

Near-miss: Dropped handrail/gate near moonpool

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A member has reported an incident in which a handrail gate was dislodged from its retaining points and fell 4.5 m to the deck.

What happened?

The incident occurred after crew members moved a lifting mandrel to secure it against a mezzanine deck. The lifting mandrel started swinging fore and aft, and a crew member went to the forward winch and attempted to draw on the lifting mandrel tension wire and secure it.

During this tensioning of the wire, the mandrel/wire rose under the lower bar of the mezzanine deck centre handrail gate, dislodging it from its retaining points. The handrail gate, which weighed 8kg and was 100cm across, fell 4.5 m to the deck, landed and bounced once.

There were no injuries, but it was calculated that such an object falling from that height might have caused a fatality had it hit someone. Hence the event was categorised as a high potential near miss.

Findings

The company's investigation revealed that:

- The immediate cause of the incident was that the lifting mandrel/wire had caught on the lower bar of the mezzanine deck centre handrail gate, as a result of someone winding in on the constant tension winch attached to the lifting mandrel without appropriate directions from the lift supervisor.
- An All Stop was not called when it was realised that the lifting mandrel was swinging forward to aft.
- There was inadequate communication between the crew man and the lift supervisor regarding his intended actions to secure the lifting mandrel. There were actions which were undirected and unexpected by the lift supervisor.
- While securing the lifting mandrel, the crewman was unable to fully see the lifting mandrel from his location while operating the winch.

What were the causes?

The underlying causes associated with the incident were:

- **Inadequate supervision:** The crewman was so focused on recognising that the lifting mandrel should be moved, to stop it swinging, that he acted immediately to correct this problem, losing sight of the overall picture. He failed to instigate standard controls specifically using the All Stop process to communicate his concerns with his team, highlight the hazards/risks and re-assess the situation as per the toolbox and All Stop process, and to ensure sufficient direction was given by the lift supervisor (and agreed lift team) in moving the lifting mandrel safely, and not blindly.
- **Inadequate communication:** The intention of the crew member to wind in the winch attached to the lifting mandrel was not properly communicated to the team. The lift supervisor did not see this happening.
- **Inadequate design:** The design of the handrail gate and its method of retention were such that there was no mode for secondary retention, which would (had the gate become dislodged) have prevented it from falling. The potential for the handrail gate to be a dropped object hazard was not identified and/or controls put in place, i.e. secondary retention or different design of the handrail gate, when this section was made and/or modified to allow for access during derrick activities. Thus the handrail gate design allowed for it to lift up and off, without any means of preventing it from dropping to the deck below.

Actions

The following corrective and preventative actions were taken:

- A thorough DROPS survey of the area for loose items and potential dropped objects.
- A thorough check for any other potential wire rope/handrail clashes.
- Procedures altered to ensure checking for clashes of this sort takes place in future.
- Re-design of gate to ensure a more positive means of locking/securing.

Lessons learnt

The following lessons were drawn from the incident:

- Good verbal/visual communication should be maintained during lifting operations.
- A banksman should be used at all times during any 'blind lifts' to continually monitor the area for potential clashes, changes to the work area, security of the load, etc.
- Personnel should remain focused on the task and potential consequences

both prior to and during lifting operations, particularly during 'routine' lifts.

Members' attention is drawn to the following IMCA material which may be of assistance:

- [IMCALR006](#) - Guidelines for lifting operations
- [Avoiding dropped objects \(poster\) and \(pocket card\)](#)
- [Lifting equipment \(pocket card\)](#)
- [Working at height \(pocket card\)](#)

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