

## Rigger sustains injury to left hand

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A rigger was struck by a lever hoist hook, which led to a restricted work case.

### What happened?

The incident occurred during lifting operations and had the potential to have resulted in a more serious outcome.

Two vessels were engaged in offshore vessel to vessel lifting operations.

A heavy lift crane was being used to lift and land the load – a product reel – from one vessel to another, when the load moved in an unplanned and unexpected way.

### What went wrong?

- Throughout the operation, banksmen on one vessel and project riggers on the other were not communicating with each other as they were operating on different radio channels.
- To aid the landing of the reel onto the cradle, changes were made to the ballasting of the crane vessel, which altered the position of the crane boom and thus caused the load to move in an unexpected way. This ballasting operation was not communicated to the project riggers on the other vessel.
- The movement of the load happened just as the project riggers connected three 6.3Te lever hoists to the load to aid its final positioning onto a cradle.
- The reel swung approximately 1.5 metres towards the riggers. This movement caused the 3 lever hoists to lose tension and disconnect. The reel then moved back towards the port side, allowing two of the lever hoist hooks to snag and come under tension.
- The riggers realised what was happening and rushed in to disconnect the lever hoists. One lever hoist was disconnected however, tension on the second lever hoist became too great, resulting in the hook disengaging from its snagging point in an uncontrolled manner and striking the rigger on the hand.

### What were the causes?

Our Member notes that this incident could have resulted in a far more serious injury or a fatality. Our member considered that the decision to use lever hoists for this type of operation was flawed and dangerous.

#### IOGP Life Saving Rules:



Work authorisation



Safe mechanical lifting

- The introduction of the lever hoists was not identified as a change and therefore was not managed via the management of change (MoC) process.
- There was ineffective communication between the banksman on the one vessel and the rigging supervisor and riggers on the other.
- The centre of gravity of the load was offset and was not corrected.
- Procedures and lift plan were not followed.
- There was insufficient 'line of fire' toolbox talk (TBT) and risk assessment.
- Personnel may have put themselves at further risk by reacting without understanding the danger.

## What lessons were learned?

- Personnel should keep clear of suspended loads until safely landed.
- Any change or deviation from procedures or lift plans, even minor, needs to be subject to a MoC process.
- Communications between all members of the lifting party is crucial and should be established before work starts.
- Load centre of gravity should be confirmed and lift rigging adjusted accordingly before lifting starts.
- Lever hoists may not be appropriate in a dynamic application during ship to ship operations and, in this case, were not used in compliance with manufacturers guidance.

Members may wish to refer to:

- [IMCA HSS001](#) – Guidelines for management of change
- [IMCA HSS019](#) – Guidelines for lifting operations

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