IMCA Safety Flash

Near miss: Crewman struck on head by crane hook (Marine Safety Forum)

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The Marine Safety Forum (MSF) has published Safety Alert 18-26, in which an AB was struck on the head by a crane hook during routine deck cargo transfer operations.

IOGP Life Saving Rules:

Bypassing safety controls

Safe mechanical lifting

What happened?

A platform supply vessel (PSV) was carrying out the routine deck cargo operations at an offshore installation. Two crew on deck were routinely hooking on and off cargo as it was being discharged and back loaded to and from the vessel. Shift change was due, so after discharge of the cargo carrying unit (CCU), the crew moved to the forward end of the cargo deck for shift change. However, before departing from deck, there was no routine check of the next CCU to ensure it was ready for discharge; this critical step was overlooked.

The crane was landing the previous CCU on the installation deck whilst the crew completed their handover on the PSV's deck. The oncoming crew were waiting in the 'safe area' for the crane hook to return to vessel in order to attach the next CCU. As the crane hook was being lowered, the new crew noticed that the lifting bridle was snagged; their attention was immediately drawn away from the approaching crane hook as they freed the lifting bridle. This took only a matter of seconds; they then stood back to look up for the crane hook, which had continued its descent to the deck unchecked by the crane operator.

As one of the crew looked up at the crane hook, it struck his hard hat before continuing its descent to the vessel deck. Luckily, his hard hat did the job and he was uninjured.

What went wrong? What were the causes?

Several critical factors were identified from this incident:

- There was a shift change as soon as the previous CCU had been discharged.
- Neither shift ensured that the lifting bridle on the next CCU was clear and ready to hook.
- When the new crew noticed the lifting bridle had snagged, their attention was drawn away from the approaching crane hook.
- Crew did not contact the crane operator to advise him to stop lowering the crane hook whilst they handled the snagged lifting bridle, therefore the crane operator did not realise that their attention was elsewhere.

The **root cause** was deemed to be failure to follow established routine and best practice procedures:

- There was a breakdown in communication between the crew and the crane operator; the crane operator should have been advised by radio and/or hand signals to stop lowering the crane hook.

- Crew should use available time when the previous CCU is discharged to inspect the next CCU and ensure that it is ready for hooking onto the crane hook when lowered.

- If extra time is needed for shift change, 'stop the job' and take the required time for handover.

What actions were taken?

- Investigation found that neither the vessel operators' nor the crane operators' procedures provided clear, detailed guidance on how cargo transfer operations should be conducted. Both parties were requested to review and update their procedures.

- The client imposed step-by-step instructions to be followed by all involved in cargo transfer operations, in order to allow the operators time to update their procedures accordingly.

The full safety alert can be found on the MSF website.

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