IMCA Safety Flash 32/16

November 2016

Basic Safety and Seamanship

Here are five different events all of which were first published by regulatory organisations or other trade bodies. Whilst there is no common focus, all incidents deal with omissions or potential omissions in the fundamentals of safety and seamanship.

1 Don't Lose Your Tow in Heavy Weather

The United States Coastguard (USCG) has published the following marine safety alert to remind owners and operators of the importance of planning for significant towing operations. Though primarily aimed at large drilling rigs, such as semi-submersibles, conical or other types of non-standard tows, it has broad application to all offshore engineering activities.

In late 2012, the *Kulluk*, a conical drilling unit, suffered a series of mishaps which ultimately caused the rig to run aground in Alaska. An investigation was conducted by the USCG and the associated Report of Investigation can be found here. The National Transportation Safety Board also published a Marine Accident Brief on the incident – see here.

In early August of this year, the *Transocean Winter* – a 17,000-ton semi-submersible drilling rig – went hard aground on the west side of the Isle of Lewis, Scotland. This incident is currently under investigation by the UK Maritime Accident Investigation Branch (MAIB). The USCG alert notes that it could have similar causal factors to the Alaskan incident.

One recommendation stemming from the USCG investigation on the *Kulluk* incident was the establishment of a workgroup to address the issues related to the towage of mobile offshore drilling units (MODUs) in high latitude environments. The workgroups final report was delivered to the Coast Guard during Q2 2016. The report provides valuable information for all organizations and professionals associated with towing large structures at sea, such as MODUs. The full report can be found here.

This USCG safety alert 14-16 can be downloaded here.

2 Be Alarmed by all Alarms!

The USCG has published the following marine safety alert regarding the possible consequences of failing to take proper actions when faced with alarm signals from equipment. Recently, Coast Guard marine inspectors experienced two different circumstances involving the alarm and control system of steering gear on board relatively new vessels.

The USCG safety alert notes:

"Although neither event resulted in a marine casualty, they serve as a reminder to the potentially dangerous results that may occur when an alarm system is deliberately ignored. A false sense of operational safety develops when crewmembers continually silence what they consider to be a "nuisance alarm," enabling a false perception of normalcy to develop.

Inspectors observed on two vessels that repetitive alarms occurred every time crewmembers performed steering tests that attempted to move the rudder through its range of motion. The alarms indicated that "hydraulic lock" events had occurred. Each time, the alarm was simply acknowledged by the crew and the steering gear adequately moved the rudder. However, no further investigation was conducted to identify the cause of the alarm.

It is well known that close calls and near misses occur more frequently than actual incidents. In this instance, the systems and alarms forewarned the operators of a problem. By ignoring the alarms, the crewmembers accepted a higher level of risk and reduced their safety margins. If the situation had been allowed to persist indefinitely, an unwanted incident could have occurred with potentially dire consequences.

As the result of these events, the Coast Guard strongly recommends that owner and operators ensure the following:

- *address the management of nuisance alarms in Safety Management Systems (SMS) and require immediate correction of their specific causes; and*
- *Include strict prohibitions against the pinning or securing of alarm acknowledgment buttons and switches. Such actions should be deemed as unacceptable corrective measures as they have contributed to serious marine casualties in the past.*

This safety alert is provided for informational purpose only and does not relieve any domestic or international safety, operational, or material requirements."

This USCG safety alert 16-16 can be downloaded here.

Members may wish to review the following similar incidents (search words: *alarm, ignored*):

- IMCA SF 19/14 – Incident 4 – *Collision and near miss caused by guard vessel;*
- IMCA SF 13/15 – Incident 1 – *Grounding and flooding of ferry – complacency.*

3 Lifeboat Launch Capability Compromised

Step Change in Safety has published the following safety alert regarding an incident in which lifeboat launch capability was compromised. The incident occurred when scaffolding was erected in close proximity to the lifeboat. It had been erected to allow safe access for sub-contract personnel to surrounding structures. During a worksite visit it was noted that the scaffold had been erected around the winch chain on the aft end of the lifeboat.

This would have rendered the lifeboat very difficult to launch. It was identified that the opening left to allow the winch chain and winch block to pass through was significantly smaller than the winch block itself. On the underside of the scaffold boards there was a scaffold pole support that would also have impaired the descent of the lifeboat.

The full report can be found here.

