

Serious injury in towing operation

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We have received a report of an incident where three men working on the aft deck of a tug were seriously injured.

What happened?

The vessel had connected to a rig and was moving to a position from the rig, paying out tow wires as it did so. A team consisting of a mate and two able seamen was in safe position on the vessel waiting to fit the stop wire. When the vessel was approximately 150m from the rig, the men, led by the mate, went onto the deck to fit the stop wire, as they had observed that the tow wire was slack and that the guiding pins were up. They did this in contravention of the operating instructions, which required that the captain give permission for the crew to go onto deck – he had not done so. The vessel had not reached its final position and the captain was still paying out wire and manoeuvring the ship. The captain did not see the three men and continued to operate the ship as if they were not there. The tow wire tensioned up and this, coupled with the stern of the ship moving to port, led to the tow wire jumping the guiding pin and seriously injuring the men.

The master had not held a toolbox talk with his crew to highlight the risks of the job prior to commencement of the work.

The vessel had been hired to assist in the positioning of the rig, in line with company procedures, and the ship fulfilled the requirements with respect to physical capability, manoeuvring and the provision of a safety wire or other similar device.

The company carried out an investigation and identified the following points as ‘what went wrong’:

- Critical Factors
 - The crew had moved into an area of danger without permission to do so.
 - The captain had not known that they were there and continued to move the vessel.
- Immediate Causes:
 - Violation by the supervisor.
 - Violation by the individual.
 - Inadequate equipment – the bridge layout did not allow the captain to see the aft deck while manoeuvring the vessel.
- System Cause:
 - Poor judgement.
 - Inadequate reinforcement of critical behaviours.
 - Inadequate leadership.
 - Inadequate safety meetings.

- Inadequate enforcement of the procedures.
- Inadequate identification of worksite/job hazards.

The following actions for the tug boat operator were identified:

- Ensure knowledge of the safety management system throughout the organisation.
- Introduce signage on the vessel reinforcing the requirement not to go aft without the master's permission.
- Consider a 'time out for safety' system.
- Fully review and risk-assess procedures for connecting a towline on deck.

The tug boat operator is reviewing its procedures on 'stop' or 'Gob' wires and has undertaken to implement any technical or procedural improvements promptly.

The following actions were identified for the contracting company:

- In the relevant operating area, ban the indiscriminate use of stop wire mechanism in anchor handling/tug operations without appropriate caution with immediate effect until a study of the tow-wire control mechanism has been completed (see below);.
- Conduct a global study on the use and safety of stop wires and closed pins in anchor handling/tug work with recommendations within a four month period.
- Create a more detailed structured vessel spot hire process for relevant areas including clarity on accountability for boat acceptability and confirmation of toolbox talks between master and crew.

The key messages from this incident were identified as:

- Ensure toolbox talks and risk assessments are carried out for all tasks, including 'routine' ones, to reinforce procedures.
- Ensure communication systems are clear and are used during jobs.
- To ensure safer operation of all spot hire vessels, a more detailed and structured selection process is needed including a study of the stop wire.

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