

## IMCA Safety Flash 13/12

December 2012

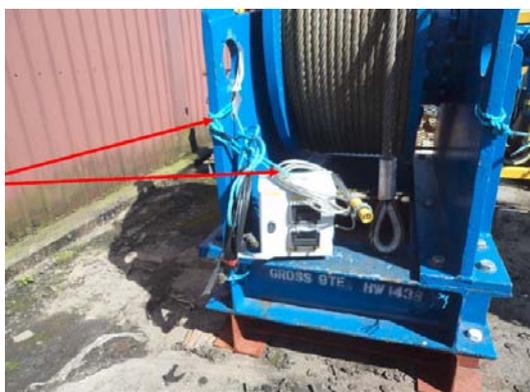
These flashes summarise key safety matters and incidents, allowing wider dissemination of lessons learnt from them. The information below has been provided in good faith by members and should be reviewed individually by recipients, who will determine its relevance to their own operations.

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](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)

### 1 Near Miss: Poorly Secured Load during Lifting Operations

A member has reported an incident in which equipment being back-loaded was found to be incorrectly and unsafely secured. The incident occurred during demobilisation of a third-party winch and running line monitor power supply unit (RLM PSU). It was noticed when this equipment was returned to the third party base that the RLM PSU had been secured to the winch frame using polypropylene rope in an unsafe manner. This could have resulted in the power pack becoming a potential dropped object or being damaged in transit.



*Red arrows illustrating how RLM PSU was secured to winch frame using polypropylene rope*



*Items appropriately secured with securing straps in place*

Our member's investigation drew the following conclusions:

- ◆ There was no identified storage area for the RLM PSU prior to the backload taking place. Appropriate storage areas should be identified for all third party equipment;
- ◆ Third party equipment such as the RLM PSU should be correctly packaged and secured before equipment load out/backload;
- ◆ All items should be thoroughly checked before lifting to ensure that appropriate securing arrangements are in place.

Members may also wish to refer to the following documents:

- ◆ IMCA SEL 019 – *Guidelines for lifting operations*
- ◆ IMCA SPP 04 – *Avoiding dropped objects*
- ◆ IMCA SPC 12 – *Avoiding dropped objects*
- ◆ IMCA SPC 04 – *Lifting operations*

### 2 LTI: Person Fell Over on Helideck and Broke Arm

The Marine Safety Forum (MSF) has published the following Safety Flash regarding an incident in which a helicopter landing officer (HLO) was thrown off his feet by turbulence from the helicopter as it landed. He fell on the helideck, breaking his arm. The immediate cause of the incident was that the HLO was not sheltering properly from the downdraft as the helicopter landed. The report can be downloaded from [www.marinesafetyforum.org/upload-files//safetyalerts/msf-safety-flash-12.41.pdf](http://www.marinesafetyforum.org/upload-files//safetyalerts/msf-safety-flash-12.41.pdf)

### 3 LTI: Serious Hand Injury during Subsea Lifting Operations

A member has reported an incident in which a diver injured his hand during subsea lifting operations. A diver was about to pull a 4m round sling (20 ton SWL) through a master link. While he was hanging the two-headed sling eyes on the corresponding hang-off point, his right hand thumb and index finger were sandwiched between the sling and hang-off point, resulting in a crush injury. The diver reported this to the dive supervisor immediately, and the supervisor arranged for emergency recovery of the injured diver. After he was recovered to surface, he received emergency medical treatment before being evacuated ashore by helicopter.



Injured hand



Illustration of the right hand position holding the sling (simulated)

The company's investigation revealed the following:

- ◆ The hang-off point was relatively short, approximately 13cm (see figure above right), while the diameter of the sling was 6cm, and the thickness of the two-headed sling eyes was 12cm;
- ◆ The sling had a tendency to come off the hook under the influence of wave surge;
- ◆ The moment the diver finished and left the area to wait for the lifting operation, the sling became unhooked, resulting in it being necessary for him to return and repeat the operation several times;
- ◆ After repeating the operation several times, the diver became irritable and grasped the sling in an incorrect way, putting himself in danger, resulting in the injury;
- ◆ The diver was working in the splash zone; the swell made it very difficult for him to control himself. The diver had reported that his bailout cylinder and helmet frequently hit the underwater structure.