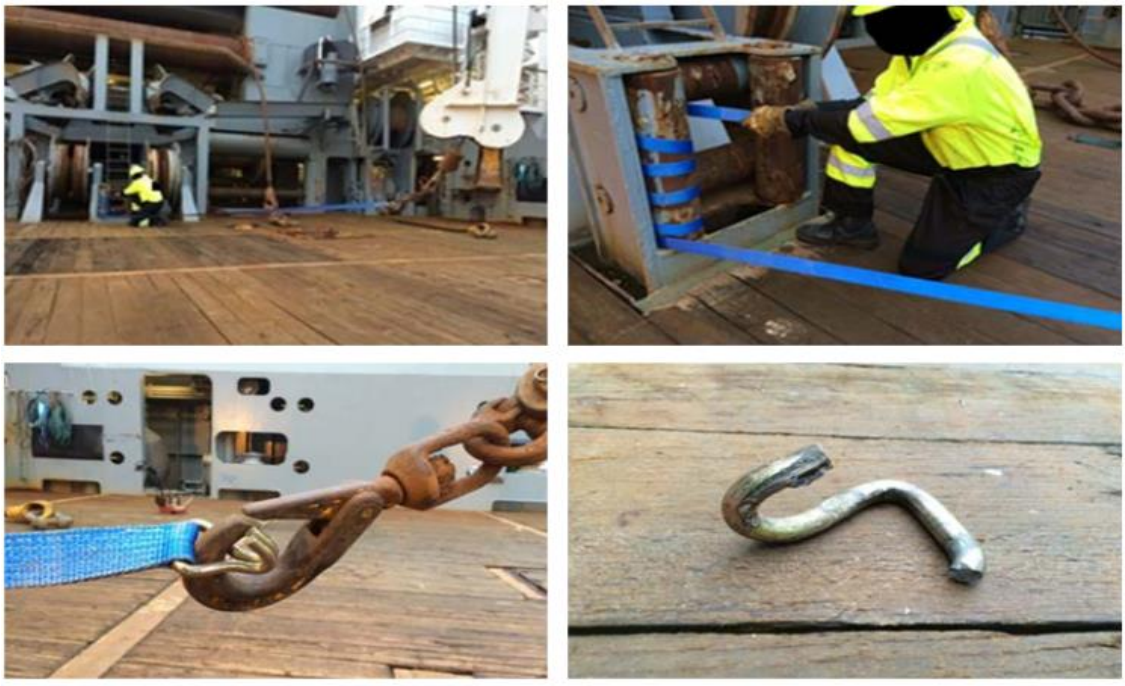
No similar incidents where safety equipment was obstructed by scaffolding were found. However, members may wish to refer to the following incidents (search words: *scaffolding*):

- IMCA SF 07/11 – *Near miss: personnel almost caught between crane house and scaffold pipe;*
- IMCA SF 15/13 – *Incidents involving use of scaffolding.*

4 Pallet Strop Hook Broke and Hit AB

The Marine Safety Forum (MSF) has published a safety alert regarding an incident in which a strop hook broke and hit a crewmember. The incident occurred during maintenance on deck. Vessel crew discovered a roller on a winch that was stuck. They decided to try and loosen it by using the rail crane fitted on the vessel. When the crane driver tried to pull it loose the pallet strap hook broke off the crane hook and hit a sailor in the back. He was severely injured.

The information provided by the MSF does not record what steps were taken to secure the pallet strop hook safely or the medical treatment provided to the injured person.



The brief and initial conclusions drawn are repeated here:

- The pallet strop hook was incorrectly secured to the crane hook making it much weaker than the safe working load (SWL) of the lifting strops;
- Equipment was used incorrectly;
- Crew were stood in the snapback zone;
- There was inadequate planning and risk assessment.

The full report can be found here.

Members may wish to refer to the following incidents (search words: *snapped. hook*):

- IMCA SF 02/10 – Incident 6 – *Fatality during anchor handling operations;*
- IMCA SF 15/15 – This safety flash concerns incidents during lifting operations.

5 Person Hit by Mud/Clay During Anchor Handling Operations

The MSF has published a safety alert number regarding an incident in which a person was hit by mud/clay during anchor handling operations. The incident occurred during recovery of anchors from the seabed. A person was injured when a 50 kg lump of mud/clay rolled onto his back as he was checking the identification number of a shackle. The injured person was a marine representative. The anchor was secured on deck and tension was off but the anchor had not been disconnected and moved to the stowage area. Most of the mud/clay had fallen off during the recovery but some mud/clay was still attached to the anchor.

The submitter of the report notes that the injured person did not see the hazard and as he was leaning down the mud/clay rolled off and hit him over his back. He fell and sprained his ankle and suffered pain in his back as the result of the incident.

It should be noted that it remains everyone's responsibility to **STOP** unsafe acts and to ensure all persons on deck are operating in a safe manner.

IMCA notes that the **root causes** of this incident are not in the report. Failure to properly control the worksite, inadequate risk assessment, and inadequate supervision, would appear to be amongst the causal factors in this incident.

The full report can be found here.