-crank of the lifting winch began rotating at high speed causing risk of injury to operating personnel.

The gangway was secured using the vessel's crane. There were no injuries.



#### What went wrong?

- ◆ An unsafe gangway had been provided and requests for repair had not been met with any response;
- ◆ The vessel crew did not use “**stop work authority**”.

#### What actions were taken?

- ◆ Inspect all lifting appliances for the gangway;
- ◆ Replace damaged parts – spring latch replaced;
- ◆ Modification to gangway to secure it from possibility of uncontrolled fall.

Members may wish to refer to:

- ◆ [Third-Party High Potential Near Miss – Dropped Gangway](#)
- ◆ [Lost Time Injury \(LTI\): Gangway Deployment](#)
- ◆ [Near Miss: Uncontrolled Movement Of Gangway](#)

## 4 Exploding Television Recovered from Sea

### What happened?

One morning the crew of a workboat noticed an old television set floating in the sea near their work area. They decided to take it on-board in order to prevent it from potentially causing damage to a passing yacht or fishing boat.

Just before they were going to land it, the television set exploded violently, destroying its case and sending shards of glass all over the aft deck. The crew were fortunate indeed; had their timing been different the TV set could have exploded in their hands on deck. Fortunately, in this incident, both crew members were still in the wheelhouse and fully protected.

The television set was covered in weeds and shells, indicating that it had been in the water for some time.



### What actions were taken?

Ensure that you are wearing appropriate personal protective equipment (PPE) and treat objects recovered from the sea with extreme caution.

Members may wish to refer to:

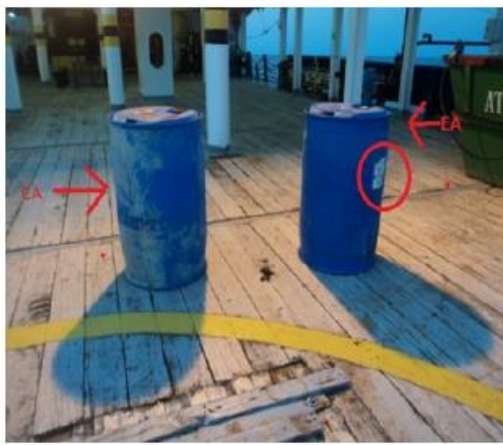
- ◆ [Floating Ignition Source drifts near to production platform](#)
- ◆ [High Potential Near Miss: Unplanned Handling Of Unexploded Ordnance](#)

## 5 Unknown Floating Objects in 500m Safety Zone

### What happened?

Several floating objects were identified in the 500m safety zone of an installation. Our members' vessel was requested to remove/tow these objects out of the safety zone to protect the installation. While doing so, the propeller of a fast rescue craft was damaged.





### What went wrong?

- ◆ Unknown floating objects in the water creating a potential hazard for damage to vessels and small boats at work or offer a potential hazard to the installation.

### What actions were taken?

- ◆ The potential risks associated with unidentified objects at sea, whether floating or on the seabed, should be properly and thoroughly assessed, particularly when retrieval, towing and handling, or other intervention, is indicated. This risk assessment should include whether or not such objects are hazardous by nature and to what extent they could harm crew or assets;
- ◆ Any potentially hazardous objects should be reported to relevant emergency response services to be dealt with. Relevant agreements should be in place and well known by crew members and to be followed;
- ◆ Vessel crew and small boat/workboat crew should be vigilant and monitor any floating objects in water.

Members may wish to refer to:

- ◆ [Floating Ignition Source drifts near to production platform](#)
- ◆ [High Potential Near Miss: Unplanned Handling Of Unexploded Ordnance](#)

## 6 Vessel Hit and Destroyed Fender

### What happened?

A vessel collided with the quay, destroying the fenders. The vessel picked up the pilot and proceeded towards the harbour. The wind was SSW 4-5 with good visibility. As the vessel passed the breakwater with a speed of 5.5 knots,

the pilot advised to change over to the bridge wing control. During the change over to the bridge wing control, the vessel began to turn to starboard.

The pilot ordered that the vessel turn hard to port, engine half ahead and bow thruster full to port. After a few seconds, the Master realized that this manoeuvre would not prevent the vessel from impacting the quay, therefore he left the bow thruster full to port and give the main engine full astern to reduce the impact. The vessel hit the fenders of the quay on starboard bow. The fenders were destroyed.

#### What went wrong?

- ◆ The combination of wind and current coming past the breakwater forced the vessel to starboard;
- ◆ Insufficient attention was given to the movement and motion of the vessel;
- ◆ The crew were distracted by the change to bridge wing control.

#### What actions were taken?

- ◆ Crew to make an overview of all items which influence this kind of incident and identify lessons learned.

Members may wish to refer to:

- ◆ [Vessel Made Contact With Rig Legs](#)
- ◆ [Have a regime when the current's abeam – ensure adequate manoeuvring space!](#)

## 7 Improper Use of Heaving Line

#### What happened?

During a mooring operation, vessel crew were found to be using a 4 ton shackle attached to a heaving line (instead of proper “monkey fist”).



#### What went wrong?

- ◆ The crew did not have an available heaving line with a “monkey fist”.

#### What actions were taken?

- ◆ Risk assessment for mooring operations to be reviewed.
- ◆ A check to be included to ensure that a sufficient number of heaving lines with "monkey fist" are available. In this case, at least 9 heaving lines were to be kept on the vessel (2 for use at each mooring station plus 1 spare).

Members may wish to refer to:

- ◆ [Incorrectly Weighted Monkey's Fist](#)
- ◆ [Near Miss: Unauthorised Release Of Shore-Controlled Mooring Lines](#)
- ◆ [Mooring practice safety guidance for offshore vessels when alongside in ports and harbours \(IMCA SEL 029\)](#)