Hook-off point in splash zone

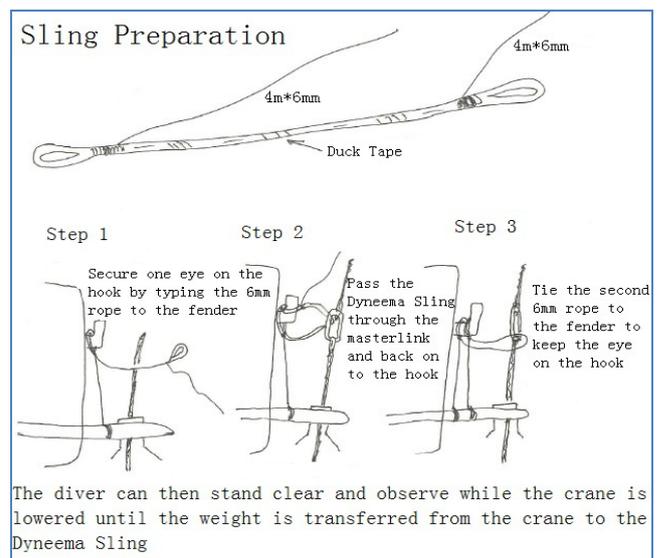


Diagram of revised operation procedure

Following safety stand-down, medical evacuation of injured person and appropriate discussion of the incident, the company took the following actions:

- ◆ Banded the 4m x 20Te SWL round sling and created plan to use two tail ropes to pull the round sling, avoiding the occurrence of unhook;
- ◆ Ensured all the divers understood about the change in work procedures.

#### 4 LTI Caused by Inadvertent Activation of Expired Line Throwing Device

A member has reported an incident in which a crewman was seriously injured when inadvertently struck by a line throwing rocket. The incident occurred when a search was made for a small diameter rope for use as a plumb line. Since no suitable rope was easily available, a member of the crew decided, without consulting anybody else, that the small diameter line from an old rocket assisted line throwing apparatus (LTA) could be used. Whilst trying to retrieve the line from the device, it slipped from the crew member's hands, dropped to the deck and unfortunately went off. A crew member was working nearby and was inadvertently struck, causing a deep cut on his left leg near the shin.



*Line throwing apparatus*



*Injured person's shin*

An investigation by the company noted the following:

- ◆ The LTA was uncontrolled and was not on any inventory list;
- ◆ The LTA had no safety pin or markings indicating date of manufacture, operating instructions or expiry date;
- ◆ There was inadequate control of spares and stock leading to a shortage of rope for the task in hand;
- ◆ The crew member took no account of the possible risk to himself and others in handling an explosive device.

The company made a number of recommendations particularly concerning pyrotechnic devices such as flares and rockets:

- ◆ Pyrotechnics should be controlled items, stored in a safe place, and only used by appropriately trained personnel;
- ◆ Pyrotechnics should be used only for the purpose for which they were intended or manufactured;
- ◆ Expired or 'out of date' pyrotechnics should be disposed of according to local regulatory requirements, and vessel crew should be fully familiar with company procedures and requirements for disposal;

The company made a number of further recommendations:

- ◆ Better control of work and toolbox talks might have prevented this incident;
- ◆ Vessel crew should be aware of vessel garbage management plan;
- ◆ Control of spares should be such that appropriate quantities of parts and stock are available for everyday operations.

#### 5 Fire in Engine Room Workshop

The Marine Safety Forum (MSF) has published the following Safety Flash regarding an incident in which there was a small fire onboard within the engine room workshop. The fire occurred when engineering personnel decided to conduct welding operations in the engine room workshop without informing anybody. The alarm was raised, the vessel emergency response team was mobilised and the fire was safely extinguished. There were no injuries.

The report can be downloaded from [www.marinesafetyforum.org/upload-files//safetyalerts/msf-safety-flash-12.42.pdf](http://www.marinesafetyforum.org/upload-files//safetyalerts/msf-safety-flash-12.42.pdf)