

Rigging incident

Safety Flash Published on 1 July 2000 Generated on 28 January 2026 IMCA SF 03/00

One of our Members has alerted us to an incident that occurred due to incorrect attachment of a personnel basket to a crane hook.

What happened?

Four people were being transferred from an FPSO to the deck of a barge some 30 metres below by a Billy Pugh personnel transfer basket suspended from the barge crane. The basket was rigged by the FPSO deck crew. As the basket has been lifted about 3 metres vertically and slewed towards the FPSO stern, it suddenly dropped and hit the FPSO handrail. One passenger jumped free onto the FPSO. One passenger was thrown clear, falling into the sea, the other two passengers fell into the sea with the basket. The three people in the sea received extensive injuries in the fall, but fortunately were quickly recovered and evacuated for urgent treatment. The other person was uninjured.

Our Member's investigation revealed the following:

Baskets of this type are fitted with two slings, one is provided as a safety sling and 'shock absorber' in case the main wire sling parts. The safety sling, which is usually longer than the steel wire sling, was attached to the master lifting ring by an adjustable swivel allowing more or less tension to be applied to the sling.

The evidence suggests that on this occasion, the basket was attached to the crane hook by placing the hook between the two slings rather than attaching the master ring to the hook. As a consequence, when the tension was applied to the rigging the safety sling, being longer, slid across the saddle of the hook until the swivel arrangement was horizontal across the saddle.

At this point the basket had been raised three metres. The adjustment/swivel mechanism bore the full load horizontally (designed for vertical loading) and broke at the base of the thread.

To prevent recurrence the company involved has initiated the following actions:

1. Ensure, by physical verification, that those responsible for rigging personnel baskets know how to attach the slings to the crane properly, and this is reflected in procedures.
2. The master ring is painted in a conspicuous colour to help crane operators see if the ring is engaged in the hook, prior to lifting.

3. Ensure that personnel using a personnel basket have the knowledge and opportunity to check the rigging prior to being lifted, and this is reflected in procedures.
4. The use of personnel baskets be minimised and eliminated where safer alternatives are available.

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