

Near-miss incidents during personnel transfer to offshore renewable energy installations

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A Member has reported a number of near miss incidents involving a workboat used to service wind turbine towers in the offshore wind farm sector. The near misses related to marine growth on the ladders and boat landing push tubes, which became exposed during a period of exceptionally low tides.

Incidents 1 and 2

In the first near miss incident, a technician slipped whilst on the rung of a ladder on the side of the turbine tower, but recovered – there was no injury or damage. The ladder was cleaned by scraping the rungs with a sharp tool.

In the second near miss incident, some days later, a technician reported that he had caught his knee on a protruding barnacle on the boat landing push tube. His immersion suit was not damaged and he was not injured.

Our member noted the following:

- The incidents occurred at a period of extremely low tides which exposed parts of the boat landing normally submerged.
- Not all small workboats are fitted with pressure washers so cleaning of boat landings might have to be performed manually.
- The manual method of cleaning by scraping the ladder rungs with a sharp tool was not effective.
- Although there was no injury or damage, the crew correctly reported the incidents and proposed revised methods of working.

The following actions were taken:

- A change to the method of cleaning -using a stiff brush and wiping with a rag: this was implemented the next day.
- Revision of risk assessment for personnel transfer to turbine towers.
- Amendment of company procedures to reflect new technique.

Incident 3

A technician transferring from a small workboat to an offshore wind turbine tower was snatched by his fall arrest device when the bow fender slipped on the boat landing.

Our member noted the following:

- The bow slippage was caused by an unanticipated wave trough.
- The wind farm operator had made a recent revision to the transfer method, to ensure that the transferring technicians were connected using fall arrest devices when on the deck of the vessel and not to disconnect until back on the deck.
- This revision did not include a step where slack in the tag line is handed to the attending deckhand to ensure that the line does not become caught if the bow slips.
- Concerns were raised about who should be watching for unexpected waves as it seems that everyone was concentrating on the transfer.
- A similar incident had been reported before but the revisions to procedures made at that time as a result were not wholly effective.

The following actions were taken:

Working in co-operation with the client, our member made a thorough revision of the procedures for personnel transfer in this context, particularly addressing the following:

- Slack in the fall arrest tag line should be handed to the deckhand.
- The Master is responsible for monitoring the passing wave sets and warning the crew of any changes.

Incidents 1 and 2 – Members may also refer to the following similar incidents (key word: ladder):

- [Pilot ladder safety](#)
- [Pilot ladder failure](#)

(Key issues in both – housekeeping and corrosion).

Members may also refer to the following similar incident (key words: turbine, slip):

- [Lost time injury \(LTI\): Crewman injured foot during offshore renewables mooring operation](#)

Incident 3 – Members may also refer to the following similar incident:

- [Crew transfer vessel trapped under a boat landing](#)

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